Hull University Teaching Hospitals NHS Trust

Trust Board Meeting Held In Public

Tuesday 9 November 2021
9.00 am – 12.00 pm

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

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

Agenda

1	**Apologies and welcome**	verbal	Stuart Hall – Acting Chair
2	**Declarations of Interest**		
	2.1 Changes to Directors' interests since the last meeting	verbal	Stuart Hall – Acting Chair
	2.2 To consider any conflicts of interest arising from this agenda	verbal	Stuart Hall – Acting Chair
3	**Minutes of the previous meeting**		
	3.1 Minutes of the meeting held 13 July 2021	attached	Stuart Hall – Acting Chair
	3.2 Board Reporting Framework	attached	Rebecca Thompson – Head of Corporate Affairs
	3.3 Board Development Framework	attached	
4	**Matters Arising**		
	4.1 Action Tracker	attached	Rebecca Thompson – Head of Corporate Affairs
	4.2 Any other matters arising	verbal	Stuart Hall – Acting Chair
5	**Patient Story**	verbal	Makani Purva – Chief Medical Officer
6	**Standing Orders and Governance**		
	6.1 CEO Report and Covid Update	attached/verbal	Chris Long – Chief Executive Officer
	6.2 Ambulance Handovers	attached	Chris Long – Chief Executive Officer
	6.3 Committees in Common Summary	attached	Stuart Hall – Acting Chair
	6.4 Audit Committee Summary	attached	Tracey Christmas – Audit Chair
	6.5 Standing Orders	attached	Rebecca Thompson – Head of Corporate Affairs
	6.6 Board Assurance Framework – Q2	attached	Rebecca Thompson – Head of Corporate Affairs.
7	**Performance/Finance/Quality/Workforce Reports**		
	7.1 Integrated Performance Report	attached	Ellen Ryabov - Chief Operating Officer/Lee Bond – Chief Financial Officer/Beverley Geary – Chief Nurse/Makani Purva – Chief Medical Officer/Simon Nearney – Director of Workforce and OD

	7.2 Summary and minutes from the Performance and Finance Committee	attached	Mike Robson – Chair of Committee
	7.2.1 Finance Report	attached	Lee Bond – Chief Financial Officer
	7.3 Summary and minutes from the Quality Committee	attached	Stuart Hall – Chair of Quality Committee
	7.3.1 Quality Report 7.3.2 IPC BAF Report 7.3.3 IPC – 6 Month Update Report	attached attached	Beverley Geary – Chief Nurse, Suzanne Rostron – Director of Quality Governance, Greta Johnson – Director of Infection, Prevention and Control
	7.4 Summary and minutes from the Workforce, Education and Culture Committee	attached	Una Macleod – Chair of Committee
	7.4.1 Workforce Report	attached	Simon Nearney – Director of Workforce and OD
	Board Reports		
	8.1 Freedom to Speak up Report	attached	Fran Moverley – Freedom to Speak up Guardian
	8.2 Digital Strategy Report	attached	Alastair Pickering – Chief Information Officer
	8.3 Responsible Officer Report	attached	Makani Purva – Chief Medical Officer
	8.4 Cardiology Report	attached	Makani Purva – Chief Medical Officer
	8.5 EPRR Annual Report*	attached	Michelle Cady – Director of Strategy and Planning
	8.6 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year	attached	Beverley Geary – Chief Nurse
	8.7 Perinatal Mortality Review Tool	attached	Beverley Geary – Chief Nurse
	8.8 Research and Innovation Update	attached	James Illingworth – R&I Manager
9	Questions from the public relating to today's agenda	verbal	Stuart Hall – Acting Chair
10	Chairman's Summary of the Meeting	verbal	Stuart Hall – Acting Chair
11	Any Other Business	verbal	Stuart Hall – Acting Chair
12	**Date and time of the next meeting:** Tuesday 11 January 2021 9am – 12pm		

Attendance 2021/22

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

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board
Held on 14 September 2021

Present:	Mr Hall	Acting Chair
	Mr Robson	Non-Executive Director
	Mr Curry	Non-Executive Director
	Prof Macleod	Non-Executive Director
	Mrs Jackson	Associate Non-Executive Director
	Dr Pathak	Associate Non-Executive Director
	Mr Bond	Deputy Chief Executive Officer
	Mrs Ryabov	Chief Operating Officer
	Mrs Geary	Chief Nurse
	Dr Purva	Chief Medical Officer
	Mr Nearney	Director of Workforce and OD
	Ms Kemp	Director of Strategy and Planning
	Mrs Rostron	Director of Quality Governance
In Attendance:	Mrs Harrison-Mizon	Director of Operations – Family and Women's HG
	Mrs Thompson	Head of Corporate Affairs (Minutes)
	Mrs Boulton	Quality Governance Officer

No	Item	Action
1	**Apologies** Mrs T Christmas, Non-Executive Director, Mr C Long, Chief Executive Officer	
2	**Declarations of interest** **2.1 Changes to Directors' interests since the last meeting** There were no declarations made. **2.2 To consider any conflicts of interest arising from this agenda** There were no declarations made.	
3	**Minutes of the previous meeting** Item 6.1 CEO update – High volume of Mental Health patients to be changed to, "an increasing number"….. The lead NED for the Green plan to be confirmed. Item 7.2 Quality Report – Mrs Rostron asked that the HSMR paragraph read that performance had improved and numbers had come down. Item 8.1 Our People – paragraph 8 – the final sentence to be removed. Item 9.1 – The deficit should read year to date and Gamma Camera to be removed from paragraph 6. Following these changes the minutes were approved as an accurate record of the meeting. **3.2 Board Reporting Framework** Mrs Thompson presented the framework and advised that the areas marked in green showed that a report had been received. There were no further issues raised.	

3.3 Board Development Programme
The Board Development Programme was received by the Board.

4 Matters Arising

4.1 Action Tracker
The medical establishment review would be discussed at the Workforce, Education and Culture Committee in October 2021.

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

5 Patient Story
Dr Purva introduced the item which was a patient story about a young lady with a rare syndrome who was rapidly diagnosed and got the appropriate treatment quickly. The patient's Mum had written to the Trust to thank the staff that had cared for her daughter.

The patient stated that all the staff were very caring and the student nurses made time to visit her to make sure she was alright. She added that all of the nurses linked to her care went above and beyond and she was never kept in the dark about her treatment.

6 Chief Executive Officer Report
Mr Bond presented the report and advised that there had been 900 patient deaths in the Trust since the pandemic began. He added that the emergency services were under pressure as was the whole health system.

Mr Bond spoke of the Zero 30 climate change initiative and the ambitious solar farm programme at Castle Hill Hospital. Prof Macleod suggested that the Trust worked with the University on the green agenda. Mr Bond agreed to discuss this with Mr Taylor and link in with the University equivalent.

Dr Pathak asked Mr Bond about cycle facilities and other modes of transport due to the car-parking issues and Mr Bond advised that there was lots of work reviewing changing facilities and storage for bikes.

6.1.1 Future new hospitals – expression of interest
Mr Bond presented the report which highlighted the Trust's and NLAG's expression of interest for a new hospitals programme that the Government were underwriting. The funding was massively over-subscribed with 30 organisations so far submitting bids.

The Humber-wide bid was to re-build Scunthorpe hospital, make improvements to HRI and CHH sites as well as Grimsby hospital. The outcome of the expression of interest was not expected until Christmas.

Resolved:
The Board noted the expression of interest and the Humber-wide bid submitted.

6.2 Committees in Common Summary
Mr Hall presented the summary and highlighted the expression of interest and the Oncology update which had been discussed in detail at the meeting.

The Oncology communications had been agreed and would be discussed at the next meeting.

Resolved:
The Board received and accepted the summary.

6.3 Audit Committee Summary
Mr Robson presented the summary and highlighted the item that had reasonable assurance relating to Single Source Waivers. There was a piece of work ongoing within the Contracts Team to review contract coverage. The outcome of this work would be presented to the next Audit Committee in October.

Resolved:
The Board received and accepted the summary.

7 Performance

7.1 Integrated Performance Report
Mr Hall introduced the report which showed the work in progress so far. The report would focus the Board's discussions to the items of high concern shown by SPC charts and exception reporting.

Mr Curry welcomed the report and wanted it to be clear on which areas the Board would be focussing on. Mrs Rostron advised that the BI team had worked really hard to ensure the datasets were transferred over and a separate task and finish group would be established to take the report further. Mr Bond added that it would take time for the report to be completed and would be work in progress for a while.

Mrs Jackson advised that it was key to identify the mandated and local targets, keep a track on who is the data owner and ensure the Executive team had an opportunity to review and sign off before publication.

Resolved:
The Board received and accepted the work in progress IPR.

The agenda was taken out of order at this point

8.8 Performance Report
Mrs Ryabov presented the report that had already been received and discussed in detail at the Performance and Finance and Committee.

Mrs Ryabov advised that the urgent care pathway performance was at 72.8% which had been fairly static but would deteriorate in September. This was a regional and national issue due to the number of Covid patients, GPs being under pressure and an increase in paediatrics patients.

Mrs Ryabov reported that NHS England's Emergency Care Intensive Support Team had visited the Trust to carry out a Missed Opportunities audit to determine which patients reviewed over a 24 hour period could have been seen elsewhere. Mrs Ryabov added that there were a large proportion of patients that were neither accident or emergency. Issues were being compounded by social care and care in the community also deteriorating.

Mrs Ryabov advised that there were 72 Covid patients in the hospital at the moment and the ICU was also under pressure. Mrs Ryabov expressed her concern for the winter pressures, Covid, Flu, Norovirus and delivering the elective programme. Work was ongoing to manage day cases where possible and reduce elective in-patients.

Cancer performance was static but was not meeting the standard, mainly due to diagnostic challenges.

52 week breaches continued to reduce as did waiting list volumes. The biggest risk going into winter was whether the workforce would be available to carry out the elective work.

Resolved:
The Board received and accepted the report.

7.2 Summary and minutes from the Performance and Finance Committee
Mr Robson advised that the Trust was not achieving its targets but there were plans in place to mitigate the risks. He added that the Performance and Finance Committee took assurance that everything that could be was being done.

Mr Robson also advised that the financial underlying run rate was an issue and would need to be managed.

Dr Pathak asked if the Trust was using the private sector and Mrs Ryabov advised that they were being used as much as possible.

Mr Bond added that it was not just Hull struggling with their elective programme and that the whole region was under pressure and staffing was the limiting factor in most cases.

Resolved:
The Board received and accepted the summary.

7.2.1 PDC Capital Application
Mr Bond presented the proposal to the Board for approval. He advised that the Trust did not have sufficient cash resources to complete the ICU replacement Gamma Camera so NHS E/I had been approached for support with the expenditure. In order to have the project underway and place the order the Trust was using its own money until the funding was released.

Resolved:
The Trust Board approved the PDC capital application.

7.3 Summary and Minutes from the Quality Committee
Mr Hall presented the report and advised that the Committee had received a HSMR update and a proposal regarding the Quality Committee sub-committees.

Resolved:
The Board received the summary and minutes from the Committee.

7.4 Quality Committee Terms of Reference
Mr Hall presented the Terms of Reference and advised that the changes were job titles, a quoracy update and changes to the sub-committees reporting to the Committee.

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

7.4 Summary and minutes from the Workforce, Education and Culture Committee
Prof Macleod presented the summary and minutes from the Workforce, Education and Culture Committee and highlighted the ongoing cultural discussion relating to the Junior Doctors.

Resolved:
The Board received and accepted the summary and minutes from the Committee.

8 Board Reports

8.1 Covid 19 Report
Mrs Kemp presented the report and advised that the Trust was in its 3rd wave of Covid activity and emergency preparedness. The Silver Command group which had been stepped down in May had been stepped back up in July and was meeting weekly.

The planning for Covid and the winter pressures was underway. Issues were being managed and funding prioritised. The Trust was also working with system partners to ensure the most effective and safe care for patients.

Dr Pathak asked why the Lamp testing had such a low uptake and Ms Kemp advised that the difficulty was because of the nil by mouth 2 hours before taking the test. This was not always feasible in practice.

Resolved:
The Board received and accepted the report.

8.2 EPPR Framework
Ms Kemp presented the report and advised that a self-assessment had been carried out and the Trust was compliant with 44 out of the 46 EPRR standards.

The 2 partially compliant standards would be subject to deep dives. A Task and Finish Group would be established to take forward the work in relation to medical gases and oxygen supply.

Ms Kemp advised that the EPPR processes were very resilient during the peaks of the pandemic and a strong assurance report had been received. Mr Hall commended the team on their hard work and positive position.

Mr Robson asked about flood resilience and Ms Kemp advised that the East Coast flood programme was a priority.

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

8.3 Workforce Race Equality Standards
Mr Nearney presented the report and advised that lots of work had been carried out and improvements made.

A BAME network had been established and was run well by Dumbor Ngaage.

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

Improvements have been made across the following indicators:
• The total number of BAME staff has increased across the staff groups by 162 (from 1266 to 1428) which is a positive, however further work to provide career progression opportunities to BAME colleagues needs to continue (in line with the national WRES Model Employer goals).
• BAME staff continue to be less likely to enter into the formal disciplinary process compared to White staff.
• BAME staff are marginally more likely to access non-mandatory training and CPD compared to White staff

The Trust will continue to work with the BAME Leadership Network and BAME colleagues across the Trust to close the gap between the lived experience for BAME colleagues and other staff groups.

Prof Macleod added that the key question to ask was what it was like to be a BAME member of staff if you are not a senior doctor. This would be given due diligence at the Workforce, Education and Culture Committee.

Resolved:
The Board received the WRES report and noted the contents.

8.4 Workforce Disability Equality Standards
Mr Nearney presented the WDES report and advised that Mrs Hillerby was the lead for the new Disability Network and was working with disabled staff to make substantial improvements.

Resolved:
The Trust Board received the WDES return and action plan and approved them.

8.5 Hospital Standardised Mortality Ratio Report
Dr Purva presented the report and advised that it had been received at the Quality Committee in August were it had been discussed in detail.

Dr Purva advised that a Task and Finish Group had been established following performance showing the Trust as an outlier. An external report was commissioned. The report highlighted that there had been no deterioration in the standard of care and no failing standards.

The peaks of the HSMR outlier status correlated with the peaks of the pandemic which gave good assurance and now the levels had reduced again in line with the easing of the pandemic.

Mr Robson asked about obesity and Covid as it was not mentioned in the report. Dr Purva advised that although obesity was a key contributory factor there was nothing out of the ordinary to report.

Resolved:
The Board received the report and took assurance from the findings of the review.

8.6 Quality Report
Mrs Geary presented the report and advised that there were 72 Covid positive patients currently in the hospital and there was also an impact on the ICU. Mrs Geary advised that the Trust had taken learning from previous outbreaks and now all patients were being tested before they were moved.

Mrs Geary advised that there had been a reduction in the C-Difficile threshold from 80 to 53 and the Trust could be fined for not achieving the threshold.

Feedback had been received from NHS I in relation to the Infection Reduction Board Assurance Framework and this would be updated and presented to the Board in due course.

Mrs Geary highlighted that the Trust had reported a Never Event relating to a wrong implant. The issue was resolved at the time and the Duty of Candour progress carried out.
There had been an increase in patient incident numbers and a reduction in falls with harm. Work was ongoing to review the Community acquired pressure ulcers to reduce them.

Mrs Geary expressed her concern about the quality impact because of the pressure the hospital was under as well as the whole system. The detail was being discussed at the Quality Committee but areas of concern were long waits in ED and ward moves as Covid numbers increase. Mrs Ryabov added that the level of risk being carried each day was increasing month and month.

Resolved:
The Board received and accepted the report.

8.6.1 Perinatal Quality Surveillance Tool
The report was received for information and had been scrutinised at the Quality Committee and reported to the LMS.

Resolved:
The Board received and accepted the report.

8.6.2 Perinatal Mortality Review Tool Report for CNST
Mrs Geary presented the report which had been presented at the Quality Committee in August 2021. Work was ongoing regarding the Continuity of Care plans that had to be in place for 2023. There were significant financial and workforce implications to be worked through.

Resolved:
The Board received and accepted the report.

8.7 Finance Report
Overall Trust income is £13.6m above the initial plan. £6.4m of this relates to additional income to offset costs of vaccination programme (£5.2m), testing (£0.9m) and deployment of final year nursing students (£0.3m). All these items were excluded from the initial plan.

£5.4m relates to cost of additional pass through drugs and devices from NHSEI. £3.0m relates to additional income above plan from the Elective Recovery Fund in the first quarter. £8.7m has been assumed delivered to date. This is above the full plan for H1 (£7.5m) but based on the centre increasing the baseline delivery for Q2 to 95% the Trust is not expecting to receive any additional income above the £8.7m. £0.7m mainly relates to improved car parking income (£0.2m) and Income generation schemes (£0.4m). The level of income from Injury Compensation scheme is £0.15m below plan.

NHSEI have indicated that they will provide further guidance on H2 in September 21 with plans due to be submitted in October 21. Early indications are that the block contracts from H1 will be rolled over but there may a reduction in the level of Covid19 funding available. Elective Recovery Funding is expected to continue but there will also be an increased efficiency requirement of up to 3% required from October 21. This is now being classed as 'waste reduction.'

The current position is reported as a deficit of £47.8m.

The Trust had spent £10m in Capital to date and work was ongoing. The liquidity position was healthy and debtors were under control.

Mr Bond advised that 2022/23 planning was key to create certainty.

Resolved:
The Board received and accepted the report.

8.9 Workforce Report
Mr Nearney presented the report and advised that staff sickness due to Covid was reducing and was at 153 staff off currently.

The vacancy rate was at 4.1% which was a positive position.

The flu vaccination programme was commencing and the Covid booster programme would commence at the end of September 2021.

Mr Nearney mentioned the Apprenticeship Programme and that there were 500 staff currently employed on it.

The leadership programmes had now been restored in full.

Mr Hall asked about Covid sickness and asked why the Trust's results were so high. Mr Nearney advised that the organisation was very cautious with Covid sickness and self-isolating which was based on 10 days and having minor ailments. He added that he was 100% confident that the data was accurate.

There was a discussion around the flu vaccination and how this would be administered to front line staff. Mr Nearney advised that it would be given in the Medical Education Centre at HRI and the lecture theatre at CHH.

Resolved:
The Board received and accepted the report.

8.10 Community Paediatrics Report
Mrs Harrison-Mizon presented the report which highlighted the clinical review of the issues arising from the transfer of Community Paediatrics to HUTH from City Healthcare Partnership CIC.

The review had been carried out and 12 patients that may have come to some harm identified.

The work was overseen by the Community Paediatric Oversight Group and although there had been a delay in follow ups initially, access plans were now in place and were being managed. There was clarity of roles and responsibilities and a strong clinical management team and attracted substantive consultants.

The conclusion of the report stated that despite workforce challenges, the reconfigured Community Paediatric Services should be much better placed to care for this vulnerable group of patients and to be an exemplar of good paediatric practice.

Resolved:
The Board received and accepted the report.

11 Any Other Business
Mr Hall presented the Ethics Committee Terms of Reference that had been changed to state that the Committee will be stood up on demand rather than meet quarterly.

Resolved:
The Board received and approved the updated Ethics Terms of Reference.

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

10 Chairman's summary of the meeting
Mr Hall stated that there had been little holiday season this year and the Trust was now gearing up for the winter and flu season with no summer pause. He thanked all staff and stated that the Board was very grateful for the commitment and enthusiasm shown in these difficult times.

12 Date and time of the next meeting:
Tuesday 9 November 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
8 June 2021			BAF 2: Equality, diversity and inclusion, Staff Survey, Staff wellbeing	BAF 3.2: Risk of harm to patients due to long waits	BAF 4: Risks to the Recovery Plan				
10 August 2021							BAF 6: Research and Innovation		Board Well-Led self-assessment Making data count training
12 October 2021		BAF 1: Board Leadership/ Leadership and culture				BAF 5: Risk that the HCAV and Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid recovery			CQC – Quality Risk Profile
14 December 2021	Strategic drivers/balanced scorecard review			BAF 3.1: Risk that the Trust is not able to make progress in continuously improving quality					Green Plan IPR Review Patient Safety
8 February 2022					BAF 4: Risks to recovery plan			BAF 7: Financial Sustainability	Estates/IT Strategy Update IPC End of Life Care

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 (November 2021)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
September 2021						
COMPLETED						
01.05	Minutes March 2021	Medical Staffing Review plan update to be received	MP/LB	December 2021		To be received at the Workforce, Education and Culture Committee

Actions referred to other Committees

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

Hull University Teaching Hospitals NHS Trust

Trust Board

9 NOVEMBER 2021

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

Purpose:	Inform the Board of key news items during the previous month and excellent staff performance.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	
	High quality care	
	Great clinical services	
	Partnership and integrated services	
	Research and Innovation	
	Financial sustainability	
Key Summary of Issues:	Cyclotron, Zero30 updates, national award winner, Queen's centre acute assessment unit	

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

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 9 NOVEMBER 2021

1. Key messages from September/October 2021

Research, development and innovation - Cyclotron delivered to Castle Hill Hospital
The Daisy Appeal charity, which is working to develop "dose-on-demand" radiotracers with improved detection and personalised treatment for patients with cancer, heart disease and dementia has taken a big step towards its goal with the delivery to Castle Hill Hospital of a consignment of UK-leading PET-CT scanning and research equipment.

The cyclotron components arrived at Castle Hill Hospital, Cottingham, and were transferred in a series of crane lifts over the roof of the admin building to the loading bay at the new Molecular Imaging Research Centre (MIRC). The pieces are being assembled in the new building and the cyclotron will become operational early in 2022.

The Daisy Appeal Medical Research Centre opened at Castle Hill Hospital in 2008 and was followed, in 2014, by the opening of the Jack Brignall PET-CT Scanning Centre, housing the first in a new type of Siemens scanner in the country. But with the radiotracers used in the Jack Brignall Centre having a short life span, the Daisy Appeal's vision was to raise funds for the MIRC and pursue a "dose-on-demand" approach by making their own isotopes.

The total cost of the new centre is around £8.5m, including equipment to the cost of about £3.5m, about £1m of which is accounted for by the cyclotron components.

The provision of cutting-edge cyclotron technology in Hull elevates the Trust to the level of a handful of clinical sites in the UK, and will enable us to deliver improved clinical imaging to diagnose and monitor treatment response in cancer, cardiac and neurological patients. The technology will also improve our research, which is already internationally competitive, and attract clinical trials to Hull to further improve standards of patient care.

Zero30 – 20,000 new LED lights fitted at the Trust
Wards, clinics and offices at Hull Royal Infirmary and Castle Hill Hospital have been fitted with new LED lighting to reduce the impact of Hull's hospitals on the environment.

Our Trust has introduced 20,000 LED light fittings at both hospitals and hospital buildings across East Yorkshire to cut its energy bill.

The major relighting project, overseen by our capital team, began in December 2020 and has just been completed.

The LED lighting switch is part of HUTH's Zero Thirty campaign, launched in the summer, to enable the Trust to be a UK leader in tackling the NHS's impact on climate change.

Other projects include the insulation of roofs and external walls to reduce heating loss, the use of wind and solar power to general electricity and the replacement of gas-fired boilers with air source heat pumps.

These projects focus on one of our largest source of emissions, the buildings that we occupy. The Trust is also exploring how we can reduce carbon emissions from everything we do, how we treat our patients, the drugs we use and how we travel to work.

Work is almost complete on a solar panel field in Cottingham that will to generate all of Castle Hill hospital's day-time energy needs during the summer months.

Compassionate care - Trust scoops national awards
Congratulations to liver nurse specialist, Dianne Backhouse, who has been announced as the deserving winner of the Nurse of the Year award at the Nursing Times Awards 2021.

In a glittering ceremony held at the Grosvenor House Hotel on Park Lane, London, nurses and organisations were honoured across 25 categories in a night of recognition dedicated to celebrating exceptional achievement.

Dianne emerged as the winner of the evening's final and arguably most coveted award, Nurse of the Year. She earned the title based on her work to develop the role of the liver nurse specialist at HUTH as well as for the work she has carried out to improve care for her patients with liver disease and support them to stay at home. The judges were won over by Dianne's innovative, patient-focused approach and genuine impact on patient care. Before her appointment at the trust, there was no hepatology specialist nursing which was greatly needed; working with the matron and consultants she established a job plan to fill this gap.

Further to the news of Dianne's success doctors, nurses, therapists and social care staff working together to help people with Parkinson's disease in Hull have won two major prizes for outstanding excellence at a national awards ceremony.

UK Parkinson's Excellence Network, supported by Parkinson's UK, presented its "Winner of Winners" award to a team from Hull University Teaching Hospitals (HUTH), City Health Care Partnership (CHCP) and Hull Clinical Commissioning Group (CCG) in recognition of their pioneering work.

The team, based at the Jean Bishop Centre in East Hull, was also named winners of the "Innovation in Practice" by the network, which has 7,000 members and is seen as the driving force behind improvements in the care of people with Parkinson's and frailty.

The judges, including a panel of Parkinson's health and service professionals, as well as patients, praised the Hull hub for its overwhelming dedication to pioneering good practice and striving to improve the experience of people with Parkinson's.

Queen's Centre acute assessment unit
A new assessment unit to see and treat patients undergoing treatment for cancer and blood disorders has opened at Castle Hill Hospital.

The Queen's Centre Acute Assessment Unit aims to help people manage their illnesses and any complications related to their treatment.

Our Trust has invested £1m in the new unit to provide timely support to Haematology and Oncology patients. Wherever possible, patients will also be able to return to their own homes after treatment instead of having to stay on a hospital ward.

The trust started a pilot scheme in 2018 to support patients with cancer and blood disorders from a small assessment area in the Radiotherapy Department before moving to Ward 29 at the start of the pandemic to help keep the patients, who are immunocompromised and at greater risk from Covid-19, as safe as possible.

Around 8,500 patients have been assessed and treated since the pilot began, with around 70 per cent well enough to go home later that day without being admitted to a ward.

2. Media/social media activity

In September there were 39 articles published about the Trust:

- 29 positive (74%)

- 3 factual (8%)
- 4 negative (10%)
- 3 neutral (8%)

Social media

Facebook

- Total "reach" for Facebook posts on all Trust pages in September – 234,289
- Hull Women and Children's Hospital – 61,036
- Castle Hill Hospital – 68,643
- HEY Jobs page – 6,695
- Hull Royal Infirmary – 52,910
- Hull University Teaching Hospitals NHS Trust – 45,005

Twitter @HullHospitals

- 97,200 impressions in September 2021
- 9,435 followers

Tweets with highest number of impressions related to National Eye Health Week.

In October there were 28 articles published about the Trust:

- 14 positive (50%)
- 2 factual (7%)
- 9 negative (32%)
- 3 neutral (11%)

Social media

Facebook

Total "reach" for Facebook posts on all Trust pages in September – 228,256

- Hull Women and Children's Hospital – 70,521
- Castle Hill Hospital – 64,116
- HEY Jobs page – 7,920
- Hull Royal Infirmary – 38,593
- Hull University Teaching Hospitals NHS Trust – 47,106

Twitter @HullHospitals

- 117,000 impressions in October 2021
- 9,530 followers

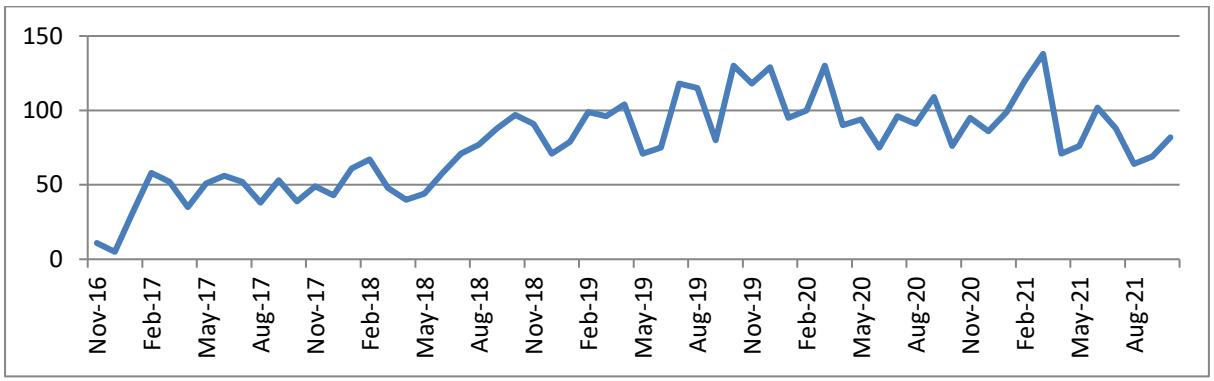
Tweets with highest number of impressions related to Dianne Backhouse being named Nursing Times 'Nurse of the Year' and Pharmacy Technician Day

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 September 2021-October 2021:


150
100
50
0
Nov-16
Feb-17
May-17
Aug-17
Nov-17
Feb-18
May-18
Aug-18
Nov-18
Feb-19
May-19
Aug-19
Nov-19
Feb-20
May-20
Aug-20
Nov-20
Feb-21
May-21
Aug-21

Hull University Teaching Hospitals NHS Trust

Agenda Item	6.2	**Meeting**	Trust Board	**Meeting Date**	9.11.21
Title	Ambulance Handover Letter NHS E/I				
Lead Director	Chris Long, Chief Executive Officer Ellen Ryabov, Chief Operating Officer				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report has not been previously considered.				

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:

Recommendation:

The Trust Board is asked to review the NHS E/I Letter and the Trust's action plan in place and decide if any further assurance/information is required.

Hull University Teaching Hospitals NHS Trust

Ambulance Handover Letter NHS E/I

1 Purpose of the Report

The purpose of the report is to inform the Board of the letter received from NHS E/I on 26 October 2021 regarding ambulance handovers and to highlight the Trust's response and actions in place.

2 Background

NHS E/I have written to all Trusts and ICSs regarding delays in handing over responsibility for the care of patients from ambulances to Emergency Departments. The delays are to be addressed through good system working and cross organisational cooperation.

NHS E/I have established a 10 point action plan that Trusts are to adopt. The plan is show below.

This year has seen significant pressure put on urgent and emergency care (UEC) services. As demand has returned to pre-pandemic levels, managing this activity whilst impacted by, for instance, staff isolation and Infection prevention and control measures has constrained the capacity within the system to manage this demand.

There are further, complex, reasons for the current challenges within UEC which mean that it will take all parts of the system working together to ensure a strong recovery across urgent and emergency care services.

The NHS has a plan on how the whole system will work together to ensure UEC services have resilience, by:

1. Supporting 999 and 111 services
2. Supporting primary care and community health services to help manage the demand for UEC services.
3. Supporting greater use of Urgent Treatment Centres (UTCs)
4. Increasing support for Children and Young People
5. Using communications to support the public to choose services wisely
6. Improving in-hospital flow and discharge (system wide)
7. Supporting adult and children's mental health needs
8. Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response
9. Reviewing staff COVID isolation rules
10. Ensuring a sustainable workforce

The letter received from NHS E/I is attached at Appendix 1.

3 HUTH Actions in place

The Trust has responded to the letter by developing a comprehensive action plan (attached at Appendix 2) which has been submitted to NHS E/I.

The action plan has also been received and agreed by the A&E Delivery Board on 28 October 2021.

4 Recommendation

The Trust Board is asked to review the NHS E/I Letter and the Trust's action plan in place and decide if any further assurance/information is required.

Rebecca Thompson
Head of Corporate Affairs
November 2021

Classification: Official
Publication approval reference: BW1101

To: ICS Leads
Acute Trust Chief Executives
Ambulance Service Chief Executives
Acute Trust Chairs

CC: CCG Accountable Officers

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

26 October 2021

Dear colleague,

For action – Addressing ambulance handover delays

We are writing to all Trusts and ICSs regarding delays in handing over responsibility for the care of patients from ambulances to Emergency Departments, recognising that these delays can only be addressed through good system working and cross-organisational cooperation.

In the UEC Recovery 10 Point Action Plan we asked that ICSs "make sure there are robust steps in place to avoid handover delays". We know, and are grateful, that staff within your system are already working incredibly hard to resolve this problem. Given the impact on patients, we must however press to identify further solutions to eliminate all handover delays.

Handover delays

National policy has set out that handovers should take no more than 15 minutes, ensuring patients receive necessary emergency care and allowing ambulances to get back on the road responding to patients in the community.

You will be keenly aware of the risks associated with hospital handover delays.

Acute trusts should take responsibility for patients from when the ambulance arrives and ED staff are informed of arrival, regardless of the patient's exact location. In practice, there is a need for close cooperation and risk sharing between services.

Taking action to eliminate delays

All systems must take action to ensure that ambulances are not used as additional ED cubicles, and that crews are able to safely offload their patient to the care of the ED. It is important that patient safety is prioritised and as a result we emphasise that corridor care is unacceptable as a solution.

We are now asking you to work together as a system and agree what actions you would need to take to immediately stop all delays. We appreciate that this may involve some difficult choices, and that we will need to discuss and involve colleagues, including the CQC, where helpful. For ease of reference we are attaching a list of measures which we know that some of you have implemented which have demonstrated clear benefits.

Today we also are asking Trusts, and their Systems, to report the actions that they have put in place to ensure delays have been eliminated in all Board Meetings, taking time to discuss the challenges with data to support the issue. You may find it helpful to invite clinical staff from the relevant areas to join these discussions.

Initiatives being used in systems

The following is not exhaustive, and a combination of initiatives is likely to be most effective:

- Establish surge capacity / priority admission unit to care for patients out with ED following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward
- Wherever practical implement "fit-to-sit" for patients that do not require a trolley
- Ensure early access to clinical decision-makers to enable prompt admission / discharge
- Establish additional community capacity to enable earlier discharge for patients no longer requiring acute medical care
- Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services
- Maximise discharge through following principles within the hospital discharge and community support: policy and operating model
- Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance
- Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients
- Work with two hour community crisis response teams to offer appropriate alternative pathways to an ambulance response
- Local agreement of staffing models e.g. using acute trust, ambulance service and community service staff in partnership to support surge capacity
- Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients
- Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site

We thank you for taking this necessary rapid action to address the risks associated with handover delays.

Yours sincerely,

Pauline Philip DBE
National Director for Emergency and Elective Care

Professor Steve Powis
National Medical Director

Richard Barker
Regional Director

HULL AND EASTRIDING AMBULANCE HANDOVER IMPROVEMENT PLAN

Escalation and Process

Aims	Action	Detail	Risk	Impact	Lead	Interdependencies	Timescale
Reduce Crowding in the ED, Making Space for Ambulance Conveyance Patients	Implementation of a 'Ambulance Delay protocol' and revision of Escalation policy	• Ensure when delays occur the Hospital moves patients out of the ED to create space for the next Ambulance. • That any patients delayed handing over are assessed by a senior clinician • That any deteriorating patient is acted on quickly	Requires the system to enable discharge of patients with no Criteria to reside.	Improve responsiveness to increased Demand. Ensure Patients are kept safe	DCOO HUTH	All system partners	November Board meeting for Approval
Ensure all Organisations are aware of predicted demand and current pressures	Revise Site meetings	• YAS representative to be present at site meetings for awareness of community activity. • Handover position to be discussed with action as required.		Focusing actions on creating immediate flow to make space for the next ambulance arrivals	DCOO HUTH	YAS	Trial new structure W/c 8 Nov
Remove duplication to improve accuracy of reported handover times	Automate 'notify' and 'Handover' times using EPR record	• Use QI change process to determine a realistic time from arrival to notify and apply this agreed time automatically to the arrival time. • Use the EPR Handover signing time to generate the 'C3 handover time'	Interoperability of the 2 YAS systems	Reduce duplication of data capture. Reduce discrepancy between record time (or lack of) and true performance	YAS	HUTH	Jan -22
Ensure Alternatives to ED are being suitably used	Report on use of alternatives to ED	• Month report on volume of patients directed to alternative provision, number of patients declined by service, and volume of patients where the service was unavailable.	Services need to be available and accessible in a timely manor	Reduction in conveyances to ED	YAS	All system partners NHS Service Finder YAS EPR upgrade	Jan 22
Reduce Demand for Ambulance attendance	Clinical Validation of Cat 3 and 4 calls	• Increase % of Category 3 and 4 calls that have clinical validation prior to an Ambulance response	Volume of Calls and time taken to Validate	Increase Availability of Ambulances for Cat 1 and 2 calls Reduce conveyance to ED	YAS	none	DEC - 21

Pre-Hospital

Aims	Action	Detail	Risk	Impact	Lead	Interdependency	Timescale
Ensure Alternatives to ED are available	Covid step-up beds available for paramedic access.	• Set criteria for patients with COVID to be taken directly to community beds • Communicate and promote within YAS the availability of Service	• May delay discharge from hospital if capacity protected for potential admissions	• Reduced Conveyance to ED • Reduced Hospital admissions	ER CCG	All system partners	November 2021
	Provide a Mental Health facility to enable streaming away from ED if no medical need	• Patients may wait within the ED for Assessment and then for a Mental Health Bed to become available.	• Locating a suitable space • Financial resource	• Reduced Crowding in ED. • Cubicle space available for a patient with Medical need	Humber	All system partners	Q4 21/22
Reduced conveyances to ED	YAS to further reduce conveyance volumes to ED	• Increased hear/see and treat. • Increased direct to SDEC conveyance	• Ambulance crew skill mix • Direct conveyance from YAS to SDEC	• Reduced Crowding	YAS	HUTH Assessment areas	Q3 2021/22
	CCG's to Compare community provision	• Ensure appropriate provision is available in both localities reflecting population need. • Produce a summary list of services available in each locality including hours of operation • Ensure DOS accurately reflects available services	•	• Increased awareness of service provision	Hull CCG	All system partners	Dec 21
	Act on Missed Opportunities review	• Where review highlighted a service could be provided outside of the ED develop plan for delivery	• Timeframe to implement additional services • Financial viability	• Reduced Crowding • Patient seen by most appropriate clinician	Hull CCG	All System Partners	Jan 22
	Commission a single point of access for Urgent Community Response	• Single phone number to a Hub that has access to and will organise the Urgent Community response. • Available to all Health care providers (GP's, paramedics etc.)	• Financial affordability	• Reduced Conveyances • Reduced Hospital admissions	Hull and East Riding CCG	All system partners	Apr -22

ED

Aims	Action	Detail	Risk	Impact	Lead	Interdependency	Timescale
Improve coordination of ambulance arrivals	YAS to provide Team Leader	• Provide a senior member of YAS staff to the Emergency Department to provide liaison/coordination and education 24/7	• Workforce available for 24/7 cover	• Improved communication and escalation of potential delays	YAS	none	NOV -21
Separation of Emergency and Urgent workload	Implement a co-located UTC	• UTC to have separate staffing resource to ED for patients with non-emergency injury or illness. • To include primary care clinicians	• Insufficient Workforce for 24/7 cover • Minimal impact on Majors Capacity	• Protects emergency workforce. • Patient able to see most appropriate clinician	COO HUTH	YAS/CHCP	Jan -22

HUTH FLOW

Aims	Action	Detail	Risk	Impact	Lead	Interdependency	Timescale
Reduce Crowding in the ED, Making Space for Ambulance Conveyance Patients	Improved Organisational Flow, reducing 'ED exit block'	• Use of discharge hub to co-ordinate discharges • Consistent and timely recording of Criteria to Reside(CtR) • All discharge communications to be using CtR with system partners • Maximise early use of discharge lounge to create flow • Reverse boarding when required to create capacity • Increase the pathways available to paramedics through SDEC • Ensure SAFER flow principles used across all wards • Use of Rockwood score for Frailty patients in HUTH	• Insufficient inpatient beds • Workforce availability to open additional capacity • Cultural change • Insufficient at home capacity	• Fewer patients in ED awaiting assessment • Reduced Majors occupancy	DCOO HUTH	DTOC System Partners	Q3 & Q4 2021/22

Post Hospital

Aims	Action	Detail	Risk	Impact	Lead	Interdependency	Timescale
Significant reduction in the volume of patients with No Criteria to Reside	Out-of-Hospital system partners to secure additional capacity to facilitate the Patient Discharge	The rapid development and enactment of a winter discharge plan with associated risk share.	• Continued or increased levels of patient with no criteria to reside • Home care market saturation • Winter pressures	• Fewer patients in ED awaiting assessment • Reduced Majors occupancy	Hull CCG	All community System Partners	November 21

Report to the Board in Public
Humber Acute Services Development Committee held on 7 October 2021

Item: Director Overview Report	Level of assurance gained: Substantial
Ivan McConnell presented the overview and advised that programmes 1 2 and 3 were progressing well. During October, November and December desk top deep dives will take place. There had been positive feedback and challenge received from the recently held peer and senate reviews.	
Item: Capital Expressions of Interest	Level of assurance gained: Substantial
Ivan McConnell advised that as part of the national programme the Trust had submitted the EOI on the 9 September and was currently undergoing an evaluation process; timings have not been released yet. We continue to develop key elements of the Capital Investment SOC with evaluation workshops being held during October and November.	
Item: Communications Plan and Engagement	Level of assurance gained: Substantial
The change programme is supported by ongoing engagement and involvement. Staff, patients, public and their representatives have been asked "What matters to you?" A total of 3883 responses were received; the feedback from these will form the basis of the evaluation framework that will be used to assess the potential options. The key theme that came out of the survey was "been seen and treated quickly" was considered extremely important. Next steps included; • Staff awareness • Public awareness • Targeted engagement • Evaluation workshop	
Item: Oncology Update	Level of assurance gained: Reasonable
Delivering against the plan and access to services are being sustained. There are however, workforce challenges and pressures on breast oncology due to capacity. Feedback from a regional stocktake would be taken to the Alliance Cancer Board next week.	

Report to the Board in Public
Quality Committee held on 28 October 2021

Item: Internal Audit Reports	Level of assurance gained: Reasonable
RSM presented 3 Audit reports relating to 18 week RTT, Contract Management – Domestic Services and the Workforce Race Equality Standards. Generally the assurance was positive although data validation is being reviewed as part of the 18 week RTT action plan.	
Item: Counter Fraud Report	Level of assurance gained: Substantial
Work was ongoing with finance and procurement and the ABPI declarations data had been released again for review. There were 2 fraud investigations ongoing. There was a further exercise relating to the NHS Counter Fraud Authority relating to action follow up notices. Work was ongoing to meet the Christmas Eve deadline.	
Item: External Audit Report	Level of assurance gained: Substantial
Since the audit of the Accounts had been undertaken Mazars opinion had been submitted and there were no further issues to report.	
Item: Standing Orders and SFI Review	Level of assurance gained: Substantial
There had been no changes or issues following the Standing Orders and SFI review.	
Item: Half Year update Remuneration and Quality Committee	Level of assurance gained: Substantial
Workplans from both committees were received. There were no gaps in process reported. Quality Committee has a new reporting structure including an Operational Risk and Compliance Committee.	
Item: Credit Card Spending	Level of assurance gained: Substantial
There was a discussion around IT purchases and why these would be made on the Credit Card. This would be reviewed and reported back to the next committee. There were no issues raised.	
Item: Review of debts >£50k and over 3 months old	Level of assurance gained: Substantial
There was only one item relating to ER CCG. There were no issues raised.	
Item: Review of losses and special payments	Level of assurance gained: Substantial
The report highlighted some concern regarding 4 instances of cash that had gone missing. This was being investigated. There were no other issues raised.	
Item: Clinical Negligence Claims	Level of assurance gained: Substantial
The claims annual report was received. The Committee requested a more risk based view of claims being received and what this could mean for the organisation and its insurance premiums.	
Item: Single Source Waivers	Level of assurance gained: Substantial
The report outlined any single source waivers and why. The majority of the single source waivers were due to either single supplier, continuity of supply or timescale issues.	

Hull University Teaching Hospitals NHS Trust

Agenda Item	6.5	**Meeting**	Trust Board	**Meeting Date**	9.11.21
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 March 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 November 2021

1 Purpose of the Report

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

2 Approval of signing and sealing of documents

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

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2021/03	Hull University Teaching Hospitals NHS Trust and HM Land Registry – Transfer of land at CHH (land to the west side of Willerby Road)	30.06.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/04	Hull University Teaching Hospitals NHS Trust and Quickline Communications Ltd – Lease of mast site relating to HRI, Anlaby Road, Hull, HU3 2JZ	03.08.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/05	Hull University Teaching Hospitals NHS Trust and DKP Consulting – Roclad sub-contractor collateral warranty	10.09.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/06	Hull University Teaching Hospitals NHS Trust and Andrew Johnson Construction Ltd – Theatre plant room 1 – Tender no T-2020-29	10.09.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/07	Hull University Teaching Hospitals NHS Trust and Unico Construction Ltd – MRI Achieva replacement	10.09.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/08	Hull University Teaching Hospitals NHS Trust and 3 names - family (Redacted) – Deed of surrender – Form Business Tenancy, south of Castle Road, Cottingham	10.09.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/09	Hull University Teaching Hospitals NHS Trust and 3 names - family (Redacted) – Deed of surrender of part and deed of variation, land south of Castle Road, Cottingham	10.09.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/10	Hull University Teaching Hospitals NHS Trust and 3 names - family (Redacted) – Deed of surrender – Farm Business Tenancy, land south of Castle Road, Cottingham	10.09.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/11	Hull University Teaching Hospitals NHS Trust and 3 names - family (Redacted) – Family business tenancy re: land South of Castle Road, Cottingham	10.09.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/12	Hull University Teaching Hospitals NHS Trust and Boots UK Ltd – Agreement for surrender	10.09.21	Chris Long – CEO Lee Bond – Chief

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
	and lease of land - Day Surgery Unit, HRI		Financial Officer
2021/13	Hull University Teaching Hospitals NHS Trust and Boots UK Ltd – Deed of surrender – pharmacy space, HRI	10.09.21	Chris Long – CEO Lee Bond – Chief Financial Officer
2021/14	Hull University Teaching Hospitals NHS Trust and Boots UK Ltd – Lease – Modular Building side of Day Surgery	10.09.21	Chris Long – CEO Lee Bond – Chief Financial Officer

4 Recommendations

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Rebecca Thompson
Head of Corporate Affairs
November 2021

Agenda Item	6.6	Meeting	Trust Board	Meeting Date	9/11/21
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 Board is asked to consider the risk ratings and decide:

- If there are any gaps in controls, sources of assurance or further actions to add.
- Approve the next steps of Board Assurance Committees using the assurance ratings as part of formal escalation next quarter.
- Confirm approval of the risks, ratings and risk appetite

Hull University Teaching Hospitals NHS Trust
Trust Board
Board Assurance Framework Q2 2021/22

1. Purpose of the Report

The purpose of the report is to present the Board Assurance Framework to the Board following review at the Board Committee meetings. An overview of all BAF risks is provided for completeness.

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 regular 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. The populated Board Assurance Framework for these risks is provided at Appendix 1.

Risk	Inherent Risk Rating (LxI)	Current Risk Rating (LxI)	Target Risk Rating (LxI)	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	5x5=25	4x4=16	3x3=9	Low

guidance not adhered to, poor compliance with fundamental standards.				
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

This 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 2 and these are shown at Appendix 2. The planned actions for Quarter 3 are also included in this table.

Discussions have taken place in each of the Board Committees which have included performance targets (ED, RTT, Cancer, diagnostics), workforce issues and clinical harm reviews.

5. Proposals for changes in risk ratings

There are no proposed changes to the risk ratings in Quarter 2. The Board is asked to consider if the actions taken in quarter two 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.

6. Assurance Ratings

Draft assurance ratings have been assigned for the first time in this paper. This is to inform the quarter 3 discussions where the requirement of Board Assurance Committees is 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. Recommendations

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

- If there are any gaps in controls, sources of assurance or further actions to add.
- Approve the next steps of Board Assurance Committees using the assurance ratings as part of formal escalation next quarter.
- Confirm approval of the risks, ratings and risk appetite

Rebecca Thompson
Head of Corporate Affairs
November 2021

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

Strategic Objective: Honest Caring and Accountable Culture
Executive Lead: Chris Long
CQC Domain: 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: **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.
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	**Outcomes:**		

Inherent risk			Risk as at 30.09.21 (Q2)			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
Risks from Risk Register:			**Metrics** Staff Survey People Performance Report **Independent / semi-independent:** CQC NHS England/Improvement Internal Audits WRES Doctors annual leave	**Outcomes:**		

Inherent risk			Risk as at 30.09.21 (Q2)			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 Theme: High quality care
Risk Appetite: Moderate
Risk: 3.1

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**

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	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	**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	**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	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.
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			**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 (Q2)**			**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 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

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

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	**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	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	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
Risks from Risk Register: 2675 - Insufficient capacity			**Metrics** Patient Safety incidents Waiting list numbers	**Outcomes:** RTT list size for April was under the trajectory at		

	within Radiology to accommodate increasing demand		4 hours or less in A&E. • Acute Patient 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	**Independent / semi-independent:** CQC inspections Internal audits – Waiting lists, recovery included in schedule	60,422 RTT list size for July was under the trajectory at 57,560	Operating Officer to monitor both the delivery of actions and outcomes of this. 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	

Inherent risk			**Risk as at 30.09.21 (Q2)**			**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	**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.	**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%.	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	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. A revised 4-hour delivery action plan has been developed, alongside a review and update of the
Risks from Risk Register Crowding in the Emergency			**Metrics** Health Group recovery plan trajectories	**Outcomes:**		

	Department Insufficient capacity within Radiology to accommodate increasing demand		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, 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.	**Independent / semi-independent:** 1. NHSE/I 2. CQC 3. Internal Audit 4. External Audit		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.	Ambulance Handover Improvement Plan.

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
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
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.	**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).		

Inherent risk			Risk as at 30.09.21 (Q2)			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	**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 struggle to identify efficiency schemes.	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			**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	**Outcomes:** 1. Achieve Board approved financial plan 2. Achieve financial control total at Trust and system level		

Inherent risk			Risk as at 30.09.21 (Q2)			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
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 (Q2)**			**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	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.	**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 (Q2)**			**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**	**Assurance Rating (Draft for Q2)**
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 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	

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	

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**	**Assurance Rating (Draft for Q2)**
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 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.	

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	Assurance Rating (Draft for Q2)
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 process. Family and Women's risk	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 CAS Alert look back exercise to be carried	National NHSE feedback received for the Trust's IPC BAF. The DIPC and Risk Manager to update the IPC BAF 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 to be undertaken with the Falls lead following the publication of the Kettering Report Gap analysis of the Emergency Department to be undertaken alongside the 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	

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.

management pilot underway Weekly patient safety summit and weekly SI Committee commenced.	out to ensure all alerts are seen by the relevant teams and any actions completed. External Agencies report to be presented quarterly to the Board 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 channel to ensure that the Trust learns lessons, shares lessons and takes positive action to embed positive change. This will allow for good	Communications and will go live on the 13th of September 2021 Quality Strategy to be drafted. Patient Safety Incident Response Plan to be drafted. Patient Safety Board Development session to be held in December 2021. Health Group Governance Frameworks to be completed and signed up to by December 2021. Core service Well-led self-assessments to commence. Risk Management Strategy to be drafted and presented to the Operational Risk and Compliance Committee. First cohort of QSIR trainees to complete Practitioner training and start the process to become an accredited faculty.	

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.

	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.		

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 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	Assurance Rating (Draft for Q2)
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 still being used for Trauma and Orthopaedics activity Urology working with external provider in	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 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	To provide a deep dive presentation to the 06 September 2021 Quality Delivery Group meeting on the Trust's Clinical Harm Review (CHR) process. To continue to provide the presentation update against the extreme risks on a monthly basis, the next update due for the 06 September 2021 meeting. To complete the new Quality Assurance Framework. This is with all the relevant leads for population and will be presented to the September 2021 Quality Committee and then to the QDG at the 04 October 2021 meeting. 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	

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.

Q1	**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 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	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 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 NLAG proposal to use one weekly day case session to begin in September Independent sector use to continue Review of theatre schedule to take place	

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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.

	• 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 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 –	Diagnostics – Continue to progress with the plans for Medinet	

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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.

	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 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		

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

	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 **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		

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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.

	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		

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.

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**	**Assurance Rating (Draft for Q2)**
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 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	

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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.

		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 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	

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.

		Missed Opportunities Audit by the ECIST Team in ED. Presentation to the Performance and Finance Committee outlining the actions.	

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.

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	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 VCSE JNCC/LNC	

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.

		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.	

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	Assurance Rating (Draft for Q2)
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.	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 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	

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.

		• Improving the profile of Trust • Recruiting high profile clinicians	

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	Assurance Rating (Draft for Q2)
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 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.'	

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.

		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	

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
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	Assurance Rating (Draft for Q2)
	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 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	

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.

		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	

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
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	Assurance Rating (Draft for Q2)
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 CDEL limit. Expenditure on these	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 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	

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.

	will not be committed until the PDC funding is confirmed.	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.	

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.

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

Integrated Performance Report

Hull University Teaching Hospitals NHS Trust

Committee

Board

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

This report covers the **Board Report (IPR)**, **Performance and Finance (PaF)**, **Quality Assurance** and **Executive Management Committee (EMC)** committees which can be filtered to using the Committee filter.

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

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

View Report in Full Screen

Date Last Refreshed: 02 Nov 2021 11:09

Proceed to Report Summary

Change Log

Date Deployed	Implemented by	Approval Notes
02/11/21	Will Frisby	A major change including; - Amend the committees to be shown within the Dashboard, alter front cover to reflect updated committees: WORKFORCE to EMC and IPR to BOARD - Additional metrics: SA062 - SA066, RTT013, UPC012, ED014, ED015, SA057 - SA061. - Updated target of 90% for Duty of Candour (SA051, SA052, SA053) previously showing baseline. - Corrected cancer 104 day target from 85% to 75%
15/09/21	Will Frisby	A minor tweak including:

Data Source: HealthBI

Date Published: 29th June 2021

Author: BI Informatics Team

Contact Email: john.taylor59@nhs.net; wfrisby@nhs.net or vicki.riddiough@nhs.net

Related Reports

EPF PandA Dashboard

ED Dashboard | Theatre Dashboard

Referrals Dashboard

Inpatient Dashboard

Other Resources *(may require additional login)*

Making Data Count

Integrated Performance Report | Executive Summary Scorecard

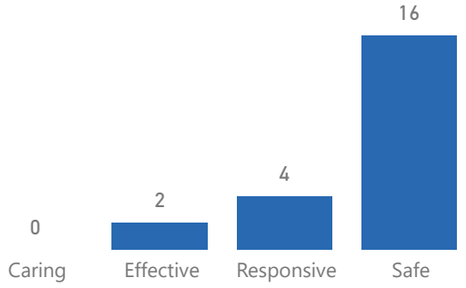
Domain: All | Sub-Group: All | Metric: All | Committee: Board

October 2021
Update Month

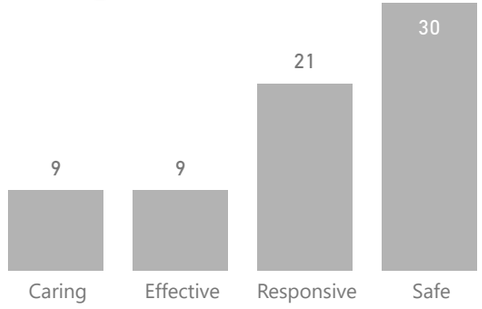
111
Metric Count

- Exec Summary
- Metric Summary
- Data Table
- Metric Metadata

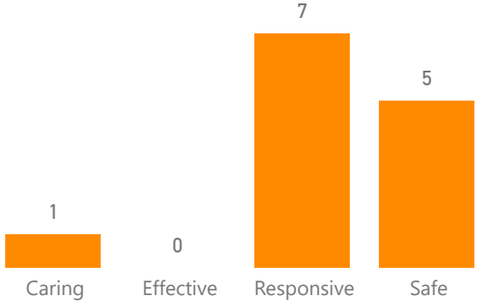
Consistently Passing



Hit and Miss



Consistently Failing



Domain	Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Unreliable	Not capable	Capable	N/A
Caring	9		1			9	1		
Effective	11				1	9		2	1
Responsive	19	7	4	2	1	21	7	4	1
Safe	42	2	5	2	5	30	5	16	5
Total	81	9	10	4	7	69	13	22	7

Integrated Performance Report | Caring

Domain: All | Sub-Group: All | Metric: All | Committee: Board

September 2...
Update Month

10
Metric Count

- Exec Summary
- **Metric Summary**
- Data Table
- Metric Metadata

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

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)
9	0	1	0	0
Common cause	**Special Cause Concerning variation**		**Special Cause Improving variation**	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
9	1	0	0
Hit and miss target	**Consistently fail target**	**Consistently hit target**	

Metric	Month	Result	Variation	Assurance
A&E FFT response rate	August 2021	17.6%	Common Cause	Unreliable
A&E Scores from Friends and Family Test - % negative	August 2021	20.0%	Concern (Low)	Not capable
A&E Scores from Friends and Family Test - % positive	August 2021	70.0%	Common Cause	Unreliable
Inpatient FFT response rate	August 2021	4.5%	Common Cause	Unreliable
Inpatient Scores from Friends and Family Test - % negative	August 2021	0.0%	Common Cause	Unreliable
Inpatient Scores from Friends and Family Test - % positive	August 2021	100.0%	Common Cause	Unreliable
Maternity FFT response rate	August 2021	8.2%	Common Cause	Unreliable
Maternity Scores from Friends and Family Test - % negative	August 2021	0.0%	Common Cause	Unreliable
Maternity Scores from Friends and Family Test - % positive	August 2021	100.0%	Common Cause	Unreliable
Mixed Sex Accommodation Breaches	September 2021	0	Common Cause	Unreliable

Integrated Performance Report | Effective

Domain: All | Sub-Group: All | Metric: All | Committee: Board

September 2...
Update Month

12
Metric Count

- Exec Summary
- **Metric Summary**
- Data Table
- Metric Metadata

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

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)
11	0	0	0	1
Common cause	Special Cause Concerning variation		Special Cause Improving variation	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
9	0	2	1
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Complaints received	September 2021	54	Common Cause	Capable
Complaints reopened	September 2021	2	Common Cause	Capable
Crude Mortality (non-elective admissions)	September 2021	4.1%	Common Cause	Unreliable
Emergency c-section rate	September 2021	17.3%	Common Cause	Unreliable
Emergency readmissions within 30 days	August 2021	6.1%	Improvement (Low)	Unreliable
Hospital Standardised Mortality Ratio - Weekend	June 2021	142.9	Common Cause	Unreliable
Hospital Standardised Mortality Ratio - monthly position	June 2021	87.7	Common Cause	Unreliable
PHSO Referrals	September 2021	0	Common Cause	N/A
PPCI within 150 minutes	August 2021	74.2%	Common Cause	Unreliable
Stroke 60 mins	September 2021	43.7%	Common Cause	Unreliable

Integrated Performance Report | Effective

Domain: All | Sub-Group: All | Metric: All | Committee: Board

September 2...
Update Month

12
Metric Count

Exec Summary
Metric Summary
Data Table
Metric Metadata

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

Metric	Month	Result		Variation		Assurance
Stroke PTs >90% stay on a Stroke Ward	September 2021	78.9%		Common Cause		Unreliable
Summary Hospital Mortality Indicator (HSCIC) - (latest data available Sept 18)	March 2021	104.7		Common Cause		Unreliable

Integrated Performance Report | Responsive

Domain: All | Sub-Group: All | Metric: All | Committee: Board

September 2...
Update Month

33
Metric Count

- Exec Summary
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- Data Table
- Metric Metadata

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

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)
19	7	4	2	1
Common cause	**Special Cause Concerning variation**		**Special Cause Improving variation**	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
21	7	4	1
Hit and miss target	**Consistently fail target**	**Consistently hit target**	

Metric	Month	Result	Variation	Assurance
A&E Type 3 Performance from April 2019	September 2021	89.6%	Concern (High)	Capable
Ambulance handovers waiting >60 minutes	September 2021	459	Concern (Low)	Unreliable
Ambulance handovers waiting 15-30 minutes	September 2021	716	Concern (High)	Unreliable
Ambulance handovers waiting 30-60 minutes	September 2021	579	Common Cause	Unreliable
Cancelled op 28 day breaches % (quarterly)	June 2021	0.8%	Common Cause	Unreliable
Cancelled Operations % of FFCEs (quarterly)	June 2021	22.4%	Common Cause	Unreliable
Cancer 104 Day Waits	August 2021	53	Common Cause	Not capable
Cancer 2 week (all cancers)	August 2021	82.6%	Common Cause	Unreliable
Cancer 2 week (breast symptoms)	August 2021	16.1%	Concern (High)	Not capable
Cancer 28 Day Wait - Faster Diagnosis Standard	August 2021	76.5%	Common Cause	Unreliable

Integrated Performance Report | Responsive

Domain: All | Sub-Group: All | Metric: All | Committee: Board

September 2...
Update Month

33
Metric Count

- Exec Summary
- **Metric Summary**
- Data Table
- Metric Metadata

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

Metric	Month	Result	Variation	Assurance
Cancer 31 day wait for second or subsequent treatment - drug treatments	August 2021	100.0%	Improvement (High)	Capable
Cancer 31 day wait for second or subsequent treatment - Radiotherapy	August 2021	98.7%	Common Cause	Capable
Cancer 31 day wait for second or subsequent treatment - surgery	August 2021	77.8%	Concern (High)	Unreliable
Cancer 31 day wait from diagnosis to first treatment	August 2021	89.8%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	August 2021	57.6%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from urgent GP referral)	August 2021	55.8%	Common Cause	Not capable
Capital forecast against plan	September 2021	(8,621)	Common Cause	Unreliable
Diagnostics: Patients waiting 6 weeks or more from referral to test	September 2021	39.3%	Concern (Low)	Not capable
ED: % of attendees assessed within 30 minutes of arrival	September 2021	86.5%	Common Cause	Unreliable
ED: % of attendees seen by doctor within 60 minutes of arrival	September 2021	28.1%	Concern (High)	Unreliable
ED: 12 hour trolley waits	September 2021	5	Concern (Low)	Unreliable
ED: Standard Performance Type 1	September 2021	55.5%	Concern (High)	Not capable
ED: Standard Performance Type 1 & 3	September 2021	63.7%	Concern (High)	Not capable
Forecast outturn compared to plan	September 2021	0	Common Cause	Unreliable
Forecast underlying surplus/deficit compared to plan	September 2021	(47,800)	Common Cause	N/A
Outpatients: Hospital Cancelled Outpatient Appointments %	September 2021	9.3%	Improvement (Low)	Unreliable
PALS Complaints	September 2021	174	Common Cause	Capable

Integrated Performance Report | Responsive

Domain: All | Sub-Group: All | Metric: All | Committee: Board

September 2...
Update Month

33
Metric Count

- Exec Summary
- **Metric Summary**
- Data Table
- Metric Metadata

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

Metric	Month	Result	Variation	Assurance
Recurrent efficiencies YTD compared to plan	September 2021	0	Common Cause	Unreliable
RTT Incomplete Pathways % performance	September 2021	57.7%	Common Cause	Not capable
RTT Total Waiting List	September 2021	58,795	Concern (Low)	Unreliable
Total efficiencies YTD compared to plan	September 2021	0	Improvement (High)	Unreliable
Written Complaints - rate (Still annual report) per 1000 bed days	September 2021	1.9	Common Cause	Unreliable
YTD actual compared to plan	September 2021	0	Common Cause	Unreliable

Integrated Performance Report | Safe

Domain: All | Sub-Group: All | Metric: All | Committee: Board

October 2021
Update Month

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Metric Count

- Exec Summary
- **Metric Summary**
- Data Table
- Metric Metadata

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

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)
42	2	5	2	5
Common cause	**Special Cause Concerning variation**		**Special Cause Improving variation**	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
30	5	16	5
Hit and miss target	**Consistently fail target**	**Consistently hit target**	

Metric	Month	Result	Variation	Assurance
Absence	September 2021	5.6%	Common Cause	Unreliable
Adjusted Vacancies WTE	September 2021	280	Common Cause	N/A
Adjusted Vacancy Rate WTE	September 2021	2.3%	Common Cause	N/A
Admission of full term babies to neo-natal care	September 2021	14	Common Cause	Unreliable
Agency WTE	September 2021	48	Improvement (Low)	Unreliable
Appraisal % - AFC by Health Group and Staff Group	September 2021	70.6%	Common Cause	Unreliable
Appraisal % - Consultant/SAS by Health Group and Staff Group	September 2021	68.8%	Improvement (High)	Capable
Bank WTE	September 2021	116	Concern (Low)	Unreliable
CAS alerts outstanding	September 2021	0	Common Cause	Unreliable
Category 1 Pressure Ulcer	September 2021	2	Common Cause	Capable

Integrated Performance Report | Safe

Domain: All | Sub-Group: All | Metric: All | Committee: Board

October 2021

Update Month

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Metric Count

- Exec Summary
- **Metric Summary**
- Data Table
- Metric Metadata

Domain

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

Metric	Month	Result	Variation	Assurance
Category 2 Pressure Ulcer	September 2021	21	Common Cause	Capable
Category 3 Pressure Ulcer	September 2021	0	Improvement (Low)	Capable
Category 4 Pressure Ulcer	September 2021	1	Concern (Low)	Unreliable
Clinical harm reviews - Cancer 104 day wait	September 2021	31	Common Cause	Unreliable
Clinical harm reviews - 104 week waits RTT	September 2021	39	Common Cause	Unreliable
Clostridium Difficile - infection rate (per 1000 bed days)	September 2021	0.3	Common Cause	Unreliable
Clostridium Difficile - number	September 2021	3	Common Cause	Capable
Consultant and SAS – Signed off Job Plans %	September 2021	54.0%	Common Cause	Capable
COVID - Positive Tests	September 2021	53	Common Cause	Unreliable
Covid Absence - Positive and Staff Isolation	September 2021	2.0%	Improvement (Low)	Unreliable
Duty of Candour; investigation compliance	August 2021	100.0%	Common Cause	Unreliable
Duty of Candour; verbal apology	August 2021	96.6%	Common Cause	Unreliable
Duty of Candour; written apology	August 2021	60.0%	Common Cause	Not capable
E.Coli	September 2021	9	Common Cause	Capable
Elective c-section rate	September 2021	19.9%	Concern (Low)	Unreliable
Establishment WTE	September 2021	8,448	Concern (Low)	Capable
Falls (rate per 1,000 bed days)	September 2021	0.0	Common Cause	Unreliable

Integrated Performance Report | Safe

Domain: All | Sub-Group: All | Metric: All | Committee: Board

October 2021

Update Month

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Metric Count

Exec Summary

Metric Summary

Data Table

Metric Metadata

Domain

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

Metric	Month	Result	Variation	Assurance
Klebsiella spp bacteraemia	September 2021	6	Common Cause	Capable
Mandatory Training by Health Group and Staff Group	September 2021	84.9%	Concern (High)	Unreliable
Maternal Deaths	August 2021	0	Common Cause	Unreliable
Medication errors causing serious harm	September 2021	0	Improvement (Low)	Unreliable
Midwife to birth ratio	September 2021	1.3	Improvement (Low)	Not capable
MRSA bactaraemias	September 2021	0	Common Cause	Unreliable
MSSA	September 2021	2	Common Cause	Capable
Never events - Incidence Rate (per 1000 bed days)	September 2021	0.100	Common Cause	Unreliable
NEWS Compliance	August 2021	100.0%	Common Cause	Unreliable
Number of Never Events in month	September 2021	2	Common Cause	Unreliable
Number of Serious Incidents in month	September 2021	10	Common Cause	Unreliable
Patient safety incidents that are harmful	March 2020	94.6%	Common Cause	Not capable
Percentage of harm free care	September 2021	95.2%	Improvement (High)	Unreliable
Percentage of new Harms	March 2020	1.8%	Common Cause	Unreliable
Pressure ulcers	September 2021	37	Common Cause	Capable
Pseudomonas aeruginosa bacteraemia	September 2021	0	Common Cause	Capable
Serious Incidents rate (per 1000 bed days)	September 2021	0.5	Common Cause	Unreliable

Integrated Performance Report | Safe

Domain: All | Sub-Group: All | Metric: All | Committee: Board

October 2021

Update Month

56

Metric Count

Exec Summary

Metric Summary

Data Table

Metric Metadata

Domain

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

Metric	Month	Result		Variation		Assurance
Serious Incidents rate (per 1000 bed days)	September 2021	0.5		Common Cause		Unreliable
SIs investigated on time within 60 days	October 2021	0.0%		Common Cause		Not capable
SIs reported to StEIS within 48 hours	September 2021	0.0%		Concern (High)		Unreliable
Staff in Post WTE	September 2021	8,003		Common Cause		N/A
Staff Survey results – Care	December 2019	0.1%		Common Cause		N/A
Staff Survey results – Work	December 2019	0.6%		Common Cause		N/A
Suspected Deep Tissue Injury	September 2021	11		Common Cause		Capable
Turnover by Health Group and Staff Group	September 2021	10.7%		Concern (Low)		Capable
Unstageable	September 2021	2		Common Cause		Capable
Vacancy Rate %	September 2021	5.3%		Common Cause		Unreliable
VTE Risk Assessment	September 2021	85.8%		Common Cause		Not capable
WHO Checklist	September 2021	98.8%		Common Cause		Unreliable

Meeting: Trust Board

Agenda Item		**Meeting**	**Trust Board**	**Meeting Date**	**09.11.21**
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 63.7% for September.
- 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.

Cancer (August Performance data)

- 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, or exceeded the 93% standard.
- Performance against the 62-day Cancer standard was 55.8% for August.
- 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.

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.

Performance and Activity Report

September 2021 Performance

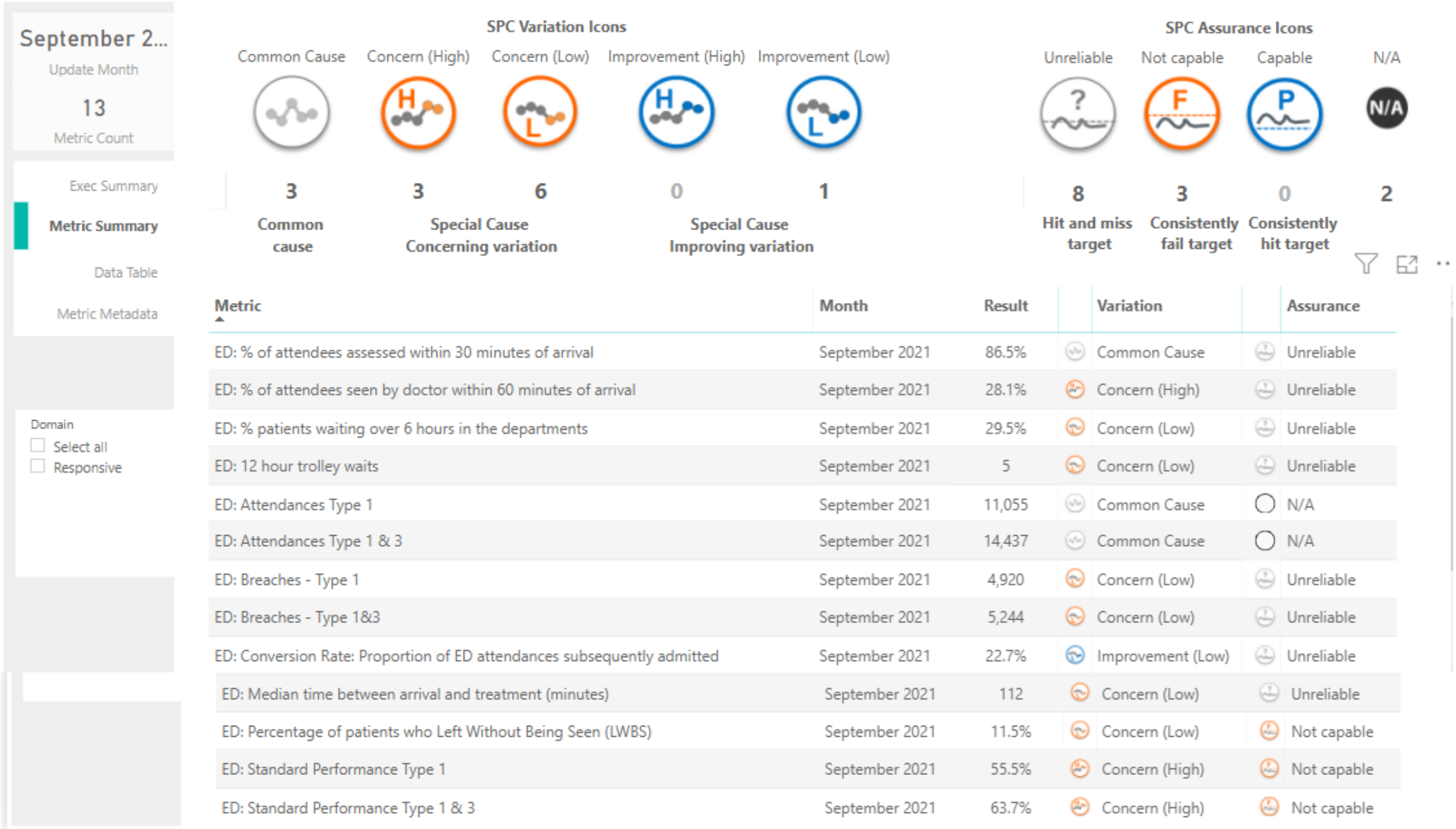
Produced October 2021

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**

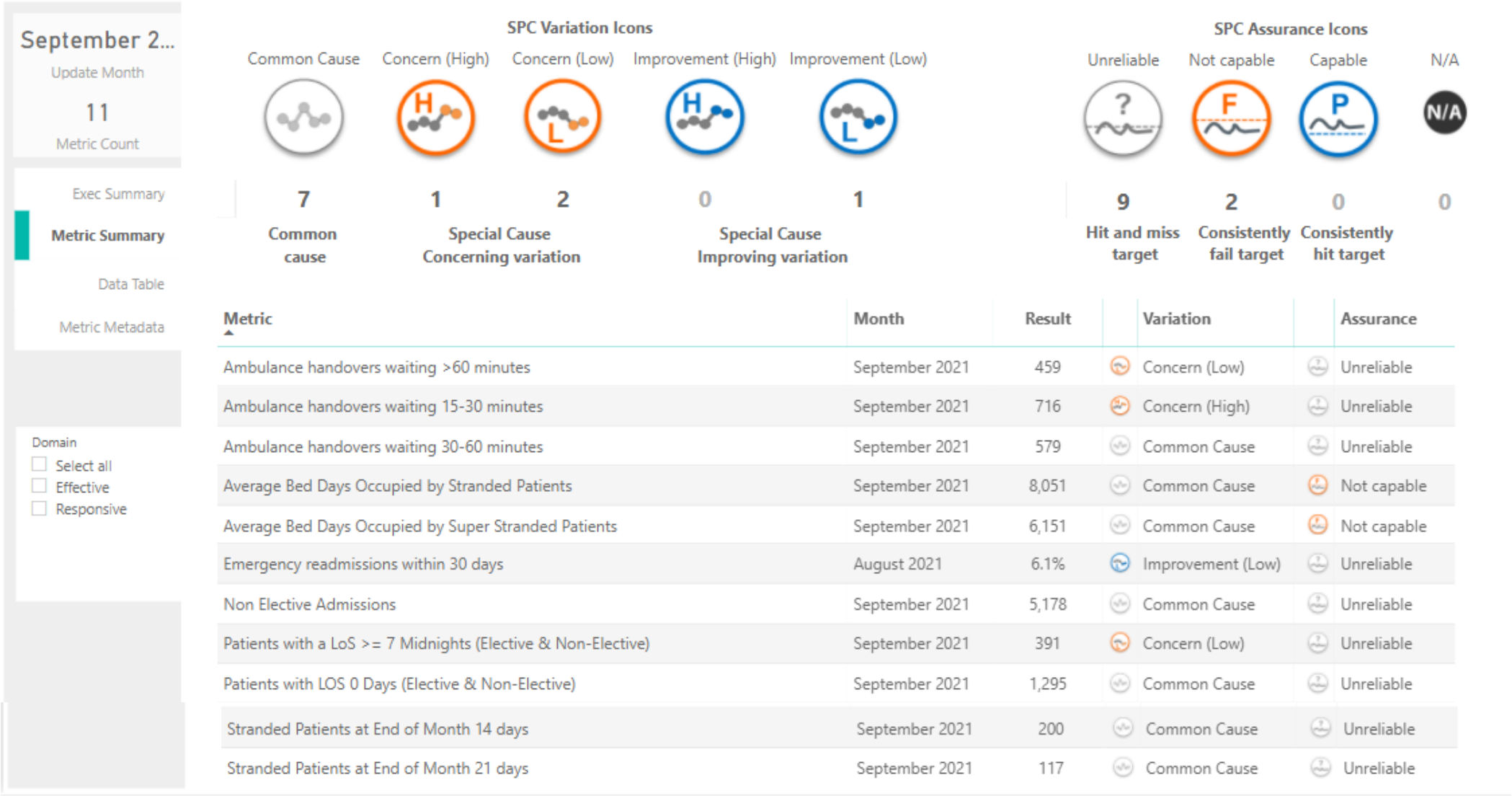
Contents

1. Operational Performance – Emergency Department



Metric	Month	Result	Variation	Assurance
ED: % of attendees assessed within 30 minutes of arrival	September 2021	86.5%	Common Cause	Unreliable
ED: % of attendees seen by doctor within 60 minutes of arrival	September 2021	28.1%	Concern (High)	Unreliable
ED: % patients waiting over 6 hours in the departments	September 2021	29.5%	Concern (Low)	Unreliable
ED: 12 hour trolley waits	September 2021	5	Concern (Low)	Unreliable
ED: Attendances Type 1	September 2021	11,055	Common Cause	N/A
ED: Attendances Type 1 & 3	September 2021	14,437	Common Cause	N/A
ED: Breaches - Type 1	September 2021	4,920	Concern (Low)	Unreliable
ED: Breaches - Type 1&3	September 2021	5,244	Concern (Low)	Unreliable
ED: Conversion Rate: Proportion of ED attendances subsequently admitted	September 2021	22.7%	Improvement (Low)	Unreliable
ED: Median time between arrival and treatment (minutes)	September 2021	112	Concern (Low)	Unreliable
ED: Percentage of patients who Left Without Being Seen (LWBS)	September 2021	11.5%	Concern (Low)	Not capable
ED: Standard Performance Type 1	September 2021	55.5%	Concern (High)	Not capable
ED: Standard Performance Type 1 & 3	September 2021	63.7%	Concern (High)	Not capable

2. Operational Performance – Unplanned Care



Metric	Month	Result	Variation	Assurance
Ambulance handovers waiting >60 minutes	September 2021	459	Concern (Low)	Unreliable
Ambulance handovers waiting 15-30 minutes	September 2021	716	Concern (High)	Unreliable
Ambulance handovers waiting 30-60 minutes	September 2021	579	Common Cause	Unreliable
Average Bed Days Occupied by Stranded Patients	September 2021	8,051	Common Cause	Not capable
Average Bed Days Occupied by Super Stranded Patients	September 2021	6,151	Common Cause	Not capable
Emergency readmissions within 30 days	August 2021	6.1%	Improvement (Low)	Unreliable
Non Elective Admissions	September 2021	5,178	Common Cause	Unreliable
Patients with a LoS >= 7 Midnights (Elective & Non-Elective)	September 2021	391	Concern (Low)	Unreliable
Patients with LOS 0 Days (Elective & Non-Elective)	September 2021	1,295	Common Cause	Unreliable
Stranded Patients at End of Month 14 days	September 2021	200	Common Cause	Unreliable
Stranded Patients at End of Month 21 days	September 2021	117	Common Cause	Unreliable

3. Operational Performance – Cancer

August 2021

Update Month

9

Metric Count

Exec Summary

Metric Summary

Data Table

Metric Metadata

Domain

Select all

Responsive

SPC Variation Icons

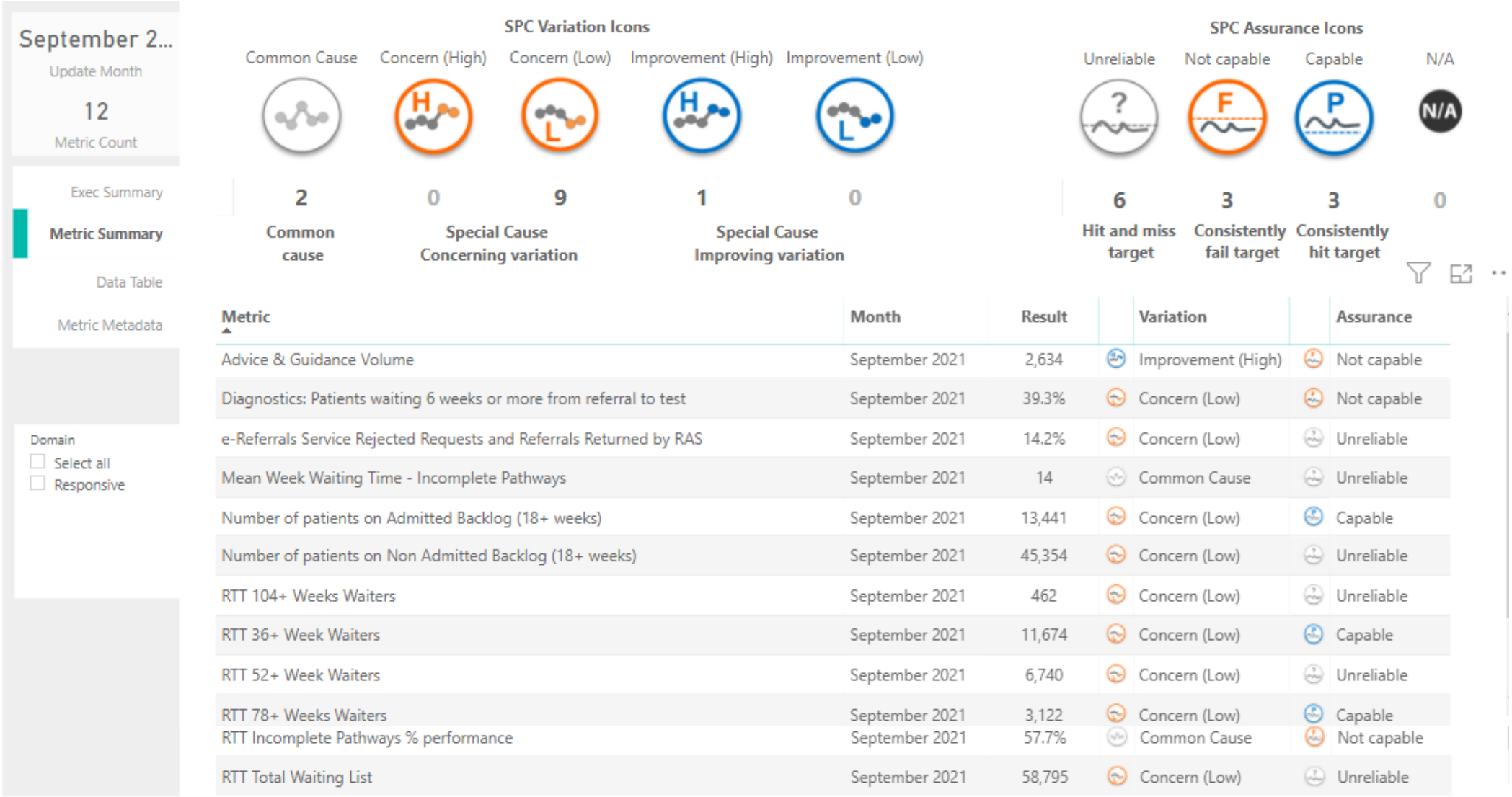
Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)
6	2	0	1	0
Common cause	Special Cause Concerning variation		Special Cause Improving variation	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
5	2	2	0
Hit and miss target	Consistently fail target	Consistently hit target	

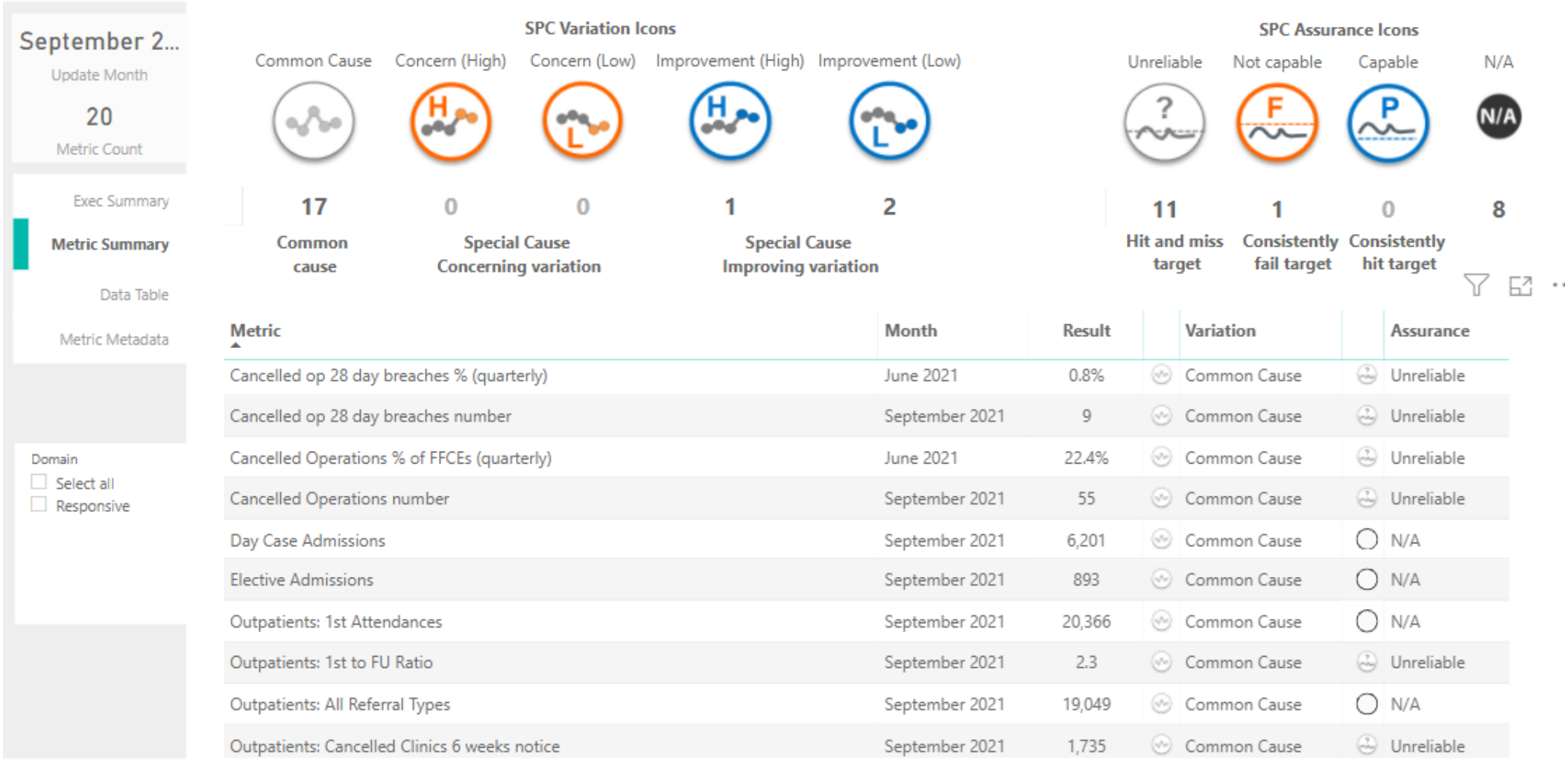
Metric	Month	Result	Variation	Assurance
Cancer 2 week (all cancers)	August 2021	82.6%	Common Cause	Unreliable
Cancer 2 week (breast symptoms)	August 2021	16.1%	Concern (High)	Not capable
Cancer 28 Day Wait - Faster Diagnosis Standard	August 2021	76.5%	Common Cause	Unreliable
Cancer 31 day wait for second or subsequent treatment - drug treatments	August 2021	100.0%	Improvement (High)	Capable
Cancer 31 day wait for second or subsequent treatment - Radiotherapy	August 2021	98.7%	Common Cause	Capable
Cancer 31 day wait for second or subsequent treatment - surgery	August 2021	77.8%	Concern (High)	Unreliable
Cancer 31 day wait from diagnosis to first treatment	August 2021	89.8%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	August 2021	57.6%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from urgent GP referral)	August 2021	55.8%	Common Cause	Not capable

4. Operational Performance – 18 weeks RTT

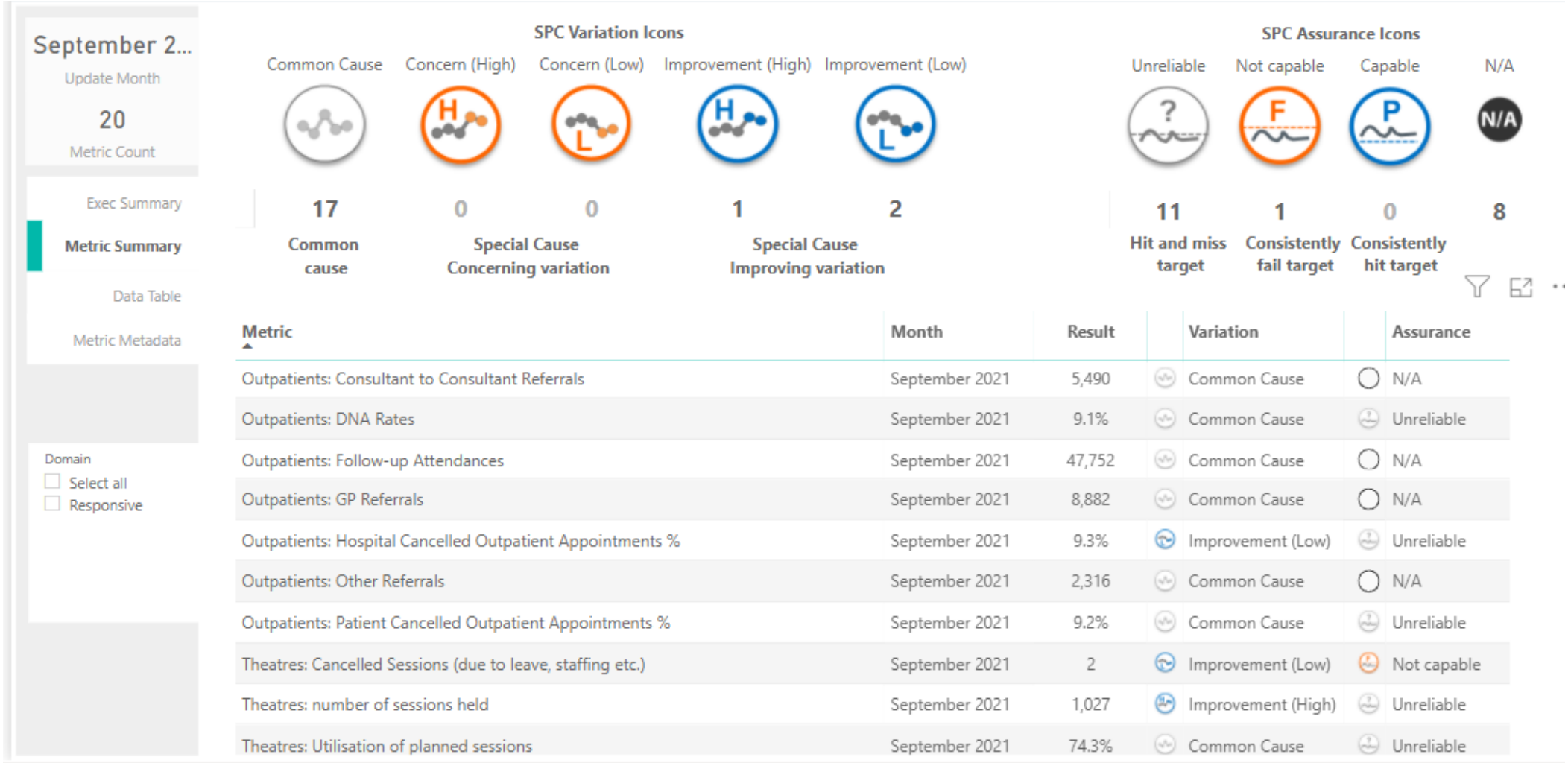


Metric	Month	Result	Variation	Assurance
Advice & Guidance Volume	September 2021	2,634	Improvement (High)	Not capable
Diagnostics: Patients waiting 6 weeks or more from referral to test	September 2021	39.3%	Concern (Low)	Not capable
e-Referrals Service Rejected Requests and Referrals Returned by RAS	September 2021	14.2%	Concern (Low)	Unreliable
Mean Week Waiting Time - Incomplete Pathways	September 2021	14	Common Cause	Unreliable
Number of patients on Admitted Backlog (18+ weeks)	September 2021	13,441	Concern (Low)	Capable
Number of patients on Non Admitted Backlog (18+ weeks)	September 2021	45,354	Concern (Low)	Unreliable
RTT 104+ Weeks Waiters	September 2021	462	Concern (Low)	Unreliable
RTT 36+ Week Waiters	September 2021	11,674	Concern (Low)	Capable
RTT 52+ Week Waiters	September 2021	6,740	Concern (Low)	Unreliable
RTT 78+ Weeks Waiters	September 2021	3,122	Concern (Low)	Capable
RTT Incomplete Pathways % performance	September 2021	57.7%	Common Cause	Not capable
RTT Total Waiting List	September 2021	58,795	Concern (Low)	Unreliable

5. Operational Performance – Planned Care



Metric	Month	Result	Variation	Assurance
Cancelled op 28 day breaches % (quarterly)	June 2021	0.8%	Common Cause	Unreliable
Cancelled op 28 day breaches number	September 2021	9	Common Cause	Unreliable
Cancelled Operations % of FFCEs (quarterly)	June 2021	22.4%	Common Cause	Unreliable
Cancelled Operations number	September 2021	55	Common Cause	Unreliable
Day Case Admissions	September 2021	6,201	Common Cause	N/A
Elective Admissions	September 2021	893	Common Cause	N/A
Outpatients: 1st Attendances	September 2021	20,366	Common Cause	N/A
Outpatients: 1st to FU Ratio	September 2021	2.3	Common Cause	Unreliable
Outpatients: All Referral Types	September 2021	19,049	Common Cause	N/A
Outpatients: Cancelled Clinics 6 weeks notice	September 2021	1,735	Common Cause	Unreliable



Metric	Month	Result	Variation	Assurance
Outpatients: Consultant to Consultant Referrals	September 2021	5,490	Common Cause	N/A
Outpatients: DNA Rates	September 2021	9.1%	Common Cause	Unreliable
Outpatients: Follow-up Attendances	September 2021	47,752	Common Cause	N/A
Outpatients: GP Referrals	September 2021	8,882	Common Cause	N/A
Outpatients: Hospital Cancelled Outpatient Appointments %	September 2021	9.3%	Improvement (Low)	Unreliable
Outpatients: Other Referrals	September 2021	2,316	Common Cause	N/A
Outpatients: Patient Cancelled Outpatient Appointments %	September 2021	9.2%	Common Cause	Unreliable
Theatres: Cancelled Sessions (due to leave, staffing etc.)	September 2021	2	Improvement (Low)	Not capable
Theatres: number of sessions held	September 2021	1,027	Improvement (High)	Unreliable
Theatres: Utilisation of planned sessions	September 2021	74.3%	Common Cause	Unreliable

6. Emergency Care Standard and Unplanned Care

Operational Context

Delivery of the 4-Hour National Standard in September was not achieved. Actual performance was 55.5% for Type 1 activity and for both Type 1&3 combined 4-Hour performance was 63.7%, a deterioration in performance of 4.9% when compared to the August.

Type 1 ED attendances for the month of September were 11,055, which is broadly similar to the previous month.

The Trust had 5 x 12-hour trolley waits on 7th, 11th and 22nd September. A rapid review has been undertaken; duty of candour was completed along with an apology to the patient for their length of wait for a bed. 4 of the 5 breaches were waiting for a bed at Hull Royal Infirmary and 1 was a Mental Health breach.

Ambulance conveyances in September were fewer than in the previous month with 3,155 ambulance arrivals in month or an average of 105 per day.

Handover times in September were 29.8% of handovers within 15 minutes (average handover time was 34 minutes). There were 459 handover delays in September >60 minutes which is similar to August. The handover times remain a significant problem as a direct result of our ongoing flow issues in and across the ground floor.

Targeted Actions

We continue to work with the ECIST team and our system partners to ensure that we can support improvement in A&E Performance and that our plans for winter are as resilient as possible.

Areas under consideration include the introduction of a UTC centre on site, which is at the planning stage. Providing an additional facility to the MH Trust on site to support MH patients who are awaiting assessment or admission and currently wait in ED as well as MH support for children in ED and on the ward.

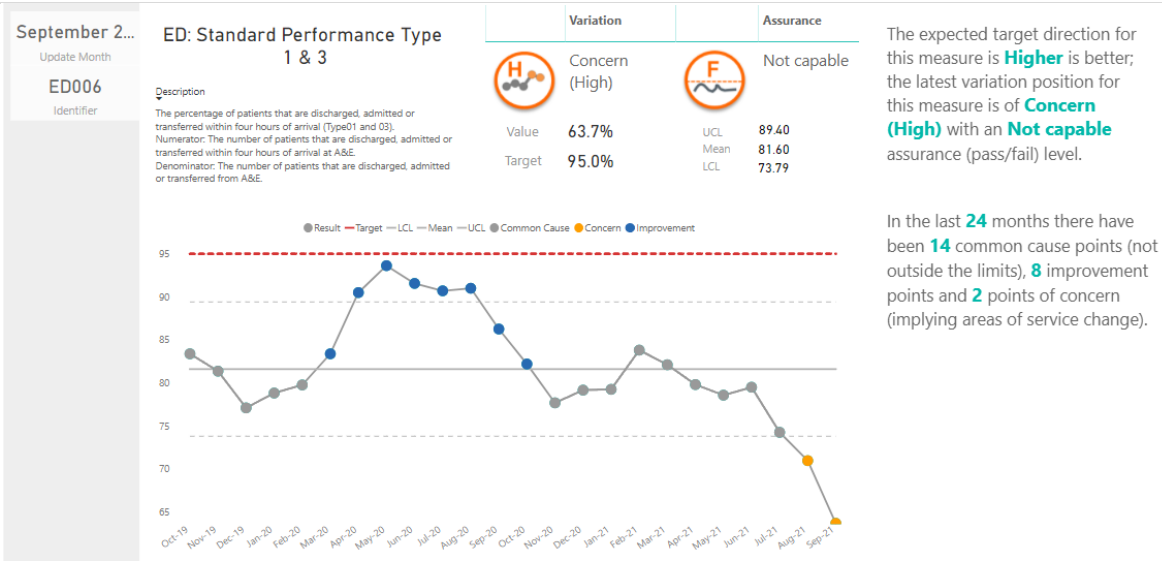
Development of a single system wide action plan for Handover improvement to be submitted to NHSE/I in October.

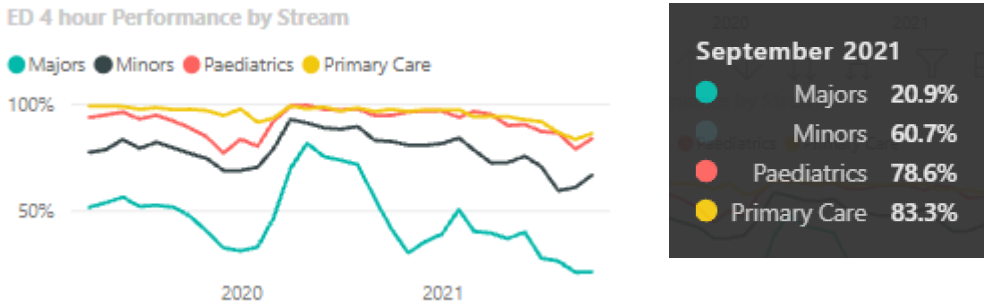
Outcome

A system wide working group will be established to monitor progress against the Ambulance handover improvement plan.

The 4 hr delivery Group will report on progress against internal actions across all emergency care standards.

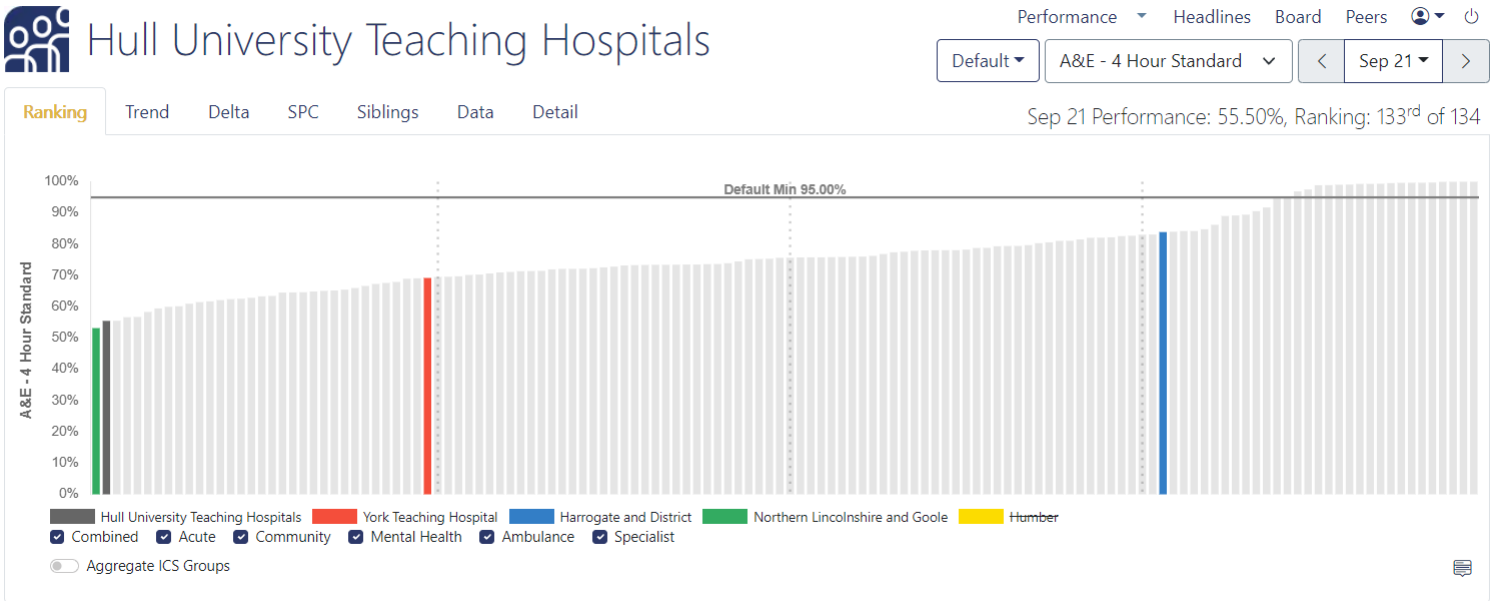
6.1 Emergency Care Standard

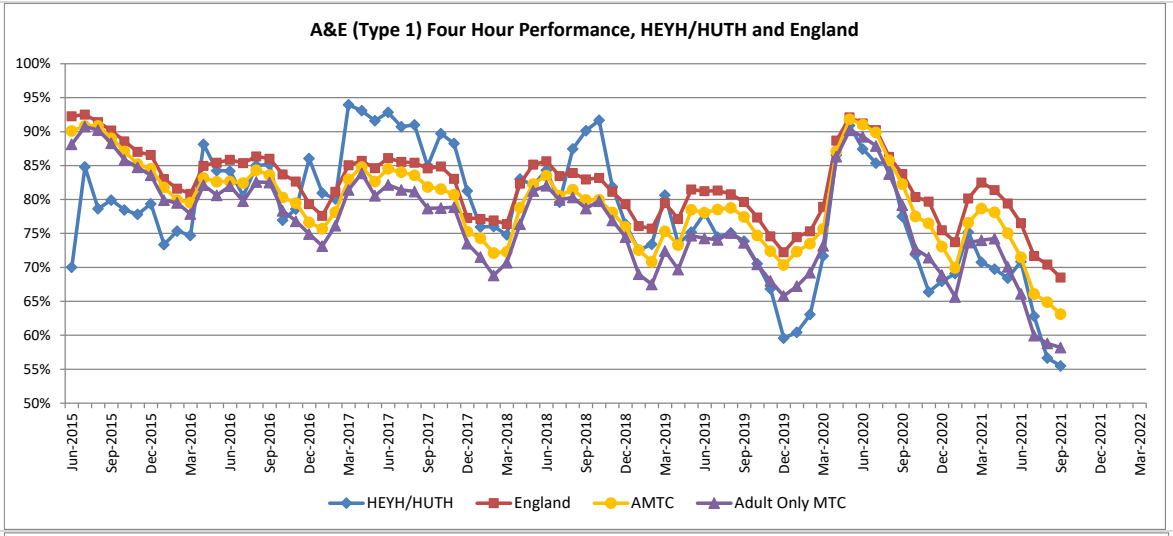
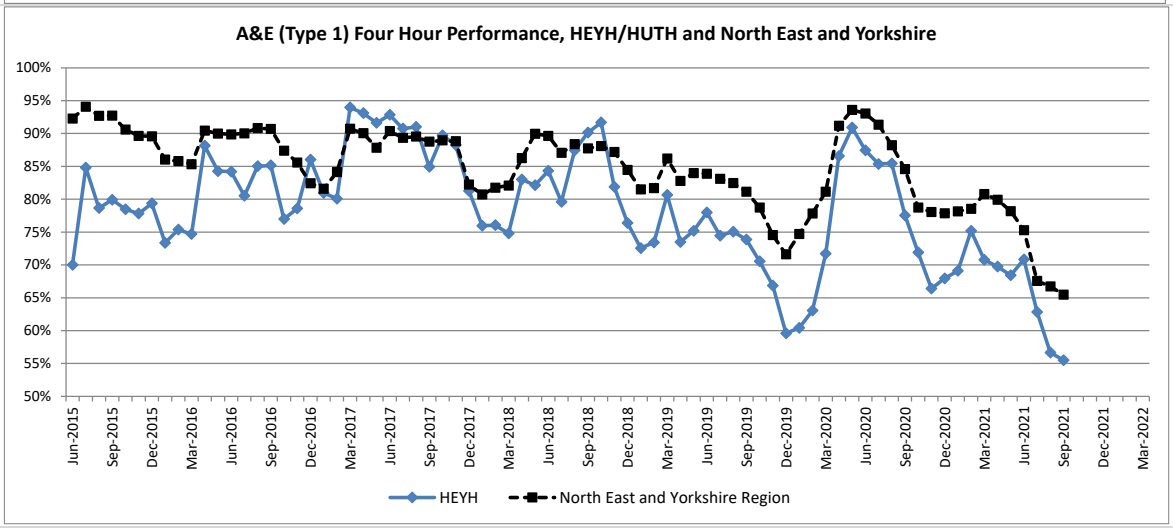
Standards	Ensure at least 95% of attendees to Accident & Emergency are admitted, transferred or discharged within 4 hours of arrival.
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	The Trust achieved 55.5% in September 2021 for Type 1. Performance for Type 1 & 3 in September was 63.7%. • There were 459 handover delays greater than 60 minutes with average handover times at 34 minutes in September. • There were Five 12-hour trolley breaches • 29.5% of patients spent more than 6 hours in the department (a deterioration of 1.4% on August) 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	 The expected target direction for this measure is **Higher** is better; the latest variation position for this measure is of **Concern (High)** with an **Not capable** assurance (pass/fail) level. In the last **24** months there have been **14** common cause points (not outside the limits), **8** improvement points and **2** points of concern (implying areas of service change).



Humber ICS Peer Analysis

In September 2021 the Trust ranked 133 out of 134 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 August month at 82.6%, which has remained static since July. Areas not achieving in month were Breast, Colorectal, Head and Neck, Skin, Upper GI and Urology.

- The Breast Service failed to achieve the 2WW wait breast symptomatic target in August with performing at 16.1%, showing a small improvement since July. September is already showing further improvement.

- In August performance against the 62-day Cancer standard was 55.8%. Challenges persist across most tumour sites mainly in the diagnostic stages of the cancer pathways. In addition, theatre and OPA capacity impedes on delivering treatment within target dates, for some services. Pathology delayed turnaround times (TAT) have impacted on some tumour sites which hinders the cancer pathways. August was a particularly difficult month in relation to responding to COVID pressures; staff redeployment, surgical ward configurations, anaesthetist shortage and staff absences due to self-isolation or infected with the coronavirus. A number of cancer surgeries were cancelled further impacting on the ability to perform well against the 62 day standard. None of the tumour sites achieved 85% in August.
- The cancer transformation work continues across the Humber which aims to iron out pathway delays and streamline patient pathways. Ongoing work is active in Lung, Head and Neck and Upper GI.

- The Trust failed to achieve the 62-day National Screening standard at 57.6 %; the majority of the breaches were in the bowel screening programme where timely access to colonoscopy continues to be the main reason for patients not being treated within target dates.

- The Trust failed to meet the 31-day primary standard performing at 89.8%. With the exception of Haematology and Brain (small numbers) all tumour sites failed to achieve the standard.

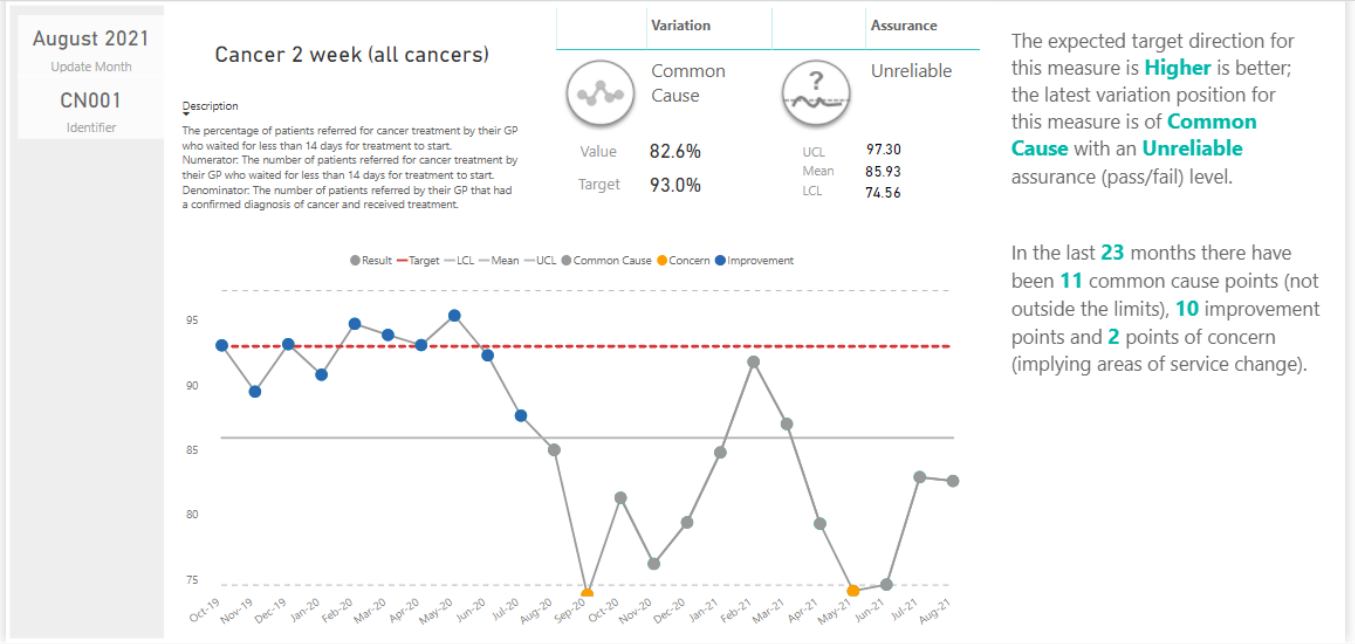
The Trust failed to meet the 31-day subsequent surgery standard at 77.8%. There were 15 breaches, primarily shared between Breast, Urology and Lung.

Targeted Actions

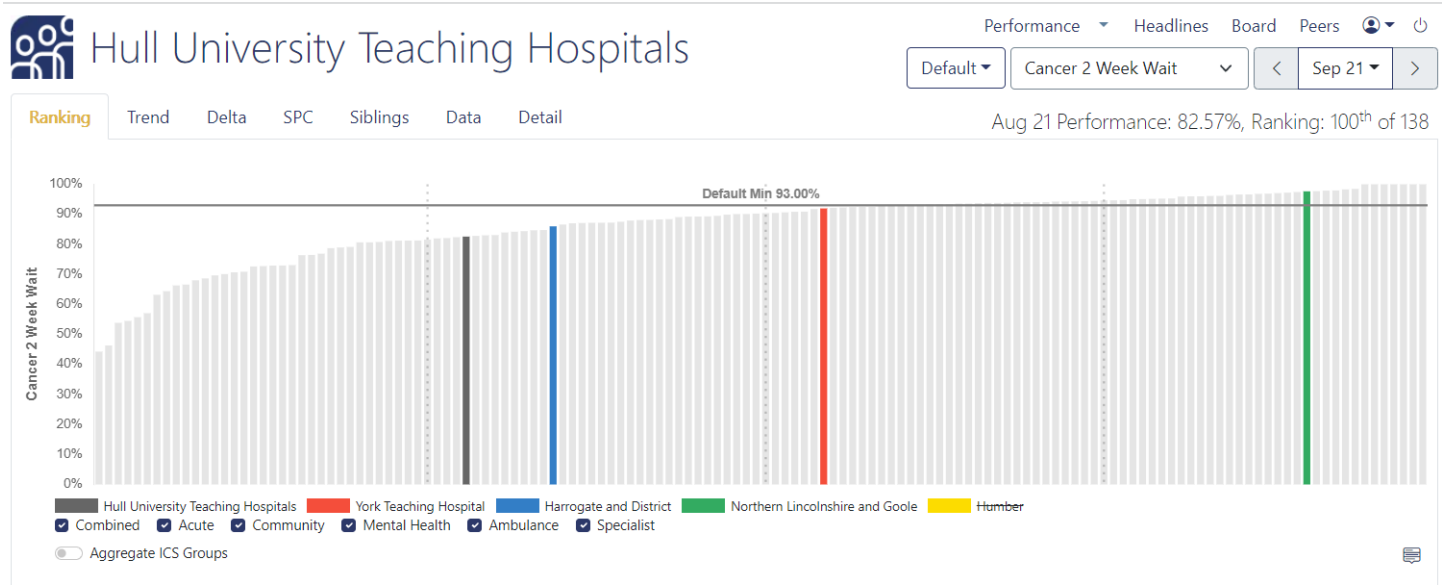
Intense and targeted management of the cancer PTLs continues at weekly meetings between the services and the cancer manager's team.

A deep dive into each high volume tumour site will commence with the Breast Cancer Service. Key findings and actions will be reported to the Performance and Finance Committee as they become available.

7.1 2 week wait Referrals

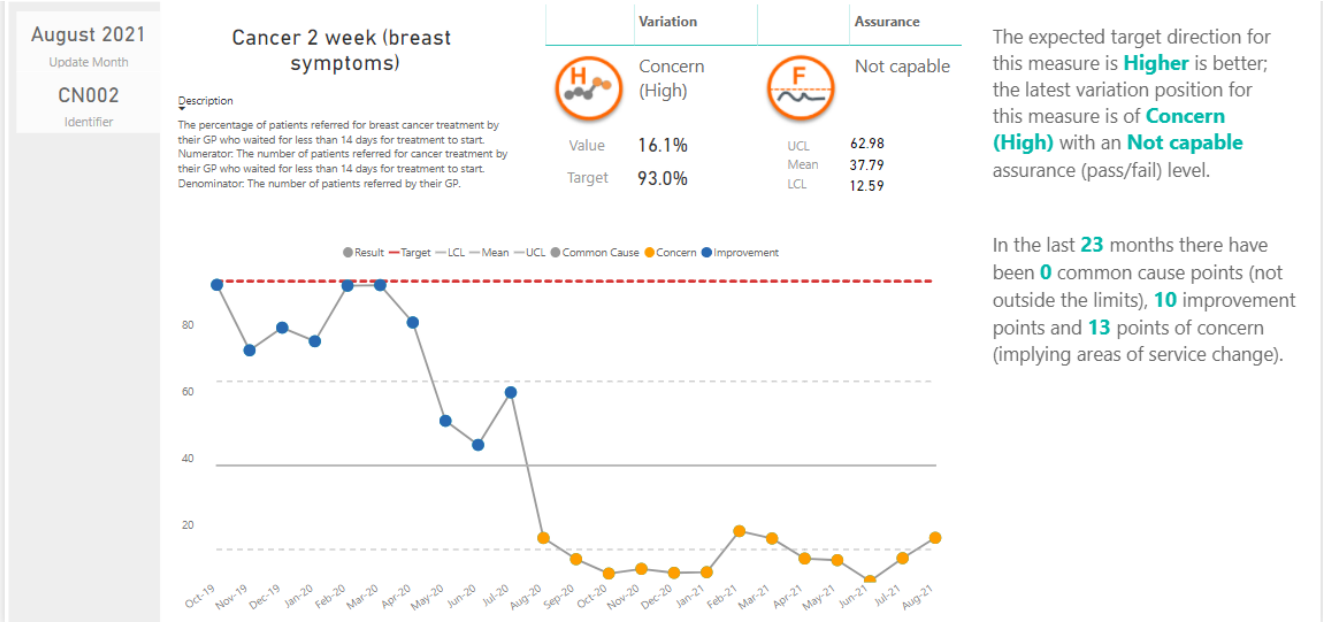
Standards	Ensure at least 93% of GP referrals for suspected cancer are seen within 2 weeks of referral.
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	Overall, the Trust delivered 82.6% performance in August 2021 (a deterioration of 0.3% on July). • There were 310 breaches of the 2ww standard with the majority in Breast at 124, Skin at 37 and Colorectal at 34. • 2ww suspected cancer referrals are now back to pre-Covid levels of demand. • The Trust has moved into the third quartile nationally for 2 week wait performance at 100 out of 138. • 40% of the breaches (4.3% improvement on previous month) are in Breast and the implementation of the business case has started to improve performance at Trust level. Performance was 69.8% for Breast 2ww cancer performance
Performance	

HCV Peer Analysis	Trust cancer 2 week wait when compared to Peer Group as at August 2021

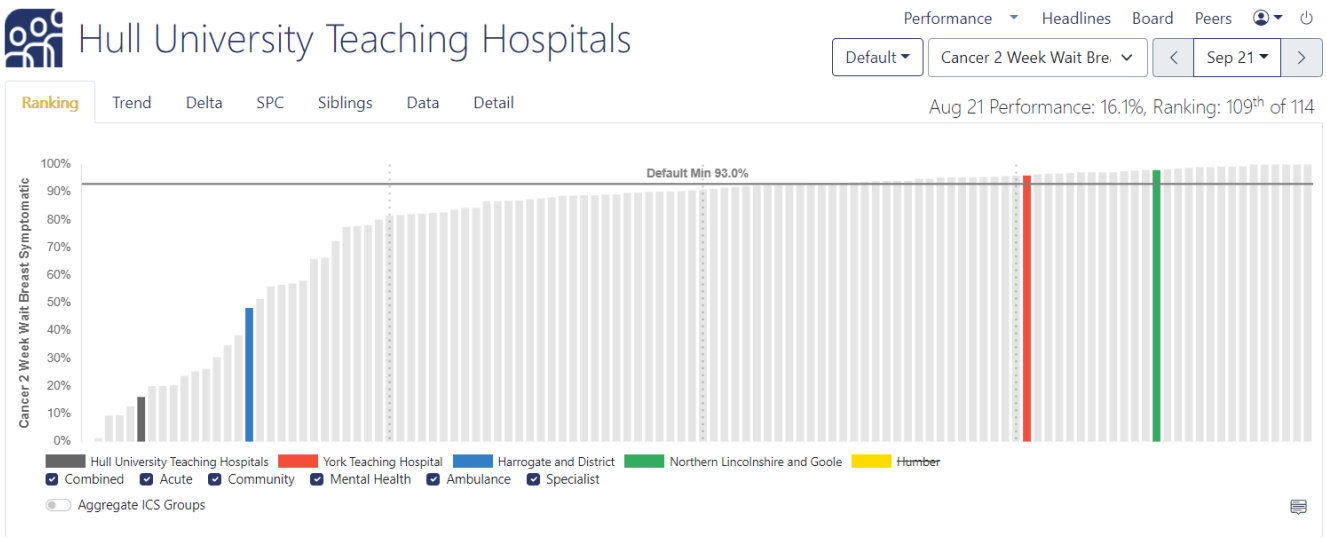


7.2 2 week wait Breast Symptomatic

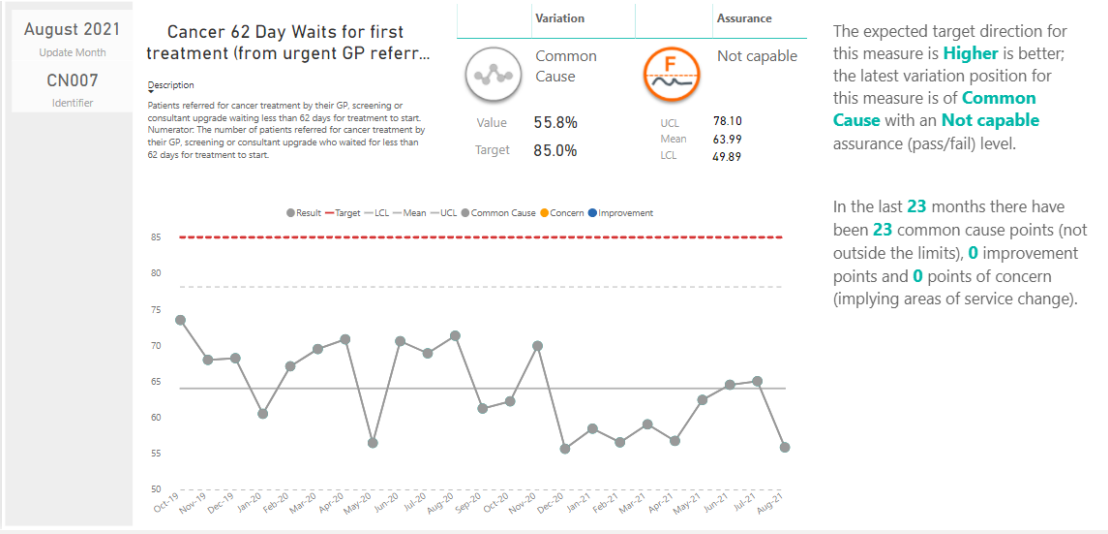
Standards	Ensure at least 93% of GP referrals for breast symptomatic are seen within 2 weeks of referral.
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	Overall, the Trust failed to achieve the standard of 93% delivering 16.1% in August (an improvement of 6.1% on July). • Of the 180 attendances, 151 patients breached the standard due to consultant staffing shortfalls and radiographer capacity constraints. • The Trust continues to be significantly lower in performance than all acute Trusts and is ranked 109 of 114.
Performance	SpC Analysis shows High Concern and Not Capable of achieving the standard. Once the Breast business case has been made fully operational the Trust should see this standard recover.



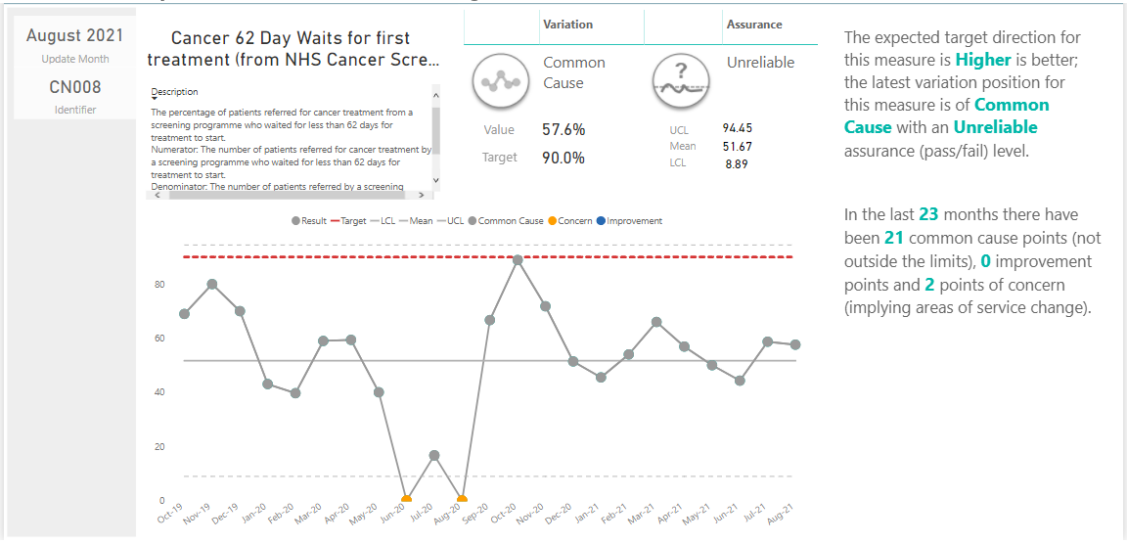
HCV Peer Analysis	Trust 2-week symptomatic Breast Performance compared to Peer Group as at August 2021.



7.3 62 Day Cancer Waiting Times

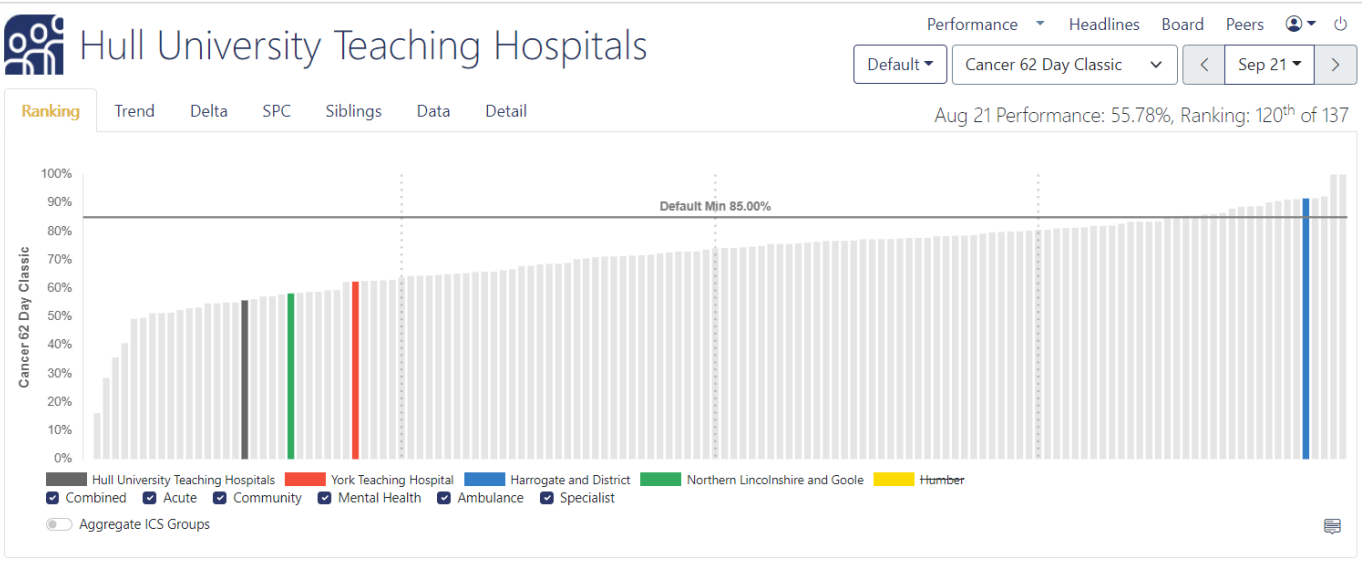
Standards	Ensure at least 85% of patients receive first definitive treatment within 62 days of urgent GP or GDP referral.
Consequence of under-achievement	Patient experience, clinical outcomes and potential impact on timely access to treatment.
Performance Update:	Overall, the Trust achieved 55.8% performance in August 2021 (an improvement of 9.2% on July). • There were 82 accountable breaches (Breast 14, Colorectal 13.5, Gynaecology 6.5, H&N 5, Lung 8, Skin 7, UGI 7, Urology, 16) • Upper GI Surgery is the tumour site with the lowest performance at 12.5% • Waiting list size at the end of August was 1,341 (an increase of 67 on the previous month) • 63+ day breaches at the end of August was 219 against a H1 trajectory of 140. 62-day screening performance for August was 57.6 8.7% (a deterioration of 1.1% on July) 104 days - At the end of August there were 45 patients recorded as having waited more than 104 days. The internal trajectory was to have no more than 34. Those above the internal trajectory are Urology x 14, Breast x 4, Skin x 6 and Haematology x 4.
Performance	**Cancer 62 day Performance – GP referral** 

Cancer 62 day Performance – Screening



HCV Peer Analysis

62 day performance against Peer.

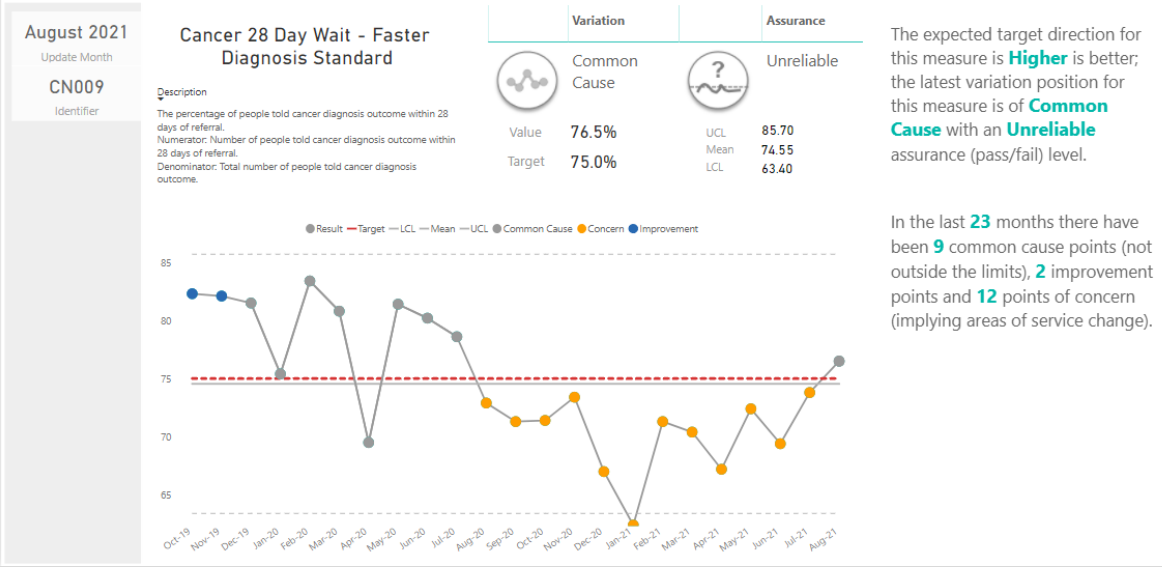


7.4 28 Day Faster Diagnosis

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 76.5% performance in August 2021 a further improvement on the July position • Colorectal remains the tumour site with the significant problem due to the backlog in Endoscopy procedures • Urology due to capacity constraints for haematuria appointments • Haematology due to late inter-hospital tumour site referrals • Gynaecology due to failed outpatient Hysteroscopy requiring GA Hysteroscopy capacity and delays in Histology • Lung due to multiple diagnostic tests to confirm diagnosis
Performance	Faster Diagnosis FDS Type: 2wwReportable, BreastSympReportable, ScreeningReportable between 01/08/21 and 31/08/21

Cancer Site	<7	8-14	15-19	20-24	25-28	>28	Total	% < 7	% < 28	% > 28
Brain	0	0	0	0	2	2	4	0.0%	50.0%	50.0%
Breast	44	269	159	57	50	69	648	6.8%	89.4%	10.6%
Colorectal	2	16	15	40	23	213	309	0.6%	31.1%	68.9%
Gynaecology	31	36	8	12	10	43	140	22.1%	69.3%	30.7%
Haematology	0	3	0	0	0	3	6	0.0%	50.0%	50.0%
Head and Neck	49	69	9	10	3	11	151	32.5%	92.7%	7.3%
Lung	4	13	3	6	4	11	41	9.8%	73.2%	26.8%
Paediatric	1	1	0	0	0	0	2	50.0%	100.0%	0.0%
Skin	38	303	21	8	2	7	379	10.0%	98.2%	1.8%
Upper GI	0	32	36	22	12	27	129	0.0%	79.1%	20.9%
Urology	10	33	6	2	7	65	123	8.1%	47.2%	52.8%
Total	**179**	**775**	**257**	**157**	**113**	**451**	**1932**	**9.3%**	**76.7%**	**23.3%**

SpC Analysis

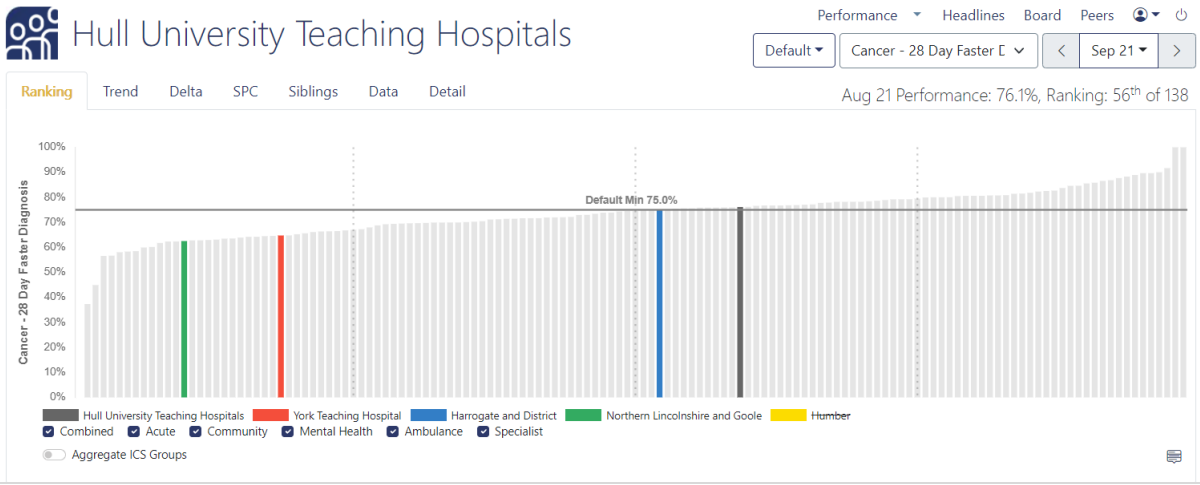


The expected target direction for this measure is **Higher** is better; the latest variation position for this measure is of **Common Cause** with an **Unreliable** assurance (pass/fail) level.

In the last **23** months there have been **9** common cause points (not outside the limits), **2** improvement points and **12** points of concern (implying areas of service change).

HCV Peer Analysis

Peer analysis shows that HUTH are performing well in HCV.



8. Planned Care

Operational Context

In September the Trust RTT performance was 57.7%, which is and improvement of 0.3% on the previous month. The waiting list volume was above the H1 plan trajectory at 58,795 (plan 55,803). 52 week breaches reported was 6,740 (an improvement of 172 on the previous month) and was below the trajectory of 6,964.

Diagnostic performance was 39.3% of patients were waiting over 6 weeks which is a deterioration on August of 0.8%. This equates to 4,891 patients waiting over 6 weeks.

The Outpatient New waiting lists has increased to 31,639 patients awaiting a first outpatient appointment (RTT applicable only) and 25,289 patients overdue their follow up >3 months (undated) which is a reduction on the previous month. Non face to face consultations in September was 20.4% of outpatient attendances which is below the H1 plan trajectory requirement of 25%. Advice and Guidance requests in August was 2,667 which is above the H1 plan of 2,537.

Patient initiated follow ups rather than traditional outpatient follow up at a clinically identified time have now been implemented in Colorectal Surgery, Dermatology, Paediatrics and Nephrology. Task & Finish Group 5, under the Elective Recovery Group is taking this work further and ensuring that the H1 plan requirements set of implementing an additional 3 main specialties is achieved. 256 patients were added to PIFU in August which is above the H1 plan trajectory of 132.

There were 55 cancelled operations in September for non-clinical reasons. 9 patients were treated in September outside of their 28 day rebooking date. There were 13 urgent cancelled operations in September but none cancelled for the second time.

In terms of activity, all Points of Delivery (POD), except Ordinary Elective were above the new national requirement of 95%. Ordinary Elective delivered 67% of H1 plan and 77% of baseline (-356 to 95%).

Targeted Actions

Elective Recovery Group

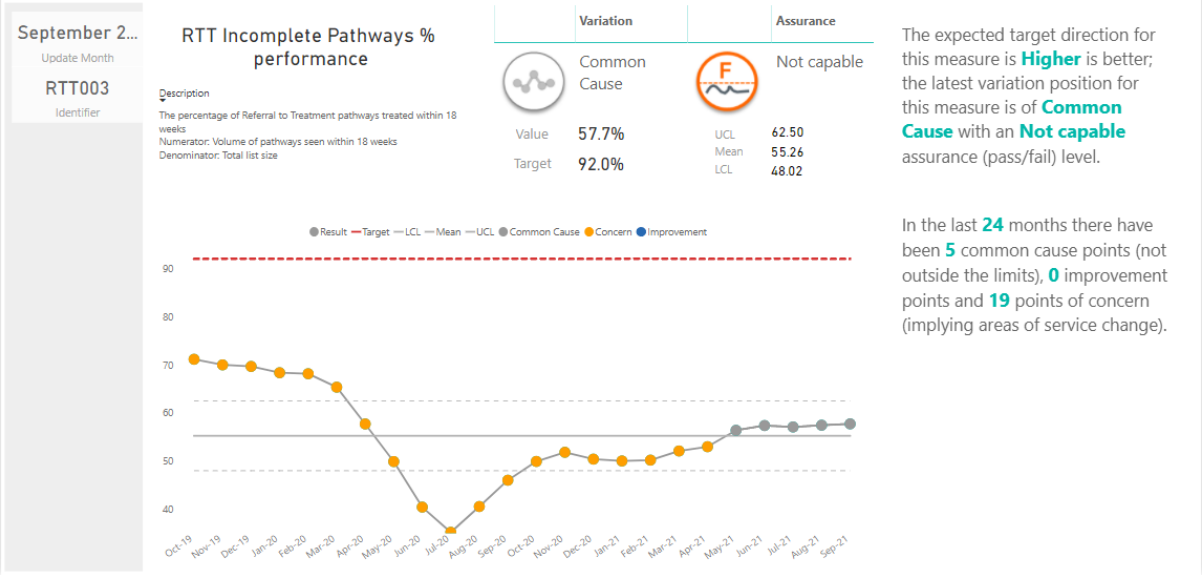
The Elective Recovery Group meet fortnightly and oversee the recovery programme and delivery of the outputs of the Task and Finish Groups. A separate Elective Recovery Report is provided for the Performance and Finance Committee, which outlines delivery of the H1 plan with exception reports for the Top 12 specialties.

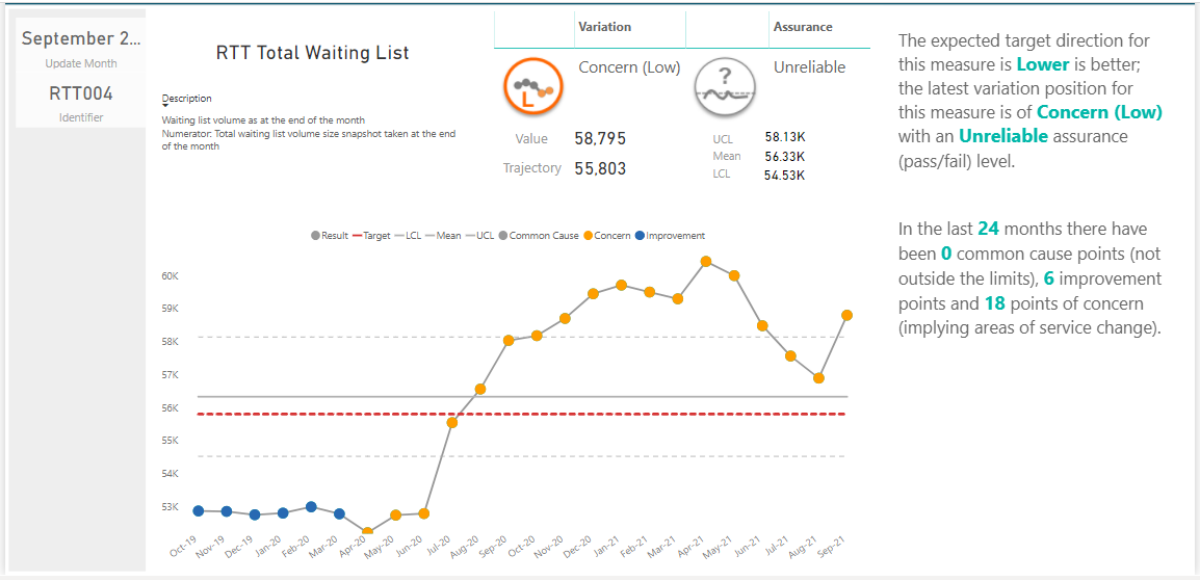
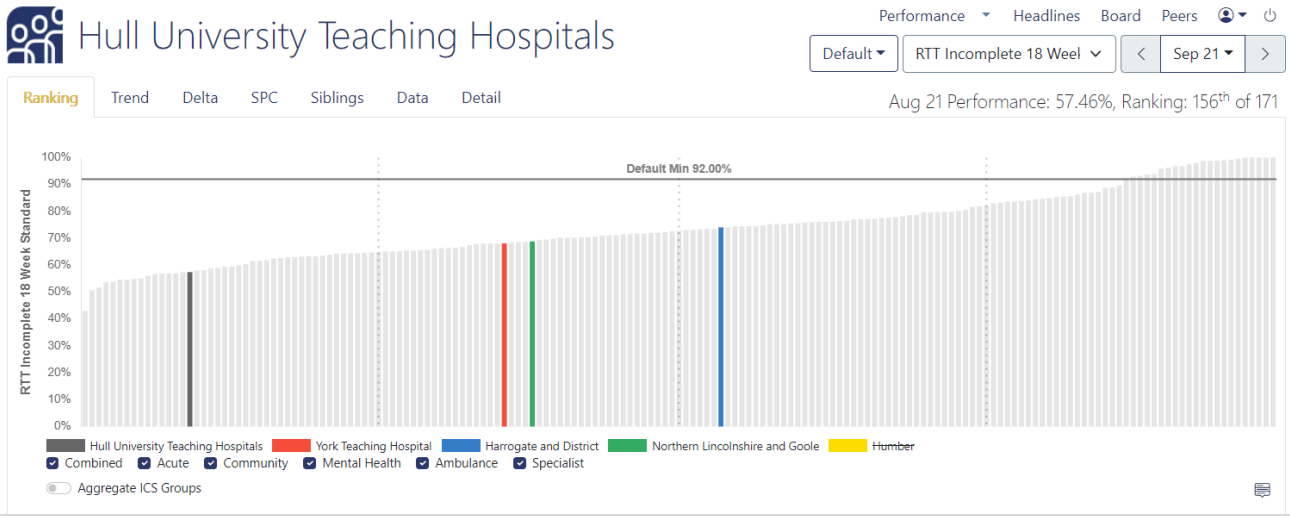
A separate weekly performance meeting has been established, chaired by the Deputy COO focussing on actions at patient level to reduce the number of patients waiting over 104 weeks.

Outcome

Quarterly review meetings have been held with the Health Group triumvirate and Clinical Lead for each of the top 12 specialties to review areas of risk and what mitigating actions are being put in place.

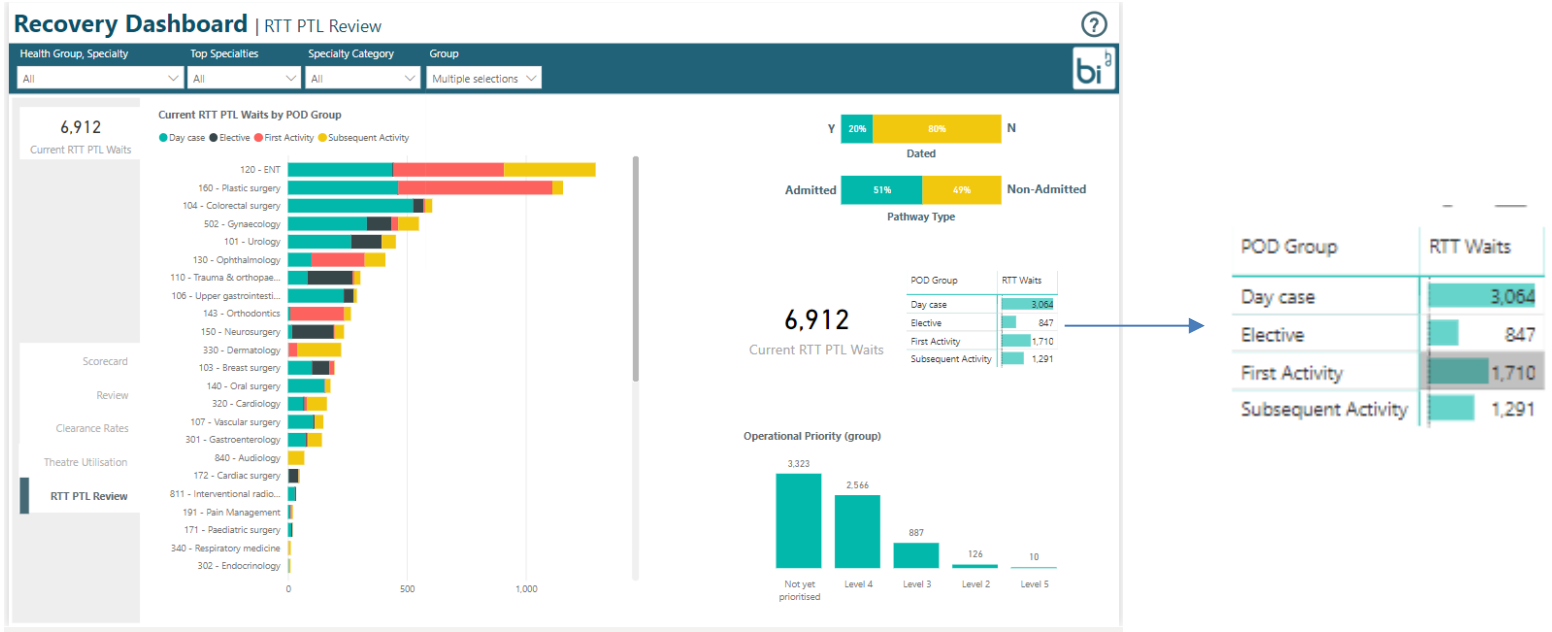
8.1 18 Week Referral to Treatment

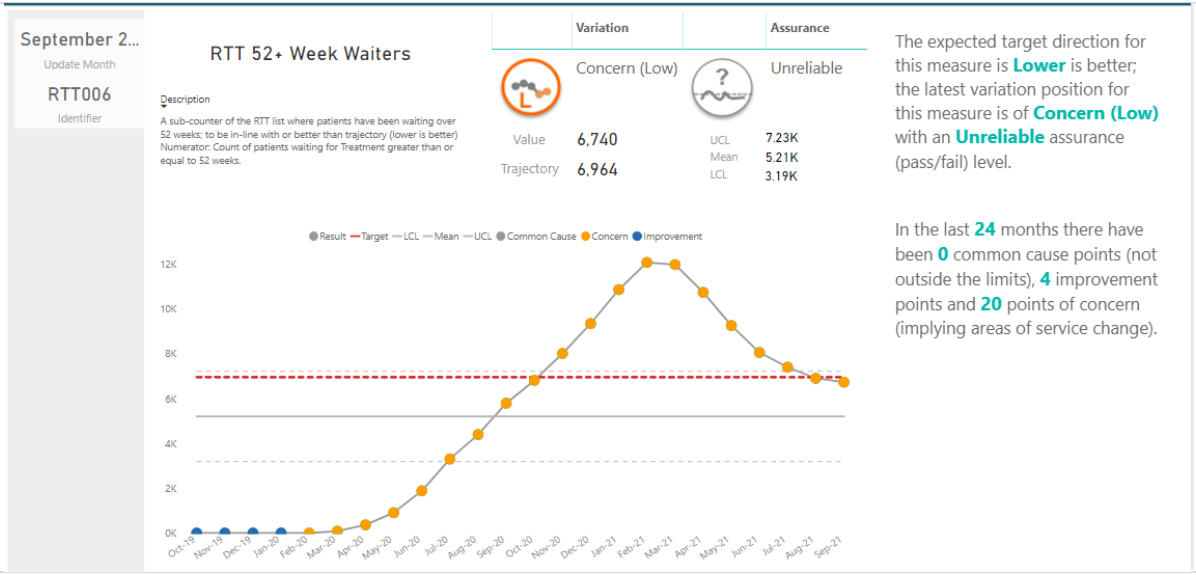
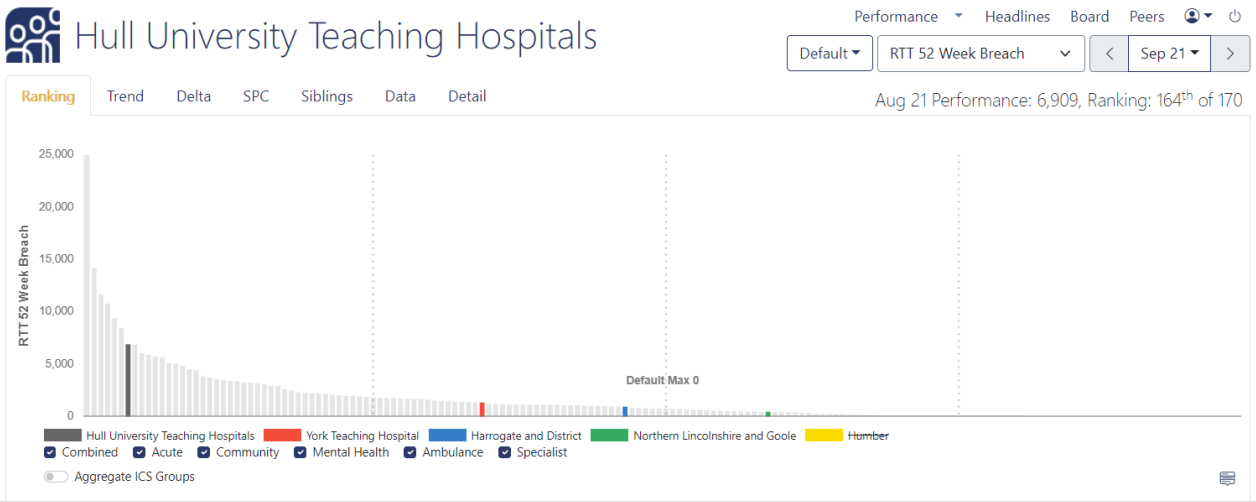
Standards	Ensure at least 92% of patients waiting on the incomplete pathways have waited less than 18 weeks. Incomplete list size trajectory to be achieved – aim to reduce to 55,803 by end of September 2021
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	**Overall the Trust delivered 57.7% performance in September 2021** • RTT list size for September was above the trajectory at 58,795 (+1,904 on August and +2,992 to trajectory). • The increase in the WLV is due to more clock starts (+1,012) than what was predicted in the RTT forecast model and a reduction in clock stops (-1,638) • Average wait in September was 16.3 weeks against a Trust 7 week standard
Performance	

RTT WLV	
Peer Analysis	RTT Incomplete Performance against peer (bars HCV providers) show HUTH ranked at 156 out of 171. 

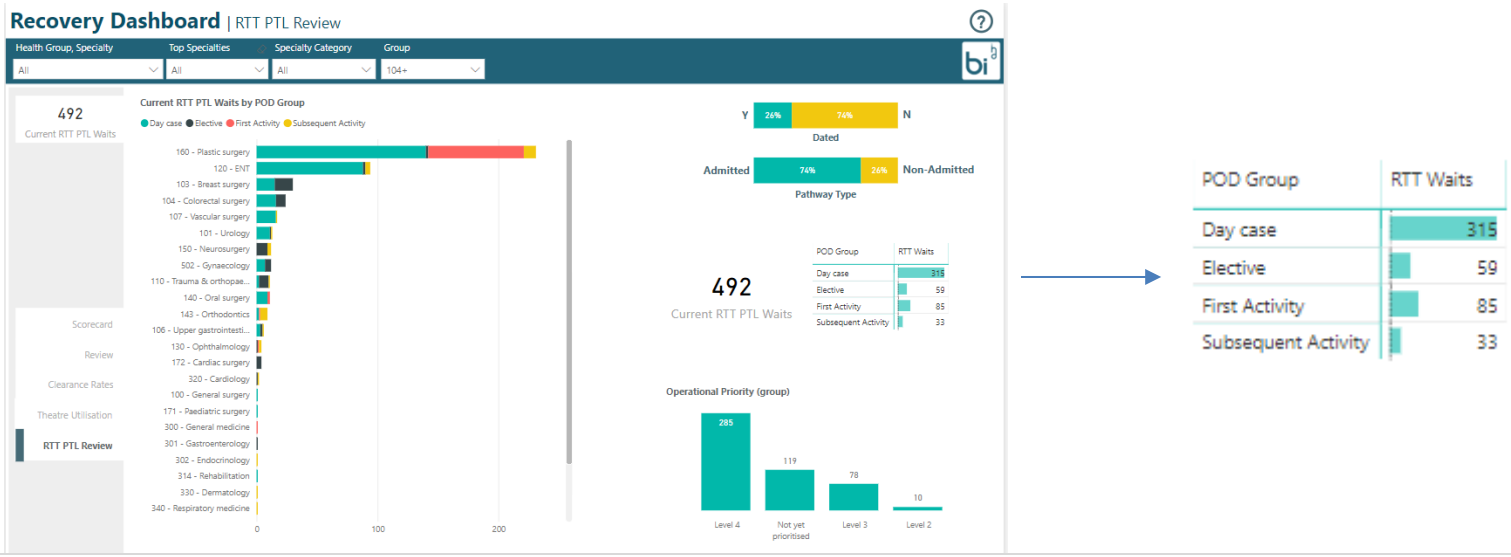
8.2 52 Week Breaches

Standards	Zero tolerance of 52 week waits
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action.
Performance Update:	**52 week breaches reported in September is 6,740 (- 172 on August 21)** • 3,467 admitted breaches • 3,273 non-admitted breaches • 18.6% of the breaches are in ENT (1,254) an improvement of 16 on August – of which 64% are on a non-admitted pathway • 16.7% of the remaining breaches are in Plastics Surgery (1,131) of which 60% are on a non-admitted pathway
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.

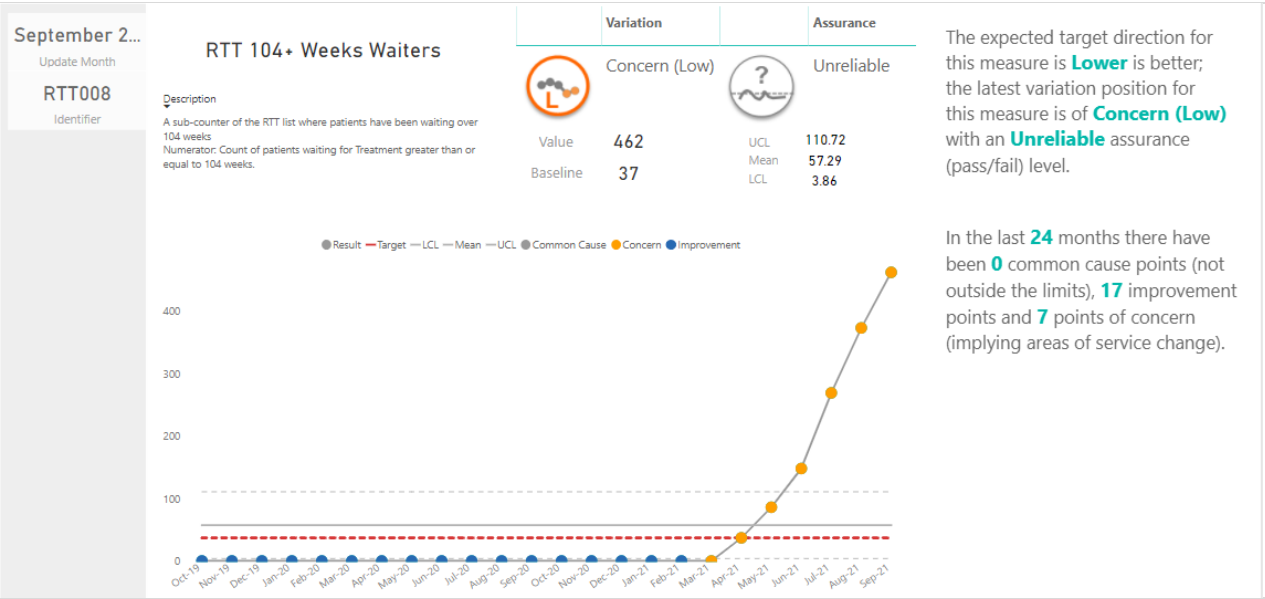


SpC Analysis	
HCV Peer Analysis	University Hospitals Birmingham has the highest number of 52 week breaches at 24,960 – data at August 2021. HUTH national ranking has improved by 1 place despite the reduction in the number of 52 week waiters 7 months in a row. 

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:	**104 week breaches reported at the end of September is 462** • 338 admitted breaches • 124 non-admitted breaches • 46.5% of the breaches are in Plastic Surgery • 20.3% of the remaining breaches are in ENT 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. The commencement of 2 new Plastic Surgeons in October and November is expected to improve this position.
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. 

SpC Analysis



The expected target direction for this measure is **Lower** is better; the latest variation position for this measure is of **Concern (Low)** with an **Unreliable** assurance (pass/fail) level.

In the last **24** months there have been **0** common cause points (not outside the limits), **17** improvement points and **7** points of concern (implying areas of service change).

8.4 Priority 2 Patients

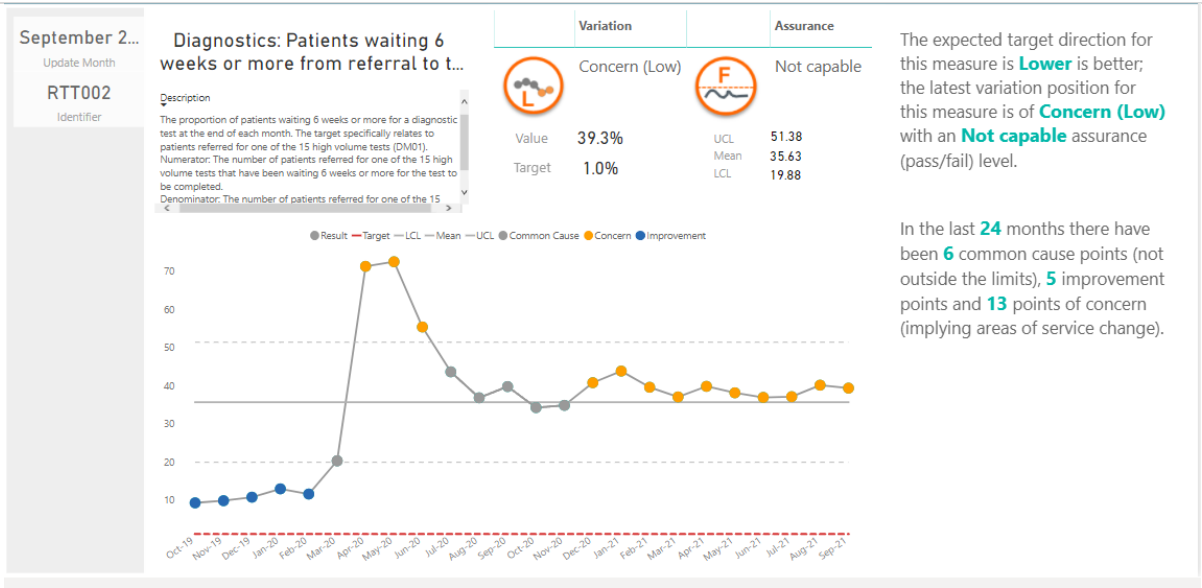
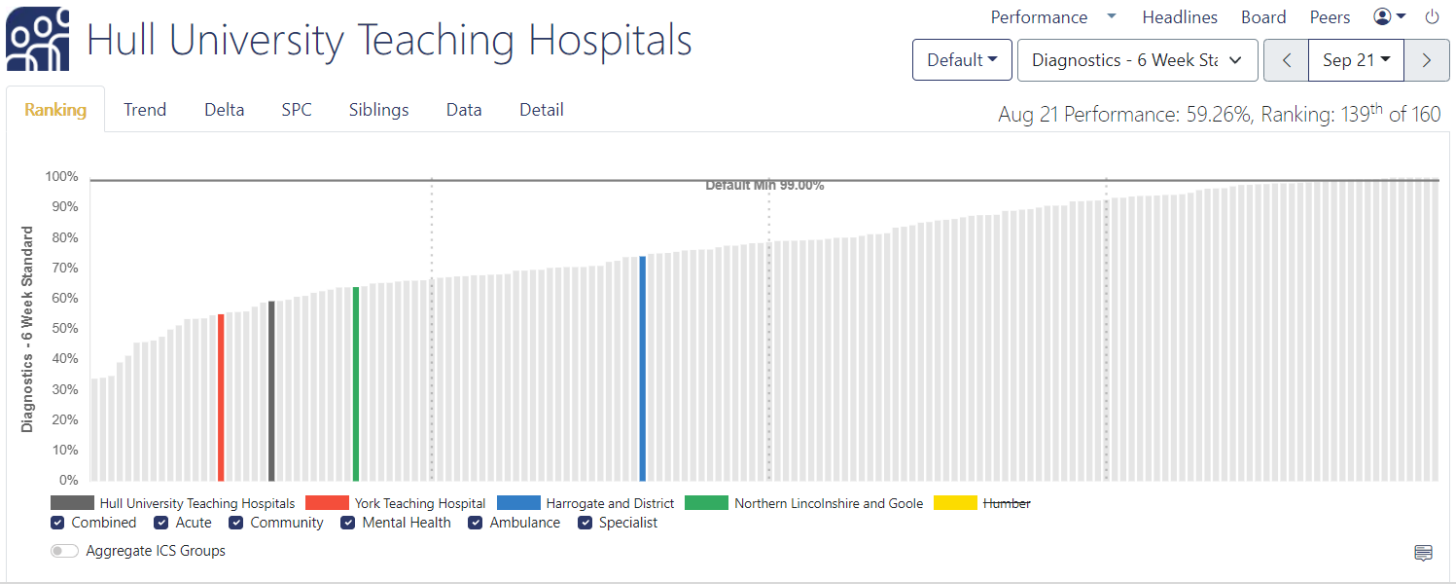
Standards	Reduction in the number of Priority 2 patients waiting longer than 12 weeks
Consequence of under-achievement	Patient experience, clinical outcomes, timely access to treatment and regulatory action. Priority 2 patients should be treated within 4 weeks of decision to treat.
Performance Update:	The number of patients waiting over 12 weeks as a Priority 2 at the end of September was 258. • Total patients waiting for a P2 procedure was 1,398 • 623 of these had waited over 4 weeks with performance at 55.4% 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.
SpC Analysis	Under development

Count of HEYNo	Priority Wait Group			
Treatment Function	< 4 wks	>= 4 wks	13+	Grand Total
Plastic surgery	152	83	37	272
Urology	93	37	17	147
Vascular surgery	39	19	61	119
Trauma & orthopaedics	58	24	18	100
Cardiac surgery	26	47	25	98
Cardiology	68	17	12	97
Colorectal surgery	27	24	19	70
Pain Management	23	23	23	69
Ophthalmology	37	10	6	53
Neurosurgery	23	18	8	49

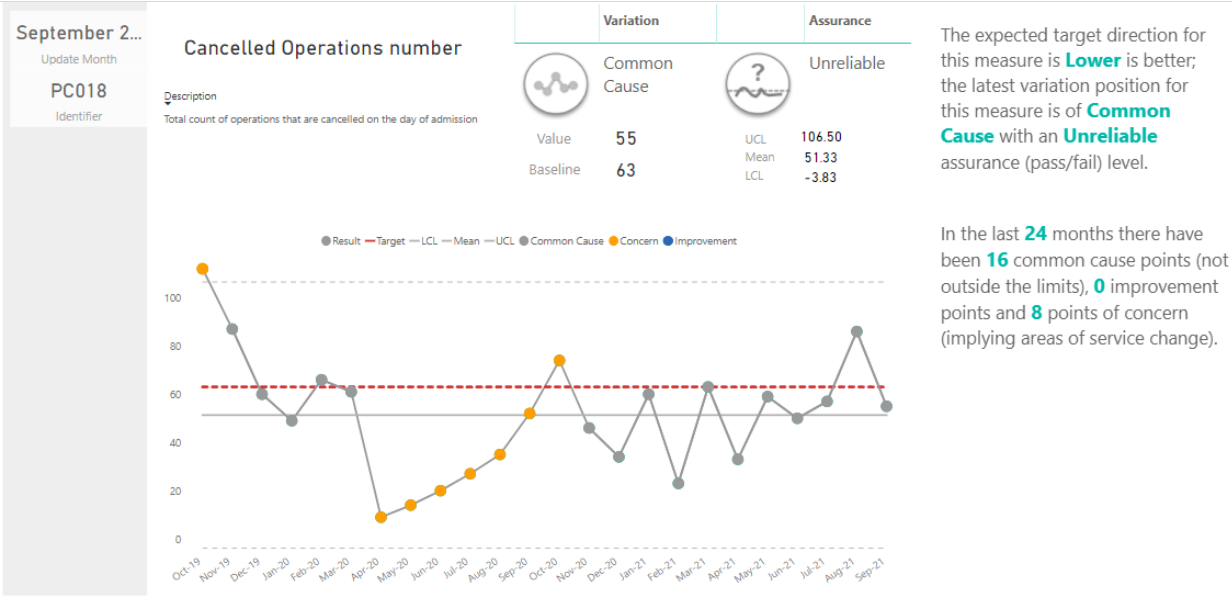
9. Diagnostic 6 week wait (top 15 tests)

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 39.3% performance in September 2021, which is 0.8% improvement on August**. • Total over 6 week waits = 4,891 which is a decrease of 250 on August • The overall waiting list has decreased slightly to 12,816 (-297)
Performance	9 modalities have seen a reduction in the number of over 6 week diagnostic waits, with only 4 seeing a slight increase.

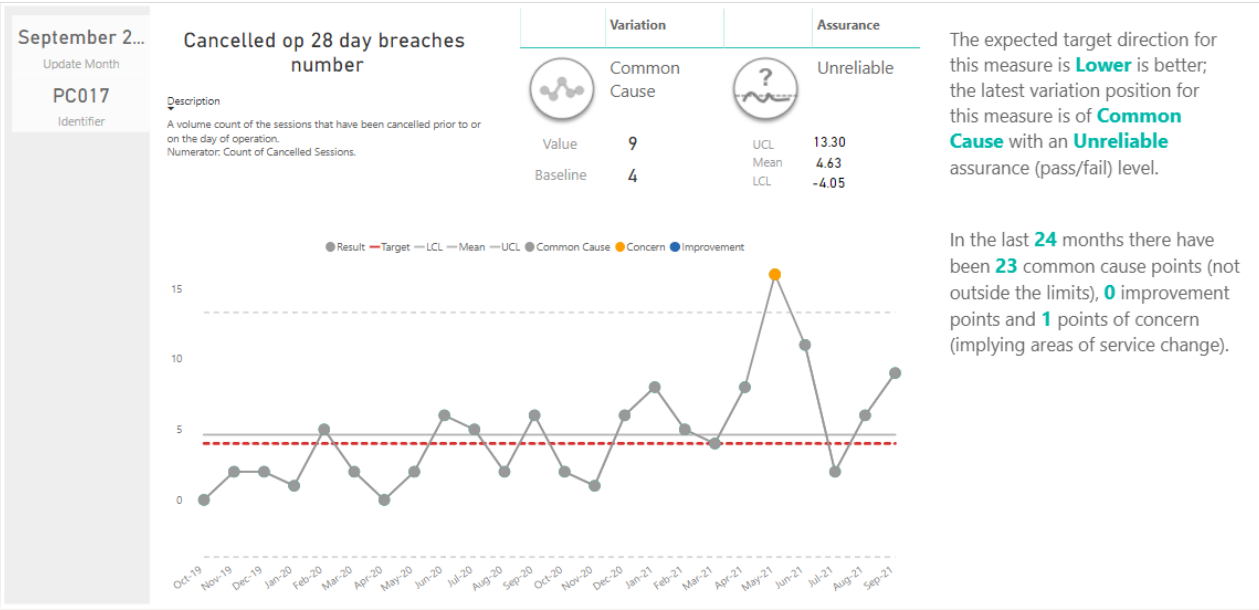
	Breaches	Variance
Magnetic Resonance Imaging	16	-7
Computed Tomography	450	-40
Non-obstetric ultrasound	27	-76
Barium Enema	0	0
Cardiology - echocardiography	1180	-127
DEXA Scan	680	50
Neurophysiology - peripheral neurophysiology	0	-5
Respiratory physiology - sleep studies	1	-1
Urodynamics - pressures & flows	63	-12
Cardiology - electrophysiology (epsip)	0	0
Colonoscopy	988	22
Flexi sigmoidoscopy	626	27
Gastroscopy + ENT	570	-87
Cystoscopy	285	16
Audiology - Audiology Assessments	5	-10
	4891	-250

SpC Analysis	
HCV Peer Analysis	HCV Peer Analysis for August 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 55 patients cancelled for non-clinical reasons in September 2021. • Total number of breaches of the 28-day standard (treated in September) = 9 - 28 day Breaches treated in Sept (T&O x2, Thoracic x1, UGI x1, Cardiology x1, Gynae x1, Ent x1, Radiology x2) • There were 13 urgent cancelled operations in September but none for the second time.
Performance	 The expected target direction for this measure is **Lower** is better; the latest variation position for this measure is of **Common Cause** with an **Unreliable** assurance (pass/fail) level. In the last **24** months there have been **16** common cause points (not outside the limits), **0** improvement points and **8** points of concern (implying areas of service change).

Performance – 28 day Breaches



The expected target direction for this measure is **Lower** is better; the latest variation position for this measure is of **Common Cause** with an **Unreliable** assurance (pass/fail) level.

In the last **24** months there have been **23** common cause points (not outside the limits), **0** improvement points and **1** points of concern (implying areas of service change).

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

Item: Performance Report	Level of assurance gained: Reasonable
The Trust had not achieved its targets for ED, Cancer and Faster Diagnosis, although improvement was noted in some of the areas. 52 week breaches saw an improvement but the waiting list volume did not meet the recovery trajectory. The 4-hour delivery action plan continues to be further developed and associated service change to be implemented alongside the plan for an UTC type facility on the HRI site.	
Item: Finance Report	Level of assurance gained: Good
The Trust has now received guidance on the financial framework for H2. The year to date deficit was in line with the plan. All health groups are struggling to identify recurrent CRES schemes and this remains a challenge for the Trust. Expenditure variances in the in-month increase was in two health groups, both with continuing pressures from previous months. The underlying deficit position has increased by £0.4m to £48.2m and there is a need to clarify recurrent income and efficiency savings to offset this.	

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 27 September 2021

Present:	Mr M Robson	Chair
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr P Walker	Deputy Chief Operating Officer
	Mr S Evans	Deputy Director of Finance
	Mrs A Drury	Deputy Director of Finance
	Mrs R Thompson	Head of Corporate Affairs
	Mrs J Railton	Assistant Director, Strategy and Planning
In Attendance:	Miss R Boulton	Quality Governance Officer (Minutes)

No **Item**

1 Apologies:
No apologies were noted.

2 Declarations
There were no declarations made.

Agenda was taken out of order at this point.

8 Performance

8.1 Performance Report
Mrs Ryabov presented the performance report and confirmed that the overall key standards had not changed significantly. We continue to work with the ECIST team and our system partners to ensure that we can support improvement in A&E Performance and that our plans for winter are as resilient as possible.

Areas under consideration are the introduction of an Urgent Treatment Centre on site, which is at the planning stage. Ongoing discussions with CHCP in relation to signposting patients to the appropriate treatment, following the visiting to Lincoln we are not pursuing the portacabin idea as it was only 50% effective at Lincoln therefore we will look to locate with the ED. CHCP are unsure if could supply the necessary staffing therefore we are in talks with an external partner in York who currently supply an out of hours provision.

Also looking at providing an additional facility to the MH Trust on site to support MH patients who are awaiting assessment or admission and currently wait in ED as well as MH support for children in ED and on the ward. Despite the work it is unlikely we will see any impact on the ground until December despite talks starting in May.

The red and green pathways remain challenging and putting staff under pressure.

The Trust did not achieve the 2-week wait cancer target in the month of July achieving 82.5%. With the exception of Breast, Colorectal, Paediatric and UGI all other tumour sites achieved, or exceeded the 93% standard.
Performance against the 62-day Cancer standard was 65% for July.

The Faster Diagnostics Standard was not achieved in July, achieving 73.7%. With the exception of Breast we know have problems given the number of cancellations relating to the bed and ICU pressures.

Faster diagnosis's held a meeting in July. There was no standard set in H1 just asked us to improve but August has seen a deterioration from July. Referral to treatment have managed to meet waiting list reduction.

Challenges of those patients staying in ED for 6 hours.
29.1% longer than 6 hours for ED, 11% significant increase on last year. There is a knock on effect to patient safety and patient discharges. Looking how we can reduce that as it is of great concern.

Mrs Christmas asked if the UTC would reduce waiting time, in terms of majors. In relation to the issues of a crowded ED and patients unable to be transferred out of ambulances, the problem seems to be getting them out of ED. Are there other options for ED as this is a high risk area for not being seen or treated.

Mrs Ryabov responded that we know occupancy is 14 beds and 80% of lodged beds within ED major should be elsewhere. We need two more wards to manage current emergency flow so we acknowledge the need. Across the hospital currently we have approximately 50 patients that are medically fit which equates to an additional two wards, which is where the social care crisis is affecting the Trust.

The challenge with opening up wards is staffing, there are always beds across the Trust as a whole but these are generally within the green pathway at CHH. We have reviewed how patients are managed and have built the new SDU and AAU to support. The exasperating factor is staffing, there is a pressure with staff sickness and isolation, staff are also tired.

Mrs Christmas stated she appreciated we cannot just keep opening wards and AAU target discharge times being extended.

Mrs Ryabov shared that there is staffing and leadership challenges within the health groups and there were discussions with the medical staff to get more support into the acute pathways.

Mr Bond reflected that it was more complex than reported, there is an expected certain flow and discharges but we would still be short of beds, despite having beds across the Trust there are no beds in medicine and that is where the requirement is. There is the added challenge of having to maintain the red and green pathway, we may have beds in the red pathway but they cannot be used for patients in the green pathway.

Mrs Ryabov agreed that it has added much more pressure on the system. The beds we have the beds on the green site are not staffed as we aren't expecting to use them.

Mr Robson questioned if the new ICU building will make a difference once open. Mrs Ryabov responded that we rarely have lack of ICU beds the issue is lack of staff, when more ICU beds are required it's the theatre nurses that get pulled into ICU. We may get efficiencies with it being closer together rather than separated but no difference in terms of patients numbers due to staffing.

Mr Bond shared that the nursing numbers look positive, when the new students get their PIN numbers we will be over established but if we open a new ward they would be

absorbed immediately. The issue is short term sickness and also a growing issue with maternity.

Mrs Ryabov shared the opening of a UTC is an incremental move the aim is a combination of UTC staff and our staff by end of December, as the ED is the area causing the highest risk. The intention will be they bring staff in, combined with our staff, they can mobilise in three months. We have an existing facility, but may need to relocate the fracture clinic so we can expand.

Mrs Drury questioned how would the activity be captured and what that means for reporting. Mrs Ryabov responded that she anticipated it would be through our reporting and we would be the CQC registered provider as the activity would be based within our buildings.

Mrs Christmas asked if there was a risk our stats will go back. Mrs Ryabov shared there may be a risk, if the facility is run efficiently more people may attend.
Mrs Christmas requested some specific information regarding the reporting. Are there initiatives around improving discharge. Mrs Ryabov confirmed we working with community to unblock the discharges.

8.2 Elective Recovery Plan

Mrs Ryabov acknowledged there was not a significant difference to last month, and we had not reached the 95% for the elective. Priority 2's 18.2% under the trajectory at 48.6%.

The H1 operational plan requirement for diagnostics is to deliver "Recovery of the highest possible diagnostic activity volumes will be particularly critical to support elective recovery".

MRI (-72), Colonoscopy (-29), Flexi-sigmoidoscopy (-69) and Gastroscopy (-64) did not deliver their H1 plans.
Flexi-sigmoidoscopy delivered 53% of 19/20 activity and 59% of their H1 plan.

Details the activity against the Trust H1 plan for the top 7 diagnostic modalities shared within the papers.

Ordinary Elective delivered 88% of H1 plan and 80% of baseline.

Overall outpatient clinical activity is back to pre-covid, but the cleaning and social distancing has reduced patients.

Emergency / elective theatre are doing more work but not seeing more patients again due to the additional cleaning and reduced patients.

Income gains and financial risk overall were documented within the papers shared.

Mrs Christmas asked what the current month looked like and if will this continue for a while. Mrs Ryabrov confirmed there were more elective cancellations than in August and there was little confidence this will improve in this quarter and if ED remains under the current pressure figures will decline in last quarter.

Mr Bond questioned that the centre is telling us to be at 95% and the covid impact is 5%, but the impact reported within the Trust is 30%. Are other organisations managing better and back to 2019/20's efficiency levels?

Mrs Ryabrov responded that our IPC are particularly specific about social distancing etc and also as a tertiary centre with lots of trauma and tertiary work we are disadvantaged compared to other centres who do not do this type of work. The Trust is applying the rules tightly compared to some others when patients are mixing in community yet being tightly managed when in the hospital. The expectation is that we manage all the normal work with the added pressures of covid.

8.4 Winter Plan

Mrs Ryabov shared that we have combined Winter / Covid plan part of winter to ensure we have the right resources and processes.
We are working effectively with partners, but they are also dependant on workforce and nursing homes have real staffing issues to the extent of some homes closing.

Some of the expected challenges this year are around the anticipated flu season, the absence of one last year and lack of the flu season within the southern hemisphere may cause this years to be more substantial as the strain in which we have vaccinated against maybe ineffective which is a concern to Public Health.

The HUTH Covid Surge Plan and a significant amount of the planning developed by the Covid/Winter Silver command team has been designed to ensure compliance with infection prevention and control guidance and to improve patient safety by reducing nosocomial infection.

Mrs Ryabov shared keys elements of the winter plans including, health group winter funding priorities, escalation planning and command along with the objectives and principles. Also discussed were the considerations following learning from covid and worst case scenarios.

NHSE modelling now predicts that we should anticipate the number of Covid-19 patients in October to be at around 40-50% of our wave 2 peak (267 patients) rising to between 60-70% of that figure in January to March. That equates to between 106 and 134 in October and between 160 and 187 during the winter.

Mrs Ryabov shared the potential key seasonal pressures along with the ED attendance and bed occupancy rates followed by the system lessons from winter 2020/21. All Health Groups have established extensive plans for winter and the anticipated impact of the continuing Covid-19 pandemic.

Mr Bond said there were a lot of conversations at HG level, and whilst we look to have additional capacity in December it is sometimes January but they hope this year to have it from October. Nurses will be over established shortly but opening extra wards will soon reduce that. Mrs Bond reflected he suspected we spent half of what we do now in in 2019/20 and there are financial pressures.

Mrs Ryabov shared the circumstances are very different and acknowledged that the covid funding isn't necessarily available this year.

Mr Robson asked if there was any additional funding from the government and Mr Bond responded that we are expecting the winter and elective recovery funding but the allocation would be confirmed this week.

Mr Robson would be interested to see how that matches our winter planning and if covid cases would rise again following Christmas.

8.3 Cancer Performance Update

Mrs Ryabov shared the key areas of the paper to the committee, including performance compared to the targets and the key areas impacting pathways.

It was noted that the assumptions there would be an increase in referrals post-lockdown has not materialised and there is consideration to if patients have presented via different routes.

Diagnostic delays, lack of timely access to crucial diagnostic tests that are necessary to enable progression on patient pathways have had a significant effect on performance. There were challenges in pathology effecting gynaecology, head, neck and skin. Other areas impacting on diagnostics were Haematuria, Colonoscopy and Radiology.

Treatment delays were ongoing with Oncology, with a lack of staff regionally and nationally.

Ward closures and a lack of theatre staff due to redeployment to support COVID-19 care has created increased treatment delays.

Mrs Ryabrov shared that the ideal number of patients for PTL was 900 to achieve target times and we had approximately 1200 currently, which was significantly more than MDT can manage.

Mr Robson commented that with cancer timeliness is everything for outcomes and questioned if the system was working well enough to not cause harm. Mrs Ryabov responded that it's not working well, none of the pathways are working the way we would like and all teams would report that. There have been no significant numbers of increasing harms although level of harm cannot be measured until operated on at which point we can determine. Teams are doing the best with the resources and are risk strategising patients.

Mr Robson asked if the acute services review, whilst we are already under pressure does it help or cause issues. Mrs Ryabov responded that we are already taking those patients so it won't increase but what we may get are those that didn't present in covid and may still come through.

Mr Bond asked what would have the biggest impact if we could target any area. Mrs Ryabov responded stating improving access to CT, endoscopy / colonoscopy and MRI would make a huge difference.

Mr Robson suggested this was an area to be looked at by the executive team.

9 Finance

9.4 Replacement LINAC

Mrs Drury presented the paper to present the case for the replacement LINAC, which is now 15 years old in the Radiotherapy Department at Castle Hill Hospital. The Trust has been successful in gaining PDC funding from NHS England to replace the equipment with a pre-requisite of it being ordered by the 30th September 2021 and on-site by the 31st march 2022. The total amount of capital required is £1,980,673. As the PDC funding allocated to HUTH is £1,880,000, the Trust will need to fund £100,673 from its capital programme. There will also be additional costs incurred in the maintenance which will result in a 50K cost pressure, capital charges.

The Capital Resource Allocation Committee (CRAC) will receive the final full report.

Mr Bond shared that we have been fortunate in last few years for additional funding for the LINAC's, which have slightly increased costs in capital and maintenance. The aim is to not replace the final LINAC, due to having new equipment and that will create savings to pay for the additional costs.

There was agreement to pursue the purchase.

9.2 H2 Planning Update
Mrs Drury shared that the Trust has had contracts in place to support the elective recovery for half a year and that the full year contract payments were accounted for.

Paper presented today was to seek approval to extend current Independent Sector (IS) contracts and enter new contracts for the rest of this financial year, which will support with the delivery of elective recovery within the Trust.

The current contracts expire end of September and due to delivery complications required extending, costs already accounted for in H1.

The Trust now have experience with the providers and opportunities have been highlighted leading to want to extend. There is a get out clause and the Trust can pull out if experience financial difficulty. The Trust doesn't yet have the financial envelope but the advantage of having the contracts in place and the clause to walk away doesn't give us a huge financial risk.

Mrs Christmas queried if the get out clause was robust and it was confirmed we have had no issues previously and would be able to give notice.

The committee approved the extension to the recommended contracts as detailed within the paper;

- Modality LLP- ICF
- HealthShare- ICF
- OneHealth – ICF

The committee approved the new contracts as recommended within the paper;

- Pioneer – SBS
- Medinet - SBS

10 Any Other Business

10.1 Contract Recommendation Paper
Replacement of contracts for postal service 468k a year, 100k savings over the year. The committee raised that there was still too much communication posted and questioned if costs would reduce costs as outgoing mail was reduced, and it was confirmed it would.

The committee agreed to approve.

10.2 Licencing Costs
Award the contract for Software Support for Microsoft ESA to Trustmarque Solutions for a period of 12 months from 15th September 2021 to 30th September 2022

Mr Bond shared that the Microsoft licences model is by user basis and that the cost has doubled as they no longer want to provide services like this. They want cloud based service. No option other than to go ahead this year but we are looking at other models going forward, so we can make a judgement 2022/2023 and have a better solution.

The committee agreed to approve and requested that the strategy option paper to come to the meeting in three months' time.

3 Minutes of the meeting held on 23 August 2021

The minutes were approved as an accurate record of the meeting.

4 Matters Arising

There were no matters arising.

5 Action Tracker

The action tracker was received and there were no issues raised.

6 Workplan

The Committee reviewed the workplan and made no changes.

7 Board Assurance Framework

Mrs Thompson updated that work was ongoing on the BAF and presented quarter two. There were no proposed changes to risk rating this month but there was a lot of work in the background and would be reviewed in quarter three.

9 9.1 Financial Report

Mr Evans shared the Trust is reporting a small surplus, we expected and is in line with the plan.

Income 13m above plan of which 8.3m is due to additional income related to the delivery of the vaccination programme.

Health Groups are showing as £1.6m above plan at Month 5, an increase of £0.6m in month.

The biggest pressure in month was in Surgery Health Group with Junior Doctors overspending by £0.2m. There are also pressure with agency consultants in Clinical Support and Family and Women's. Vacancies in ED on nursing and medical staff posts partially offset some of these costs.

All health groups are struggling to identify recurrent CRES schemes and this remains a challenge for the Trust. The Trust plan for H1 included delivery of £1.2m savings from the Elective Recovery scheme and this has been achieved. The Trust has delivered additional income above plan and this is being held centrally to build up a reserve to cover potential additional costs in H2.

The Trust has identified £3.1m of expenditure to date in dealing with Covid19 with £1.1m being spent in month 5. The Trust is spending very little on additional PPE now as the majority is sourced through national procurement routes and covered centrally.

The Trust's liquidity position remains healthy at the end of August. The forecast cash balance by the end of March 22 will be reviewed regularly to reflect any changes in financial arrangements in H2 and the timings of capital spend along with costs and income associated with elective recovery.

The Trust currently has £2.6m of debt which is over 90 days. This has decreased by £0.2m in month.

Mr Evans advised that the Trust will have delivered its H1 position by the end of September..

9.3 Productivity and Efficiency
Mr Evans shared that during covid productivity and efficiency was suspended but has been reintroduced. The Trust was required to deliver savings of £3m within H1 due to the Trust not delivering satisfactory savings prior to the suspension due to covid, which we have delivered.

Although efficiency planning will recommence in H2 it is expected that the impact is more likely to be in 2022/23. There will be some challenges to the achievement of the target above. Delivery of elective recovery savings will be more challenging if the threshold is set at a higher level and agreement will need to be reached with the ICS regarding the contingency.

The expected increased efficiency requirement in H2 demonstrates that NHSEI are looking at Trusts to increase their level of savings to support the recovery from covid19. Efficiency targets of 3% have been mentioned; although that has not been confirmed and planning, guidance for 22/23 is expected in November or December 21.

Productivity and Efficiency Board (PEB) will recommence from October 21 with fortnightly meetings, which will not be welcomed by the operational team but the Trust needs to start to review areas of potential savings using the latest data available to support identification of schemes. This will include use of GIRFT, Model Hospital, National Corporate Benchmarking, NHS Benchmarking network.

Mr Robson shared that looking at future savings can help identify immediate savings.

Mr Evans noted that we know estates and energy efficiency is in place but also requires capital investment, so maybe cost neutral initially.

Mrs Christmas asked how realistic the efficiency savings were as we are seen as quite efficient as a Trust. Mr Evans responded that prior to covid we had a 3 year plan, in which savings were identified of 1 – 2% percent each year. We also have potential to bring in income. The 3% targets were undeliverable. Following covid they want some financial recovery.

Mrs Christmas asked what the consequences are if we do not deliver. Mr Evans responded they are set but know will not be able to deliver but partially delivered is accepted as long as in line with other Trusts, there is an understanding that it is a challenge.

Mrs Christmas asked if the health groups on board, which Mr Evans confirmed they were not and it would be a difficult challenge.

11 Date and time of the next meeting
Monday 25 October 2021, 1.30pm – 4pm via Teams

Mr Robson requested that the ED Missed Opportunities report be on October's agenda.

Agenda Item	7.2.1	**Meeting**	Trust Board	**Meeting Date**	09.11.21
Title	Finance Report – month 6				
Lead Director	Lee Bond				
Author	Stephen Evans				
Report previously considered by (date)					

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

Key Recommendations to be considered:

The Trust Board is asked to note the following:

a) The year to date deficit of £1.7m in line with plan. This is delivery of the H1 control total.
b) The current underlying position of a deficit of £47.8m, unchanged from month 5
c) The struggle to identify new efficiency schemes, which is a concern given increase in target for H2.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

FINANCIAL UPDATE - 2021/22 MONTH 6

1. Purpose of Paper

To inform the Trust Board on the month 6 reported financial position (H1).

2. Background

The Trust has set a target plan of a deficit of £1.7m for the H1 period. This includes the£7.5m expected income to be received from the Elective Recovery Fund (ERF) and the associated expenditure.

3. Month 6 Reported Position

The Trust is reporting a deficit of £1.7m at month 6, which is in line plan.

Appendix 1 shows this position at health group level with a high-level commentary on the variance.

Appendix 2 shows the same position but at Trust level by income and expenditure type, that is, the gross income and expenditure.

4. Income Variances

Overall Trust income is £26.6m above the plan.

The Trust is expecting to receive £9.6m of additional income to offset costs of vaccination programme (£7.8m), testing (£1.5m), deployment of final year nursing students (£0.3m) and quarantine costs (£0.1m). These are all in line with NHSEI guidance and are outside of the current block envelope. £4.7m has been validated for Q1 with £4.9m to be confirmed for Q2.

The Trust is £7.4m above plan for pass through income to offset the costs of high cost drugs and devices. This is a £2.0m increase in month.

The Trust is reporting that it has delivered £8.9m of income for the Elective Recovery Fund in H1. This is £1.3m above the plan

The Trust has received £0.5m above plan for donated and grant income. This is an additional £3.3m from NHSEI for Covid19 donated assets offset by a delay in the receipt of income for the Salix grant. The Salix grant reduction is a phasing issue and the full income is still expected.

In line with NHSEI guidance, the Trust has accrued £5.5m of income to meet the 3% pay award paid in September 21. The income will be paid to Trusts in October as part of the H2 planning uplift.

The Trust has received £0.8m additional education income. The main element of this is the increase in the numbers of GP trainees that started in August 21.

£1.2m mainly relates to improved car parking and catering income (£0.3m) and Income generation schemes (£0.4m). The Trust has also received additional income from commissioners for Breast Screening (£0.3m). The level of income from Injury Compensation scheme is £0.4m below plan.

5. Expenditure Variances

Health Groups are showing as £2.0m above plan at Month 6, an increase of £0.4m in month.

The in-month increase was in two health groups, Clinical Support Services (£0.2m) and Family & Women's (£0.2m), both with continuing pressures from previous months. Clinical Support Services have pressures on use of agency consultants in Oncology and Haematology and pathology consumables. Family and Women's have pressure on cost of continuity of care, Paediatric Gastro outsourcing and Neonatology Junior Doctors. Other health groups reported small surpluses in month.

All health groups are struggling to identify recurrent CRES schemes and this remains a challenge for the Trust. The Trust plan for H1 included delivery of £1.2m savings from the Elective Recovery scheme and this has been achieved. The Trust has accrued £2.7m for IS contracts that were planned to be funded from the Elective Recovery Income. These are for One Health, Medinet and Modality contracts.

£2.1m of Covid19 funding was built into the expenditure plan for H1 (Including cleaning costs, psychology support posts and home working). On top of this, a further £2.1m has been spent in the first 6 months of H1. The breakdown using NHSEI categories is shown below:

	M6 Actual	YTD Actual
	£000	£000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	544	1,661
PPE associated costs	4	35
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	71	172
Remote management of patients	114	702
Support for stay at home models	14	38
Segregation of patient pathways	147	751
Decontamination	127	775
Remote working for non-patient activities	0	28
	1,021	4,162

6. H2 and Underlying Run Rate

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. Support for lost income has been

reduced by 25% (£0.2m), but this should be able to be met by the increased car parking income the Trust is receiving.

Discussions are ongoing with the ICS on other areas of funding, notably on Covid19 support and urgent and emergency capacity. Early discussions indicate that the Trust will retain the same level of Covid19 funding as in H1 less the 6% national reduction. Discussions also indicate that the Trust will receive around £1m to support winter pressures.

The current ICS plan looks to include an additional £1.7m of income for the Trust to enable it to move from a deficit in H1 to break-even in H2. This would still leave the Trust with a full year position of a deficit of £1.7m from H1.

The current ICS modelling shows a deficit of between £4m to £5m, which will need to be addressed across the patch. How this will be shared between organisations is still to be determined but it will require additional savings to be made.

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.

If CCGs commission increased IS work above the 2019/20 baseline then this will be nationally funded through the elective recovery funding. This does not apply to Trust commissioned IS work.

ICS financial plans have to be submitted by 16th November 21 with Trust level plans to follow on 25th November 21.

The impact of the planning guidance on the potential underlying position of the Trust is being worked through and will be factored into the run rate position for Month 7.

Underlying Position at Month 5	£47.8m deficit
Changes in Month 6	
Obstetric & Gynaecology Consultants 3 wte	£0.4m
Underlying Position at Month 6	£48.2m deficit

EMC have agreed to support recruitment of 3 wte consultants in Obstetrics and Gynaecology following updated guidance from the royal college regarding support for Junior Doctors and requirement for increased consultant presence on maternity wards.

7. Statement of Financial Position (SOFP) and Statement of Cash flow (SOCF)

The SOFP and SOCF for month 6 are reported in appendices 3 and 4.

Capital

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 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.

Cash

The Trust's liquidity position remains healthy with a cash balance of £50.9m at the end of September. The cash balance did drop in month as the 3% pay award backdated to April 21 was paid. The Trust will receive the cash to meet the pay award from commissioners in October 21. The forecast cash balance by the end of March 22 at £35m will be reviewed regularly to reflect any changes in financial arrangements in H2 and the timings of capital spend along with costs and income associated with elective recovery.

To date the Trust has paid 96.6% by volume and 89.4% by value of non-NHS invoices within best practice terms. In August, the figures were 97% and 85% respectively.

Stocks

Stock levels are at £16.8m, an increase of £1.1m in month and £1.8m higher than the year-end figures.

Health Group	Mar 21 £000	Aug 21 £000	Sep 21 £000	Change from March 21 £000
Clinical Support	7,460	7,190	8,114	654
Surgery	4,247	4,433	4,482	235
Medicine	1,026	1,946	2,079	1,053
F & WH	1,174	993	1,009	(165)
Other	439	439	440	1
PPE Stock	635	635	635	0
Total	14,982	15,637	16,760	1,778

Stock levels in medicine have been increased in the Cardiology area mainly to reflect increased levels of activity in the Cath labs and also to mitigate against delays in deliveries of supplies due to leaving the EU and the pandemic.

The increase in stock in the month in Clinical Support services is within pharmacy and relates to pre bagged chemotherapy as the Aseptic unit was closed for 4 weeks to undertake the maintenance of the ducting. This should be lower next month.

Debtors

The Trust currently has £2.8m of debt which is over 90 days. This has increased by £0.2m in month. The main debtors been as follows

Debtors Over 90 Days	August 21	September 21	Change
	£	£	£
York & Scarborough Teaching Hospitals Nhs Ft	592,633	607,723	15,091
City Health Care Partnership	115,545	158,421	42,876
Humber Teaching Nhs Foundation Trust	119,471	131,995	12,524
University Of Hull	91,727	108,181	16,454
Fresenius Medical Care Renal Services Ltd	83,583	83,583	0
Crawford & Company Adjusters (Uk) Ltd	70,320	70,320	0
Nhs East Riding Of Yorkshire Ccg	4,339	60,339	56,000
Northern Lincolnshire And Goole Nhs Ft	35,086	52,287	17,201
Ge Healthcare	51,962	51,962	0
Leeds Teaching Hospitals Nhs Trust	52,527	43,753	-8,774
Others	1,414,286	1,454,012	39,726
Total	2,631,479	2,822,576	191,097

Discussions continue with York to make mutual payments to reduce outstanding balances and it has been escalated to the Chief Finance Officer.

8. Recommendations

The Trust Board is asked to note the following:

a) The year to date deficit of £1.7m in line with plan. This achieves the H1 control total.

b) The underlying deficit position of £48.2m and the need to clarify recurrent income and efficiency savings to offset this. This has increased by £0.4m in month due to approval to support 3 consultants in Obstetrics and Gynaecology

c) The struggle to identify new efficiency schemes which is a concern given the increased target from October 21.

Stephen Evans
Deputy Director of Finance
October 2021

APPENDIX 1

APPENDIX 1

Month 6 2021/22

	Budget £000	Actual £000	Variance £000	Comments
Nhs Contract Income	316,608	316,889	281	
Education + Training Income	10,374	10,374	0	
Donated and Grant Income	9,293	9,820	527	Covid donated assets income less reprofiling of Salix income
Other Income	9,087	10,025	938	ERF Income less shortfall on Injury Compensation claims
Total Income	**345,362**	**347,108**	**1,746**	
Surgery	(70,315)	(70,787)	(472)	Junior Medical staff pay pressures
Medicine	(43,218)	(43,676)	(458)	Nursing costs in Elderly Medicine, Agency Stroke Consultant, pressure on Rheumatology ward medical staffing and Renal Fluids.
Emergency Care Health Group	(9,103)	(8,664)	439	Vacancies in Medical and Nursing staffing and underspend on drugs.
Clinical Support Services	(53,834)	(54,288)	(454)	Agency spend in Oncology and Heamatology.
Clinical Support Services - pass through drugs	(33,701)	(34,376)	(675)	Increased Drugs under Block Contract
Family + Womens Health	(42,691)	(43,132)	(441)	Continuity of Care, Paediatric Gastro outsourcing, Neonatology Junior Doctors
Corporate Directorates	(38,985)	(38,993)	(8)	
Estates Facilities & Developmt	(23,518)	(23,509)	9	
Other Operating Expenditure	(4,068)	(3,986)	82	
Reserves	(2,296)	(1,537)	759	Release of reserves to offset Expenditure
Total Operating Expenditure	**(321,729)**	**(322,948)**	**(1,219)**	
EBITDA	**23,633**	**24,160**	**527**	
Total Non Operating Expenditure	**(16,011)**	**(16,074)**	**(63)**	Loss on disposal of assets
Net Surplus/Deficit	**7,622**	**8,086**	**464**	
Donated and Grant Assets/Loss on Disposals Adjustment	(9,293)	(9,757)	(464)	Technical Adjustments related to donated assets/Loss on disposal excluded from performance position
Adjusted Financial Performance Surplus/Deficit	**(1,671)**	**(1,671)**	**0**	

APPENDIX 2

Month 6 2021/22

	Budget £000	Actual £000	Variance £000	Comments
Income from Patient Care Activities	319,739	332,778	13,039	Pass Through Drugs & Devices, Pay Award Funding
ERF Income	7,547	8,873	1,326	Over delivered in H1
Covid19 Income outside Envelope	0	9,634	9,634	Reimbursement for costs incurred
Education + Training Income	15,497	16,297	800	Income to match GP training scheme
Donated and Grant Income	9,593	10,121	528	Grant to cover cost of covid19 assets less change in profile of Salix Grant
Other Income	9,541	10,771	1,230	Gains in Car Parking, Income generation and income to offset pay costs
Total Income	**361,917**	**388,474**	**26,557**	
Pay	(209,030)	(213,584)	(4,554)	Pay Award less vacancies in Nursing and non clinical staff
Non Pay	(129,254)	(141,096)	(11,842)	Pass Through drugs and devices, purchase of non NHS healthcare. Clinical supplies for Elective Recovery
Covid19 Expenditure outside Envelpe	0	(9,634)	(9,634)	Costs Covered by Income
Total Operating Expenditure	**(338,284)**	**(364,314)**	**(26,030)**	
EBITDA	**23,633**	**24,160**	**527**	
Total Non Operating Expenditure	**(16,011)**	**(16,074)**	**(63)**	Loss on disposal of asset
Net Surplus/Deficit	**7,622**	**8,086**	**464**	
Donated and Grant Assets/Gains on Disposals Adjustment	(9,293)	(9,757)	(464)	Technical Adjustments related to donated assets excluded from performance position
Adjusted Financial Performance Surplus/Deficit	**(1,671)**	**(1,671)**	**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 31/07/2021 YTD £000	Actual 31/08/2021 YTD £000	Actual 31/09/2021 YTD £000	Movement from 31/03/21 £000
Non-current assets						
Intangible assets	5,980	5,602	7,166	7,039	6,914	934
Property, plant and equipment: on-SoFP IFRIC 12 assets	59,606	59,224	59,606	59,606	59,605	(1)
Property, plant and equipment: other	274,732	275,459	277,786	279,932	288,070	13,338
Investment property	100	100	100	0	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	1,469	1,469	1,529	60
Receivables: due from non-NHS/DHSC group bodies	2,253	2,253	2,253	2,253	2,193	(60)
Other assets						
Total non-current assets	**344,532**	**344,499**	**348,772**	**350,691**	**358,803**	**14,271**
Current assets						
Inventories	14,982	15,565	15,485	15,636	16,760	1,778
Receivables: due from NHS and DHSC group bodies	8,871	19,978	25,191	13,364	18,766	9,895
Receivables: due from non-NHS/DHSC group bodies	10,298	11,406	12,435	9,555	11,305	1,007
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	50,212	59,838	50,912	(8,003)
Cash and cash equivalents: commercial / in hand / other	12	12	16	8	8	(4)
Total current assets	**93,078**	**102,131**	**103,339**	**98,401**	**97,751**	**4,673**
Current liabilities						
Trade and other payables: capital	(26,808)	(6,708)	(9,570)	(9,906)	(9,850)	16,958
Trade and other payables: non-capital	(70,087)	(96,971)	(99,018)	(94,056)	(100,160)	(30,073)
Borrowings	(2,917)	(3,035)	(3,074)	(3,113)	(2,946)	(29)
Other financial liabilities	0	0	0	0	0	0
Provisions	(202)	(170)	(170)	(169)	(137)	65
Other liabilities: deferred income including contract liabili	(730)	0	0	0	0	730
Liabilities in disposal groups	0	0	0	0	0	0
Total current liabilities	**(100,744)**	**(106,884)**	**(111,832)**	**(107,244)**	**(113,093)**	**(12,349)**
Total assets less current liabilities	**336,866**	**339,746**	**340,279**	**341,848**	**343,461**	**6,595**
Non-current liabilities						
Trade and other payables	0	0	0	0	0	0
Borrowings	(54,350)	(53,920)	(53,774)	(53,636)	(52,868)	1,482
Other financial liabilities	0					0
Provisions	(5,683)	(5,683)	(5,683)	(5,682)	(5,682)	1
Other liabilities	0	0	0	0	0	0
Total non-current liabilities	**(60,033)**	**(59,603)**	**(59,457)**	**(59,318)**	**(58,550)**	**1,483**
Total assets employed	**276,833**	**280,143**	**280,822**	**282,530**	**284,911**	**8,078**
Financed by						
Taxpayers' equity						
Public dividend capital	292,247	292,247	292,247	292,247	292,247	0
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)	(33,373)	(31,665)	(29,284)	8,078
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**	**280,822**	**282,530**	**284,911**	**8,078**

APPENDIX 4

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF CASH FLOWS

	Accounts 31/03/2021 2020/21 £000	Actual 31/9/2021 YTD £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	1,304	15,060
Operating surplus/(deficit) of discontinued operations		
Operating surplus/(deficit)	**1,304**	**15,060**
Non-cash or non-operating income and expense:		
Depreciation and amortisation	16,506	9,102
Impairments and reversals	15,258	0
Income recognised in respect of capital donations (cash and non-cash)	(2,608)	(10,112)
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	(10,902)
(Increase)/decrease in other assets	0	0
(Increase)/decrease in inventories	(382)	(1,778)
Increase/(decrease) in trade and other payables	14,244	29,533
Increase/(decrease) in other liabilities	219	(730)
Increase/(decrease) in provisions	1,026	(66)
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**	**30,107**
Cash flows from investing activities		
Interest received	8	0
Purchase of financial assets / investments		
Proceeds from sales / settlements of financial assets / investments		
Purchase of intangible assets	(1,569)	0
Proceeds from sales of intangible assets		
Purchase of property, plant and equipment and investment property	(42,225)	(40,394)
Proceeds from sales of property, plant and equipment and investment property	3,069	0
Receipt of cash donations to purchase capital assets	807	10,112
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)**	**(30,282)**
Cash flows from financing activities		
Public dividend capital received	65,464	0
Public dividend capital repaid	0	0
Movement in loans from the Department of Health and Social Care	(36,555)	(630)
Movement in other loans	0	0
Other capital receipts		0
Capital element of finance lease rental payments	(56)	(22)
Capital element of PFI, LIFT and other service concession payments	(1,929)	(793)
Interest on DHSC loans	(512)	(205)
Interest on other loans		
Other interest (e.g. overdrafts)		
Interest element of finance lease	(4)	(2)
Interest element of PFI, LIFT and other service concession obligations	(5,783)	(2,920)
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**	**(7,832)**
Increase/(decrease) in cash and cash equivalents	**39,493**	**(8,007)**
Cash and cash equivalents at 1 April - brought forward	19,434	58,927
Prior period adjustments		
Cash and cash equivalents at 1 April - restated	**19,434**	**58,927**
Cash and cash equivalents at start of period for new FTs	0	
Cash and cash equivalents transferred by absorption	0	
Unrealised gains/(losses) on foreign exchange		
Cash transferred to NHS foundation trust upon authorisation as FT	0	0
Cash and cash equivalents at Month (Year) End	**58,927**	**50,920**

Report to the Board in Public
Quality Committee
October 2021

Item: Cardiology Report	Level of assurance gained: Limited
The Committee viewed the full report and the work already undertaken following the recommendations discussed and acknowledged. Whilst progress against the action plan was noted, the Committee raised concerns regarding some of the cultural issues highlighted by the report. The Trust's action plan will be shared at the next committee.	
Item: Mortuary / Body Storage Board Assurance	Level of assurance gained: Substantial
Comprehensive report providing assurance shared with the Committee following letter from NHS England regarding compliance.	
Item: Mortality - Learning from Deaths framework (inc Medical Examiner)	Level of assurance gained: Substantial
Report presented to the committee shared a summary of mortality statistics and learning from deaths in line with the requirements set by NHS Improvement for quarter two. The Medical Examiner Office (MEO) currently now scrutinise all deaths that occur at HRI. There is an improvement plan in place to roll out scrutiny to CHH and community deaths, along with the improvement of capturing themes, identification of learning and reporting.	
Item: Infection Prevention Control	Level of assurance gained: Substantial
The committee received the new IPC Board Assurance Framework, which provided assurance along with comprehensive actions. A dedicated Task and Finish Group completed the work to ensure multidisciplinary working across the organisation.	
Item: Enhanced Monitoring/QRP	Level of assurance gained: Substantial
No significant changes noted in the report. The QRP is assisting identifying the escalations and risks and focusing the meetings in keys areas.	

Hull University Teaching Hospitals NHS Trust
Quality Committee
Held on 27 September 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
	Miss L Coneyworth	Head of Effectiveness and Improvement
	Mrs J Ledger	Deputy Chief Nurse
	Mrs D Lowe	Acting Director of Nursing and Quality
	Mrs M Stern	Patient Representative
	Mrs R Thompson	Head of Corporate Affairs
	Prof U Macleod	Non Executive Director
	Mr S Gaines	Deputy Chief Pharmacist
In Attendance:	Miss R Boulton	Quality Governance Officer (Minutes)
	Ms K Rudston	Assistant Chief Nurse

No **Item** **Action**

1 Apologies

Apologies were received from Mrs B Geary, Chief Nurse and Ernesto Quider, Associate Director of Quality

Mrs Lowe introduced herself to the meeting and shared that she will be attending the meetings moving forward.

2 Declarations of interest

There were no declarations received.

3 3.1 Minutes of the meeting held on 24 August 2021

The minutes of the meeting were approved as an accurate record of the meeting.

Page 1 – Dr Green asked that her title and job description be amended to Dr in place of Mrs and job title to Lead Clinical Nurse Specialist.
Page 2 – Paragraph 3 – Mr Hall was unsure that Dr Pathak had received an answer regarding the recovery position and would will seek a response and then circulate.
Page 5 – Third paragraph – Dr Purva corrected that we had met with Grant Thornton which had given helpful pointers but were not working with them.

3.2 Matters Arising

None raised.

3.3 Action Tracking List

The Committee reviewed the Action Tracking list and there were no items for review in September.

Mental Health actions were on the agenda today.
Fiona Thomson was due to be invited to the October meeting to present the learning from deaths paper

Items completed could now be removed from the tracker.

3.4 Workplan
The Committee reviewed the workplan and no changes made.

BAF
Mrs Thompson presented the BAF to the committee and highlighted that there were no proposed changes to the risk ratings this month.

Mr Hall acknowledged the work that has been undertaken with the BAF and attached appendix, it was clear a lot of sources have been used to obtain the assurances. There were no proposed changes to the risk ratings for this quarter.

Prof Macleod stated that 3.2 & 3.4 are within the remit of the committee and they are red, need to be mindful of how is it highlighting areas of concern and how we are using it. Mrs Rostron agreed and explained that there are dedicated papers on the agenda today and work plan to ensure that the committee is continuously evaluating progress and sources of assurance against these items. It was also discussed that it is often Q4 before target risk ratings or any significant changes in rating are seen.

The agenda was taken out of order at this point.

4.2 Mental Health Patient Actions
Ms Rudston presented the paper on Mental Health Patients actions. The purpose of the paper was to share what actions are being taken by the Trust to offer assurance for treatment for patients with mental health in the acute trust.

Ms Rudston outlined that Mental Health care is an increasing concern locally, regionally and nationally. There is an increasing trend of attendances and inpatient admissions for patients who have mental health issues. Mental health crisis, self-harm, attempts to take their own life are becoming more prevalent in the Trust. Increase in patients with Dementia and Delirium who have had a long-term MH condition is an area of concern, which often results in higher levels of aggression, detainment and restraint. Children with MH problems is a common theme in the trust and the paediatric wards manage the complexities of this co-hort of children and young people on a daily basis often with 3 to 4 children at a time awaiting a mental health inpatient bed either for acute MH issues or eating disorders.

Ms Ruston manages the Mental Health agenda and has introduced several initiatives to improve the governance and safeguarding of patients with mental health issues, which were outlined within the report.

Ms Rudston shared that the Trust is in a strong place with awareness of the issues, ongoing work towards the compliance will give a good benchmark along with looking at CQC reports from other acute Trusts. Ms Rudston felt that we need to look at specific posts to support the work, similar to the LD liaison nurse and will build a business case to seek resources for this agenda as it is an increasing risk and a significant risk for the organisation.

Prof Macleod queried if the Specialist Psychiatric Liaison Service was good enough. Ms Rudston acknowledged that it could be better, patients were not always seen within the timeframe but also felt we also need to refer more timely. Trust are staff supporting where possible, which is why increasing awareness for all staff.

Mr Hall requested a follow up paper to a future meeting

Mrs Lowe shared that it is a big challenge and the Trust were taking a proactive view. MH paperwork scrutiny is key as errors can reflect in unlawful detainments. Training of staff will need to include a blended approach to reducing restrictions, de-escalation, restrictive practice and environment risk assessments especially ligature risks.

Dr Green asked what the toll on the staff was and if there was scope to access psychological support for staff. Ms Rudston confirmed that we are mindful what staff are dealing with on a daily basis, and there were options for support if staff were feeling particularly impacted.

Dr Pathak asked if there was a staff impact on the paediatric wards if there was an increase to their physical and physiologically wellbeing. Also queried was if the MH response was good enough and if Hull had a specialist Eating Disorder unit.

Ms Rudston assured that paediatric staff had received a higher level of training than other areas which was designed by MH CAMHS team, which we will continue to deliver. There is no specialist Eating Disorder unit in Hull but there is Inspire, which is a specialist child MH unit. The challenge being their clinical team is not trained to deliver food by nasal tubes.

Mrs Lowe shared that there is ongoing communication with SPECOM and that whilst escalated locally it is a national issue.
HUTH are doing an incredible amount of work but can only go so far. A meeting is being arranged where we can have those discussions regarding beds and escalation, which HUTH will be invited to.

Mr Hall thanked Ms Rudston for the comprehensive paper and reflected that the reason the paper was requested was previously there was not the assurance, but the paper collates the significant risks and work being done to mitigate and improve these risks working with wider system partners. In light of the information, it feels we can start moving towards assurance, as the Trust is aware of the risks. There is still an element of how much is out of our control, and what is the risk to our physical health patients when staff are taken up with MH patients.

Resolved:
Mr Hall suggested that we now had limited assurance, which was agreed.

4.1 Quality Report
Mrs Ledger presented the quality review to the committee; there were 12 SI's declared in August and no Never Events.

There are currently 65 open serious incident investigations. The Trust is not currently investigating the incidents within the 60 working day timeframe due to ongoing pressures within the Trust. This was agreed with the commissioners as part of the pandemic actions. There is a focus on understanding the backlog of SI's within the trust and agreeing a pragmatic trajectory with commissioners via the SI review group.

Mrs Rostron confirmed that the CCG Quality Manager is currently working with our Patient Safety Team reviewing outstanding SI's to propose next steps.

The Health Services Journal is reporting today that there are numerous trusts struggling as a result of the pandemic to conclude investigations within the 60 working day timeframe. Whilst we are wanting to reduce the outstanding SI number, this must be done in a way that we don't want to miss learning or opportunities to engage with patients and their families to investigate fully.

There has been an increase in the number of pressure ulcers reported in August. 78 incidents were reported. Following investigation, 41 of the 78 incidents were found not to be hospital acquired skin injury from pressure. Of the remaining 36, 14 are still being reviewed so the total figure may be less than 36 once investigated and validated.

All wards will be re-audited for the Tissue Viability fundamental standard as soon as the new audit tool has been ratified and approved. The Tissue Viablity team will be supporting the digital rollout of the new Pressure Ulcer Risk Assessment tool, which will be implemented across the organisation once the educational programme is complete. All CHH wards will go live w/c 4th October. The Trust has appointed a 4th Tissue Viability nurse.

Within Infection Prevention and Control, MRSA was still an issue in August, there were two outbreaks of diarrhoea and vomiting reported affecting patients on two wards at the HRI site and we saw an increase in COVID cases.

A number of queries were raised to the CQC by the National Clinical Audit Team for discussion and monitoring at a local engagement level.

At the engagement meeting between the CQC and Trust on the 16th August the following national audits were discussed regarding current position, assurance and action plan;

- National Lung Audit
- National Paediatrics Diabetes Audit
- National Bowel Cancer Audit

A further meeting has been held with the CQC and progress updates have been provided against these audit concerns and a submission of evidence is to be provided for assurance. The national lung cancer audit shows that we are an outlier. The Committee would like to know how this reflects nationally. Mrs Rostron confirmed that an update on progress with the Lung Cancer audit actions will come to this Committee in a future CQC update report. This will also be discussed at the new Patient Safety and Effectiveness Sub-committee.

Mrs Rostron shared that this was the first time the report had been presented to the meeting in this format. The BI team have done a great job in supporting this work. However, anomalies have been fed back to the BI team such as the need to amend the target line and control limits to match the data sets appropriately.

Prof Macleod commented that the number of covid outbreaks, were concerning. Prof Macleod asked whilst the University report is being reviewed and finalised, has there been learning from previous waves.

Mrs Ledger explained that the Covid paper outlines what we have learnt from previous waves, which is a lot. The elective perspective is interesting as we now

can't guarantee isolation, as the restrictions have been lifted in the general population.

Dr Purva suggested that the University Paper be submitted to the committee in subsequent months, once this is finalised.

Dr Purva explained that the general feel on the wards is that we understand it better now, we have changed how we manage patients and the environment is better and we are more conscious that where the environment is a challenge we need increase the protections. Therefore feel in an overall better position that last time.

Mrs Ledger also felt that we are better at looking at patient movement and have improved testing. If the infection levels remain at the current levels it is felt we can manage the patients on existing covid wards.

4.1.2 Patient Experience
Ms Rudston shared that there were no open PALS cases with a backlog of 360 being closed, and the remaining backlog planned to be up to date by the end of the month.

Ms Rudston said the complaints were at 53% compliance for August and were not expected to improve until October, the struggle being clinician engagement. Recruitment is in progress for the band 4 position.

Ms Rudston confirmed that we should have the PET dogs into the Trust by Christmas.

Mr Hall congratulated the team on the work done to improve this position.

Dr Pathak asked if the IPC team had been happy with the PET dogs, and Ms Rudston confirmed they have drafted the process, which is pending committee approval.

4.2.3 Safeguarding
Ms Rudston shared that there had been a decrease in July / August's figures, which was suspected to be low due to summer holidays. The Trust's training levels were in a positive position.

Resolved:
Mr Hall confirmed that there was good assurance on this for the board.

4.3 Cardiology Report
Dr Purva shared that the focus of the report was to provide an update on the issues we have experienced with cardiology service and to share the communication plan. The full report will be shared with the cardiology team and then with the quality committee in its entirety at the next meeting.
The communication plan is to share the report with the cardiology consultants, CCG's and patients and the board. The preliminary report was shared with private board this month and the cardiology team. At the next quality committee there will be opportunity for a detailed discussion along with the action plan.

Mr Hall suggested that questions were restricted to the communication plan with final recommendations coming to the next meeting with the report.

Dr Pathak enquired if the NEDs will have sight of the recommendations, which Dr Purva confirmed that they would share the report before the next meeting.

Mr Hall suggested that due to the report being a lengthy document that the report was published on Team Engine in good time to allow it to be read.

Mrs Rostron suggested that timescales would be tight as currently the report still needed redacting to remove information that would identify patients.

Resolved:
Mr Hall suggested that assurance was deferred until paper shared in full.

4.4 Understanding and Improving Hospital Standardised Mortality Ratio (HSMR) at HUTH
Mr Hall stated that he had sighted considerable aspects of this this report at the Board.

Dr Purva confirmed it was identical to the board paper. The report from the investigation into the Trust's HSMR outlier status aimed to provide assurance that the HSMR ratio is reducing and returning back within the control limits. Telstra Health UK the organisation that runs it was commissioned by the Trust to look at our stats and provide recommendations.

Telstra endorsed our conclusion that last winter the covid data was not cleaned from the figures, therefore some of the covid deaths remained within HSMR and resulted in higher than normal patient deaths for the Trust.

The local social deprivation and lack of GP's within the area are unique factors negatively impact on mortality.

Dr Purva shared that we are happy that our internal conclusions were verified by external investigations and confirmed that we are still addressing through the Mortality and Morbidity Committee.

Dr Pathak said it was a good paper but questioned why weekend mortality rates still higher than weekday.

Dr Purva responded that there was little difference between weekday / weekend and following detailed case note analysis there was no evidence to suggest care was delivered differently during a weekend.

Mr Hall stated that at other Trust's there is significant difference between weekday/weekend rates. There is a report going to Mortality and Morbidity in October.

Dr Purva shared that Leah Coneyworth and Pete Sedman need to be congratulated on their in depth work into mortality, and thanked them.

Resolved:
Good assurance was agreed for the board.

5.1 Operational Quality Committee - Escalation Report
Dr Purva shared that the operational quality committee will be standing down and the last meeting focused on the new governance structure.

Mr Hall requested to have sight of the terms of reference for the new meeting structure and Mrs Rostron confirmed they would need approval through the Quality Committee, once the committees had met for the first time to review.

5.2 Medicine Management
Mr Gaines shared a presentation.

The new chief pharmacist started with the Trust today Joanne Goode, with David Corral retiring.

The Medicines Optimisation Framework supports a patient centred approach with 4 key principles leading to improved patient outcomes.

The recent annual CQC pharmacy engagement meeting was positive. The CQC shared that they are moving towards a patient outcome focus, although will remain interested in storage, fridges, and controlled drugs; therefore we still need to ensure the basics are well managed. The CQC still want to see ward to board assurance. The Trust Board lead for medicines management is Dr Purva.

Pharmacy continue to ensure that we feed into the Trust governance structure, there are two main committees Drugs and Therapeutics and Safe Medication Practice. The health groups have lead Pharmacists that attend the governance meetings and there was good assurance regarding audits.

Mr Gaines agreed there would be a further update to the quality committee in January 2022 by Joanne Goode.

The pharmacy team are working to ensure that joined up medicines optimisation is in place – e.g. joint formularies with NLAG, with the red / amber drug lists being aligned as part of the HASR Neurology work.

The medication safety officer role, which is an NHS requirement, is in place (Mr Gaines).

Electronic Prescribing and Medicines Administration is now live on C1, C7, Queens Centre and CHH surgery, with phase two (CICU) going live now, phase three will be next month ensuring that all CHH site will be live by the end of the year. HRI site will start to be rolled out in 2022.
Mr Hall stated he was keen to see how EMPA would go across the organisation and the progress against the HCV.

Mr Gaines reflected that the improvements have gone ahead despite COVID-19 and the staffing pressures.

Mr Hall said that he would look at the work plan and share when would be the best meeting for Joanne Goode to attend with an update.

6.1 CQC Well-Led Report
Mrs Rostron shared that a board development session was undertaken in August to self-assess against the Well-led key lines of enquiry.

Following the development session, Mrs Thompson and Miss Coneyworth collated further evidence and finalised the ratings based on the Board's input. The overall ratings would suggest a maintained rating of 'good' for the organisations overall 'Well-led' rating.

Mrs Rostron stated that there are plans to repeat this exercise with core services to support them in knowing what to expect. The quality governance team will prepare a lot of the work and then approach the services. The services currently identified for the initial review will be Paediatrics and Maternity. It was felt that it would be unreasonable to undertake an assurance visit in ED with the current pressures despite knowing that ED is an area that will be inspected.

Mrs Rostron asked the Quality Committee to approve the proposed ratings and the improvement actions, many of which are already underway.

Mr Hall said the paper was interesting and informative, and clearly a lot of work had been done.

Mr Hall asked in regards of the Amber / Green if achieving the agreed actions would move us from amber to green, and if Mrs Rostron had confidence that it will get us there.

Mrs Rostron confirmed the confidence was we would achieve green as the work undertaken was based on CQC inspections.

Work has already commenced on improvements to our BAF, and we have QSIR training starting this week. QSIR is a recognised accredited quality improvement methodology, which would build on the current arrangements.

Dr Green asked about the Trust Strategy on Pattie which is 2019 – 2024 but didn't feel a living document and as we are coming to the end of 2021 things have changed hugely. As part of KLOE 2 should we have an updated strategy.

Mrs Rostron confirmed that the work has happened via the Strategic Development Group, which reports into the Executive Management Committee in addition to updates to the Trust Board and a Board Development session. It was acknowledged that whilst this Committee would not see the full strategy updates it will be involved in the development and monitoring of the Quality Strategy, as it currently is with the QIP and Quality Accounts.

6.2 Enhanced Monitoring/QRP

Mrs Rostron presented the enhanced monitoring paper which is received each month. The meeting in September was stood down due to the operational pressures which was the correct decision but the work was ongoing.

Mrs Rostron reviewed the Appendix 1 paper. Incidents and PALS are not showing anything out of limits. A clinical harm review has been undertaken in gynaecology which have declared SI's, which resulted in a deep dive on those on the internal audit, changes to SOP as well as talks on cases and screening, therefore all actions taken.

We have been close or achieving targets but should expect to see a dip due to the ongoing pressures, the executive team are looking at a plan to try and reduce harm, which is a balance of risk, roadshows set up starting this week to discuss with staff possible solutions.

Mrs Rostron thanked Miss Coneyworth for a well put together paper.

Mrs Lowe said the next Quality Delivery Group - Quality Risk Profile meeting was the 4th October. Quality Risk Profile challenges the decision making for risk and how the Trust arrived at those decisions, 8 risks identified in total. A template has been created to support escalation, some areas that HUTH have identified are system issues, and the template hopefully should support the escalation and is currently being testing.

Mrs Rostron confirmed the template had been shared and will come to Quality Committee once populated.

Prof Macleod stated there was a lot of information and asked Dr Purva and Mrs Ledger how it felt in terms of patient safety.

Dr Purva replied that the daily pressures are extreme and questioned how long it was possible to maintain the extraordinary effort of our teams. This weekend there were four theatres opened, which is unheard of, the risk is that errors could occur which will relate to patient harm.

Mrs Ledger stated that we are proud of the teams on their response; staff recognised that services are not as they were pre-covid and are trying to balance the risk.

There is frustration that despite the work we are unable to discharge patients, which results in putting more wards in and reducing elective activity.

Mrs Rostron said that the teams are mitigating risks on a daily basis and plans are in place for Winter. However, it was not possible to predict the impact of this winter and the sustained pressure the Trust is under.

Resolved:
Mr Hall agreed that we should keep the assurance level but would still escalate to the board as there is concern over what the next few months will bring.

6.3 Infection prevention and control (IPC)
Safety Support Improvement Programme, Feedback on documentation review
Mr Hall stated that although the report was not easy reading there was already work in progress.

Mrs Rostron shared that this was a supportive review from NHSI that the Trust requested as part of our continuous improvement and not a regulatory intervention. Following the Hospital Onset Hospital Acquired Infections data it was important to know if we are doing everything we can. The IPC team were working hard with the Health Groups, Directorates and Quality Governance team to address the recommendations. As part of this, the new IPC BAF would be presented to the Quality Committee next month ahead of being taken to the Trust Board.

Ernesto Quider is leading a task and finish group set up to review the work needed and will be using a BAF template from Newcastle. The task and finish group has created sub-groups to get a wider involvement of completion of the

work and not left just with the IPC team. Greta Johnson has been freed up to be DIPC and focus on that role.

Mrs Ledger said a big element has been to separate the IPC nurse and DIPC role. IPC nurses, audits tightened and closed the loop. Now being more proactive rather than reactive.

Mrs Rostron acknowledged that there were absolutely areas for improvement within the report but also many positives. It was fed back that the staff involved were open and honest when engaging this process.

Prof Macleod stated there was an importance of team working highlighted by the task and finish group.

Resolved:
Mr Hall stated that in terms of assurance, we are looking to strengthen our resources and are putting things in place to achieve this.

7 Any Other Business
There was no other business discussed.

8 Chairman's Summary to the Board
The summary would be presented to the Board in October 2021.

Mr Hall has picked up through the delegate position, the unrelenting pressure at this point of the year and is confident the team will rise to the challenge. How long we can continue to expect this is what Mr Hall will be raising with the Board.

9 Date and time of the next meeting:
Monday 25th October 2021 – 9am – 11am via Teams

Hull University Teaching Hospitals NHS Trust

Agenda Item	4.1	**Meeting**	Quality Committee	**Meeting Date**	25 October 2021
Title	Quality Report by exception				
Lead Director	Beverley Geary, Chief Nurse Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The report is scrutinised each month 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 Committee is asked to review the Quality section of the Integrated Performance Report and decide whether any further information or assurance is required.

Hull University Teaching Hospitals NHS Trust

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

The information in this report is taken from September 2021.

Domain	Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Unreliable	Not capable	Capable	N/A
Caring	9			1		9	1		
Effective	8				1	6		2	1
Responsive	11	3	3	1		8	6	4	
Safe	17	2	1	2	1	13	1	9	
Total	45	5	4	4	2	36	8	15	1

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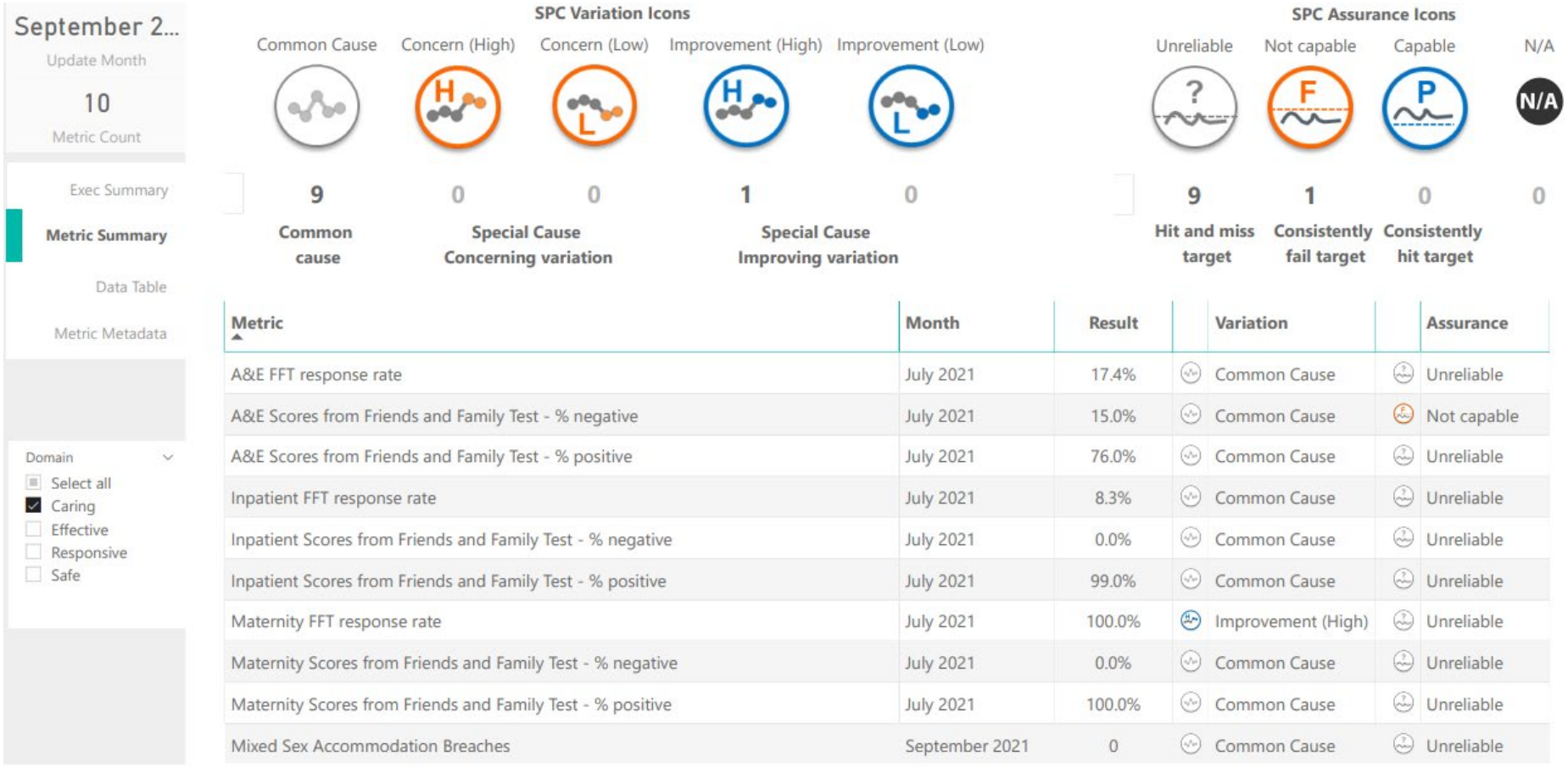

Metric	Month	Result	Variation	Assurance
A&E FFT response rate	July 2021	17.4%	Common Cause	Unreliable
A&E Scores from Friends and Family Test - % negative	July 2021	15.0%	Common Cause	Not capable
A&E Scores from Friends and Family Test - % positive	July 2021	76.0%	Common Cause	Unreliable
Inpatient FFT response rate	July 2021	8.3%	Common Cause	Unreliable
Inpatient Scores from Friends and Family Test - % negative	July 2021	0.0%	Common Cause	Unreliable
Inpatient Scores from Friends and Family Test - % positive	July 2021	99.0%	Common Cause	Unreliable
Maternity FFT response rate	July 2021	100.0%	Improvement (High)	Unreliable
Maternity Scores from Friends and Family Test - % negative	July 2021	0.0%	Common Cause	Unreliable
Maternity Scores from Friends and Family Test - % positive	July 2021	100.0%	Common Cause	Unreliable
Mixed Sex Accommodation Breaches	September 2021	0	Common Cause	Unreliable

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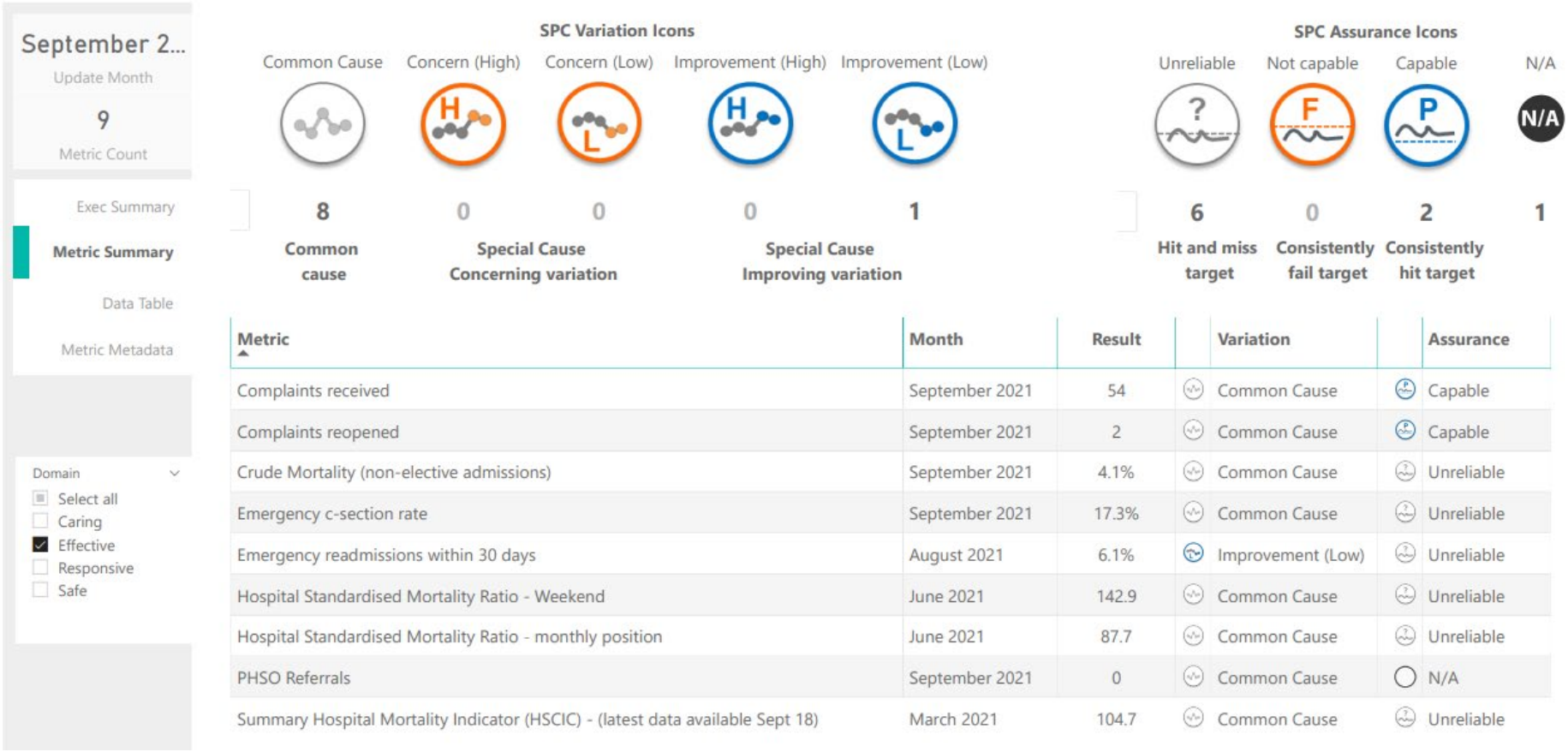

Metric	Month	Result	Variation	Assurance
Complaints received	September 2021	54	Common Cause	Capable
Complaints reopened	September 2021	2	Common Cause	Capable
Crude Mortality (non-elective admissions)	September 2021	4.1%	Common Cause	Unreliable
Emergency c-section rate	September 2021	17.3%	Common Cause	Unreliable
Emergency readmissions within 30 days	August 2021	6.1%	Improvement (Low)	Unreliable
Hospital Standardised Mortality Ratio - Weekend	June 2021	142.9	Common Cause	Unreliable
Hospital Standardised Mortality Ratio - monthly position	June 2021	87.7	Common Cause	Unreliable
PHSO Referrals	September 2021	0	Common Cause	N/A
Summary Hospital Mortality Indicator (HSCIC) - (latest data available Sept 18)	March 2021	104.7	Common Cause	Unreliable

Hull University Teaching Hospitals NHS Trust

September 2...
Update Month

18
Metric Count

Exec Summary
Metric Summary
Data Table
Metric Metadata

Metric	Month	Result	Variation	Assurance
Cancer 62 Day Waits for first treatment (from urgent GP referral)	August 2021	55.8%	Common Cause	Not capable
Diagnostics: Patients waiting 6 weeks or more from referral to test	September 2021	39.3%	Concern (Low)	Not capable
ED: 12 hour trolley waits	September 2021	5	Concern (Low)	Unreliable
ED: Standard Performance Type 1	September 2021	55.5%	Concern (High)	Not capable
PALS Complaints	September 2021	174	Common Cause	Capable
RTT 52+ Week Waiters	August 2021	6,912	Concern (Low)	Capable
RTT Incomplete Pathways % performance	August 2021	57.5%	Common Cause	Not capable
Written Complaints - rate (Still annual report) per 1000 bed days	September 2021	1.9	Common Cause	Unreliable

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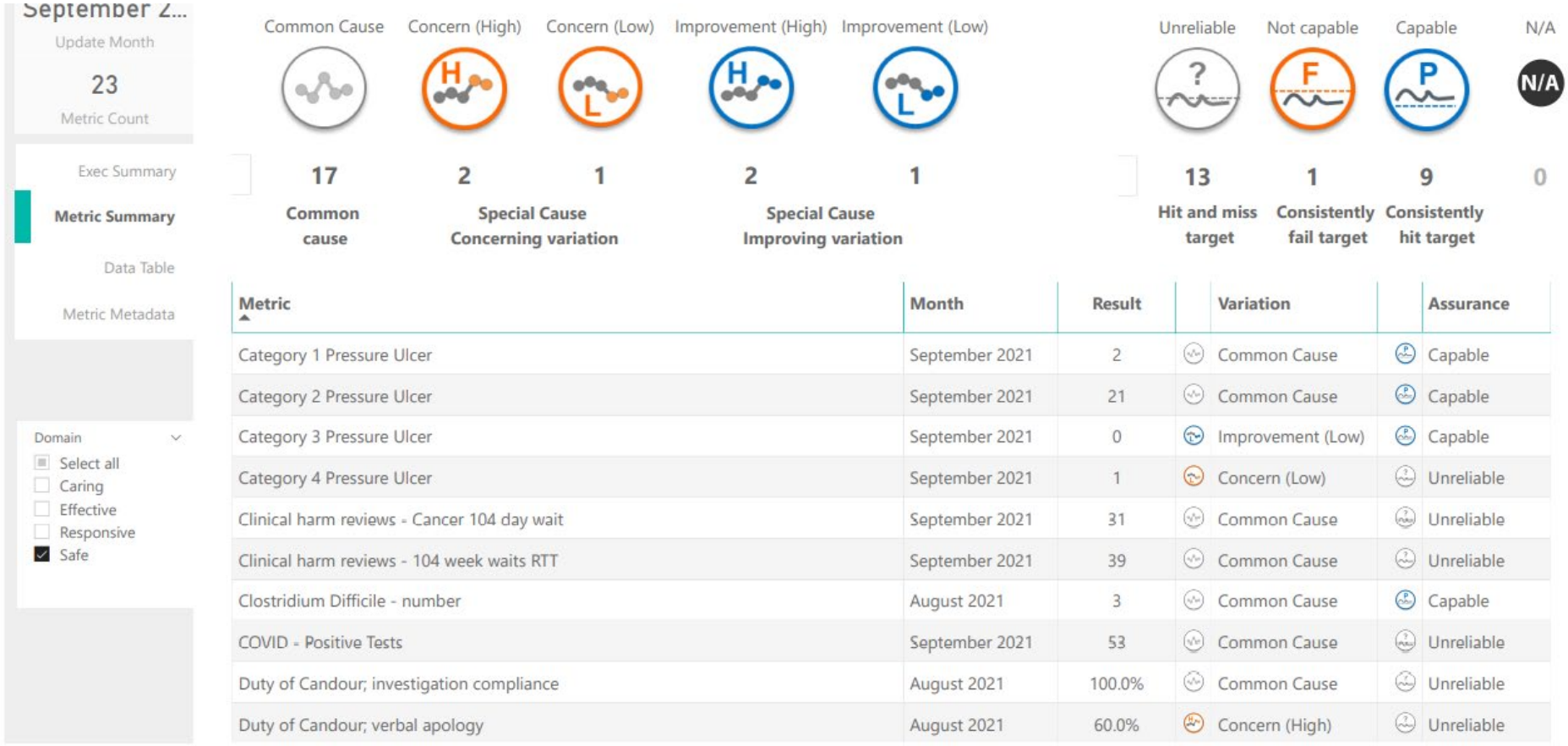

Metric	Month	Result	Variation	Assurance
Category 1 Pressure Ulcer	September 2021	2	Common Cause	Capable
Category 2 Pressure Ulcer	September 2021	21	Common Cause	Capable
Category 3 Pressure Ulcer	September 2021	0	Improvement (Low)	Capable
Category 4 Pressure Ulcer	September 2021	1	Concern (Low)	Unreliable
Clinical harm reviews - Cancer 104 day wait	September 2021	31	Common Cause	Unreliable
Clinical harm reviews - 104 week waits RTT	September 2021	39	Common Cause	Unreliable
Clostridium Difficile - number	August 2021	3	Common Cause	Capable
COVID - Positive Tests	September 2021	53	Common Cause	Unreliable
Duty of Candour; investigation compliance	August 2021	100.0%	Common Cause	Unreliable
Duty of Candour; verbal apology	August 2021	60.0%	Concern (High)	Unreliable

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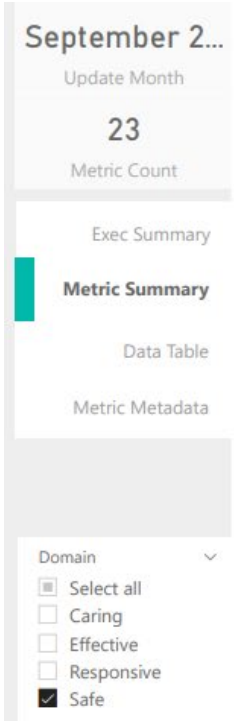

Metric	Month	Result	Variation	Assurance
Duty of Candour; written apology	August 2021	96.6%	Improvement (High)	Unreliable
E.Coli	August 2021	7	Common Cause	Capable
Klebsiella spp bacteraemia	August 2021	2	Common Cause	Capable
Maternal Deaths	August 2021	0	Common Cause	Unreliable
MRSA bactaraemias	August 2021	0	Common Cause	Unreliable
MSSA	August 2021	3	Common Cause	Capable
NEWS Compliance	August 2021	100.0%	Common Cause	Unreliable
Number of Never Events in month	September 2021	2	Common Cause	Unreliable
Percentage of harm free care	August 2021	86.0%	Improvement (High)	Unreliable
Pressure ulcers	August 2021	30	Common Cause	Capable
Pseudomonas aeruginosa bacteraemia	July 2021	2	Common Cause	Capable
SIs investigated on time within 60 days	September 2021	50.0%	Common Cause	Not capable
SIs reported to StEIS within 48 hours	September 2021	0.0%	Concern (High)	Unreliable

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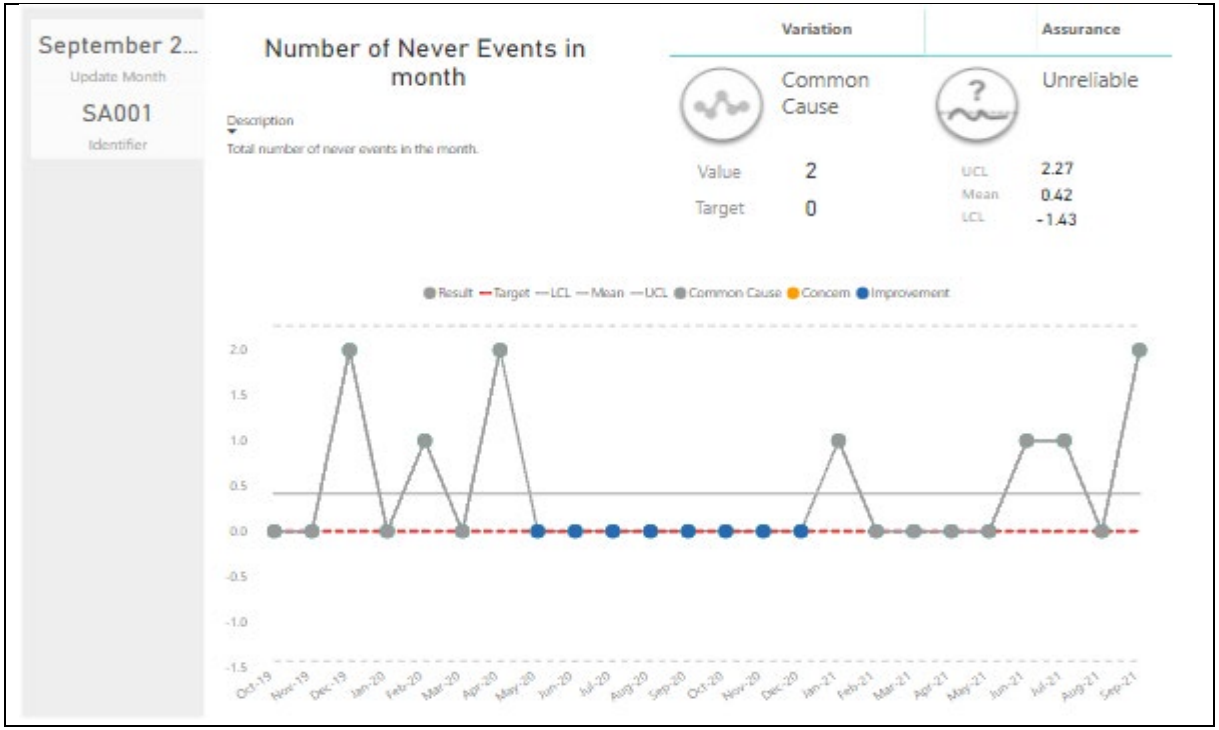
Never Events



Performance (Date)
Variance Type
Common Cause
Target/Plan
0
Board Escalation
Required

What the chart tells us	Issues	Actions	Mitigations
There have been 2 Never Events reported in September 2021 One wrong site surgery in the Day Surgery Unit, HRI. After injection of local anaesthetic and before 'knife to skin' the surgeon asked the patient if he could feel his finger. It was established that the surgeon had injected the left middle finger instead of the left ring finger. The error was made due to the patient's hand being turned over prior to injection meaning the marking on his hand was not visible.	This is the second wrong site surgery relating to a procedure on an incorrect digit although the Never Events		

One administration of medication by the wrong route - oral/enteral medication or feed/flush by any parenteral route.	occurred in different areas. The previous Never Event was due to terminology used to identify the correct digit.		

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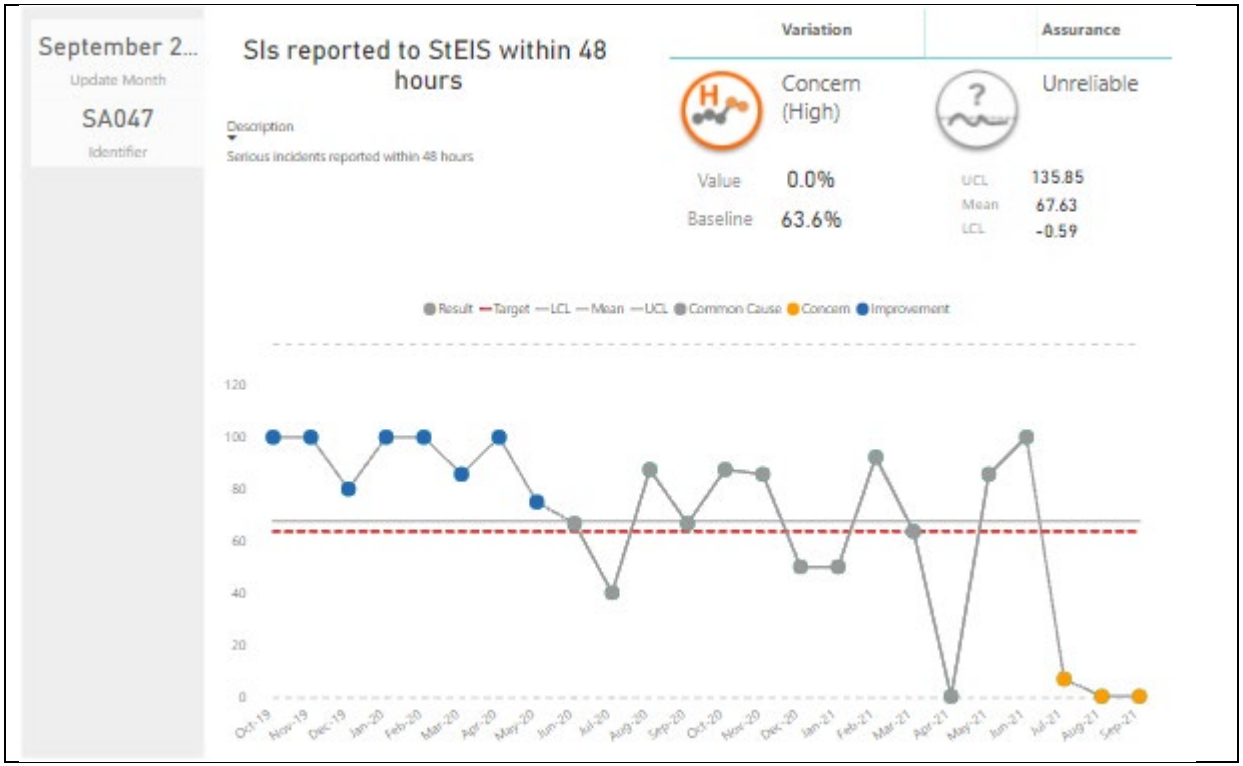

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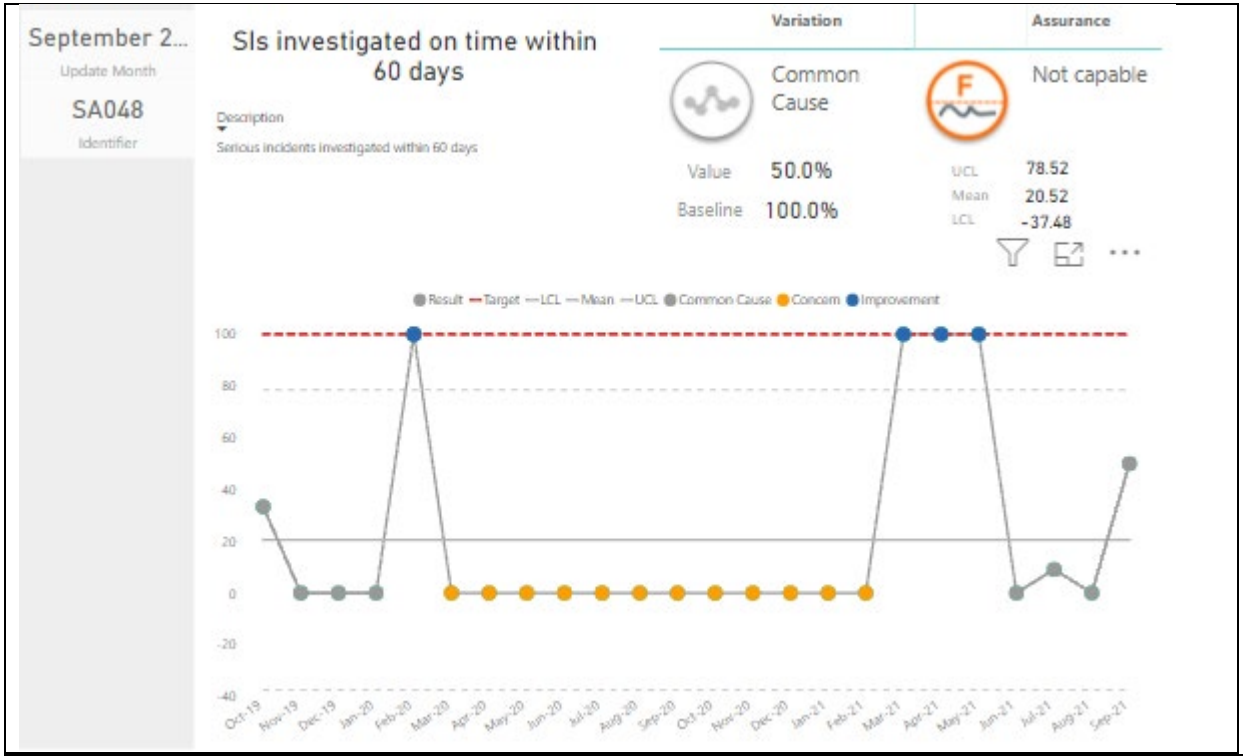

Serious Incidents

Performance (Date)
10 Serious Incidents reported in month
Variance Type
Common Cause
Target/Plan
Board Escalation
Not required

What the chart tells us	Issues	Actions	Mitigations
10 serious incidents (including one Never Event) were reported in September, slightly down on the 12 reported in August. None of the 10 SIs were reported onto StEIS within 48 hours of the decision to declare a SI is made. SI investigations are not being completed within 60 working days of declaration. 4 SI investigations were completed in September; 2 (50%) were completed to timescales	1. At the end of September, there were 65 open serious incident investigations. 2. The Trust has not been investigating the incidents within 60 day timeframes due to recent	1. To clear the 'backlog' of the serious incidents which are over the 60-day timeframe for investigation. 2. The 60-day timeframe for completion of serious incidents declared has been re-introduced for	1. 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 actions/learning points. 2. Monitoring via the Serious Incident Review Group.

	pressures within the Trust; this had been agreed with the commissioners 3. The patient safety team relies on the completion of Rapid Review Reports (RRR) by the health groups before a serious incident is declared onto StEIS; this enables the initial findings and immediate actions identified to be included in the declaration. 4. The Health Groups are not submitting the RRR within 48 hours.	SIs declared since 10 September 2021. 3. Patient safety team to declare onto StEIS within 48 hours of the agreement for SI made using the information available on Datix A new metric to be introduced; Health groups to submit the RRR within 72 hours and for the RRR to double up as the 72 hour report that is submitted to Hull CCG.	3. The Quality and Patient Safety Lead at Hull CCG to work with the Patient Safety Team 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 are providing support.

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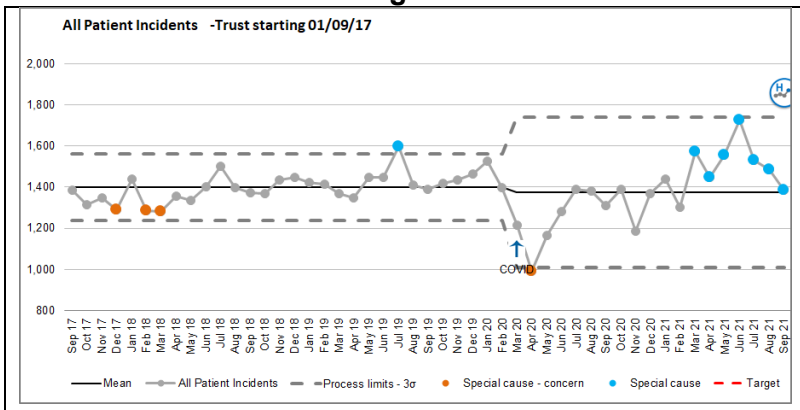
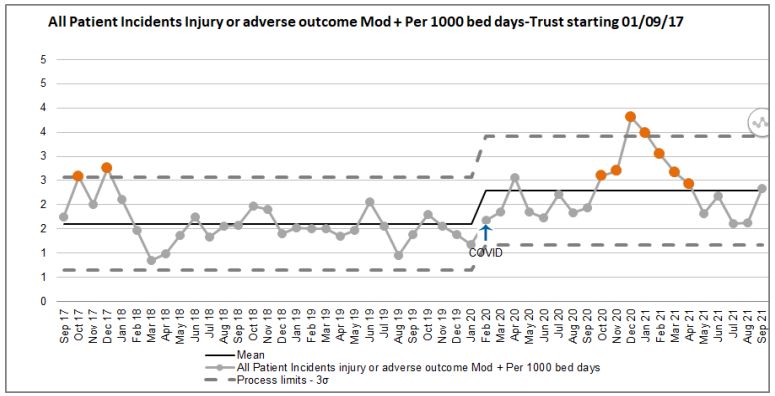
Patient Incidents - Percentage of harm free care





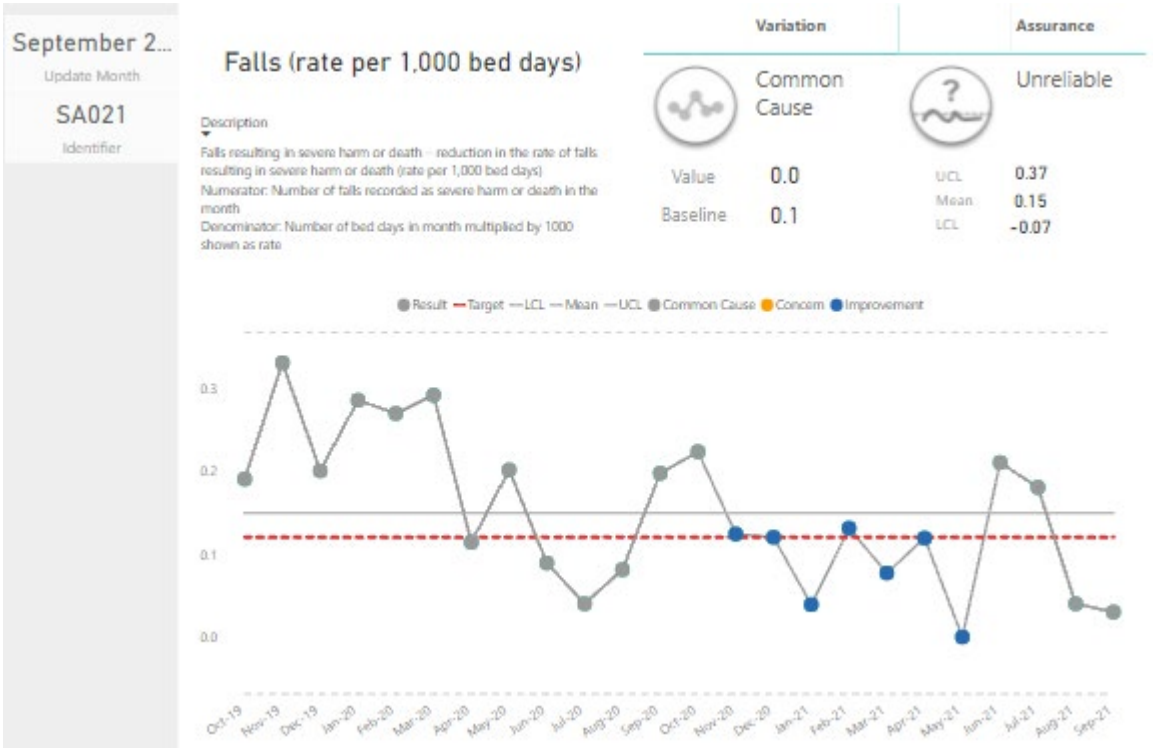
Performance (Date)
Variance Type
Target/Plan
Board Escalation
Not required

What the chart tells us	Issues	Actions	Mitigations
All variation within control limits and show a decrease for 4 consecutive months, however when more than seven sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. The total number of patient safety incidents reported in September was **1406**. Although now back in line with the	The highest category of incidents were un-witness slips, trips or falls at 168 incidents, the next was	Health Groups continue monitoring their themes and trends and review learnings from incidents through the	

mean, over the last 7 months there has been an increase in the number of incidents reported, however this demonstrates a good reporting culture within the trust. The difference in the reduction since June 2021 is 323 less incidents reported in September. **72** incidents were reported with the severity of moderate or above harm to the. This equates to 5.12% of the total number of incidents reported and 2.3 incidents per 1000 bed days.	administration of care incidents at 86 reported. The highest category of incidents causing moderate or above harm to a patient were hospital acquired pressure ulcers at 19 incidents.	governance structure.	

Hull University Teaching Hospitals NHS Trust

Falls



Performance (Date)
Variance Type
Target/Plan
Board Escalation
To be escalated

What the chart tells us	Issues	Actions	Mitigations
In September 2021, 2 patient safety incidents occurred resulting in major harm to a patient; both incidents were considered as serious incidents at the Weekly Patient Safety Summit as the patient's had suffered fractured neck of femurs. Both incidents, which were reported within the Medicine Health Group. The Falls Prevention Committee will review the Rapid Reviews submitted to identify and further learning to be shared with the Health Group.	A theme from Serious Incident investigation's submitted in September continue to be related to poor documentation, in the first instance	Work is ongoing by the Practice Development Matron and the Patient Safety Team to address actions via the Falls Prevention Committee and the Falls QIP	There is an ongoing improvement project to implement electronic falls documentation across the Trust. The rollout of the electronic system will support staff in the completion by prompting staff to complete all areas, including appropriate interventions, without gaps, and will offer suggested

The number of falls per 1000 bed days continues to fall and remains below target for the second consecutive month, which is positive taking into account the current pressures on the Trust.			actions for staff to follow as prompts.

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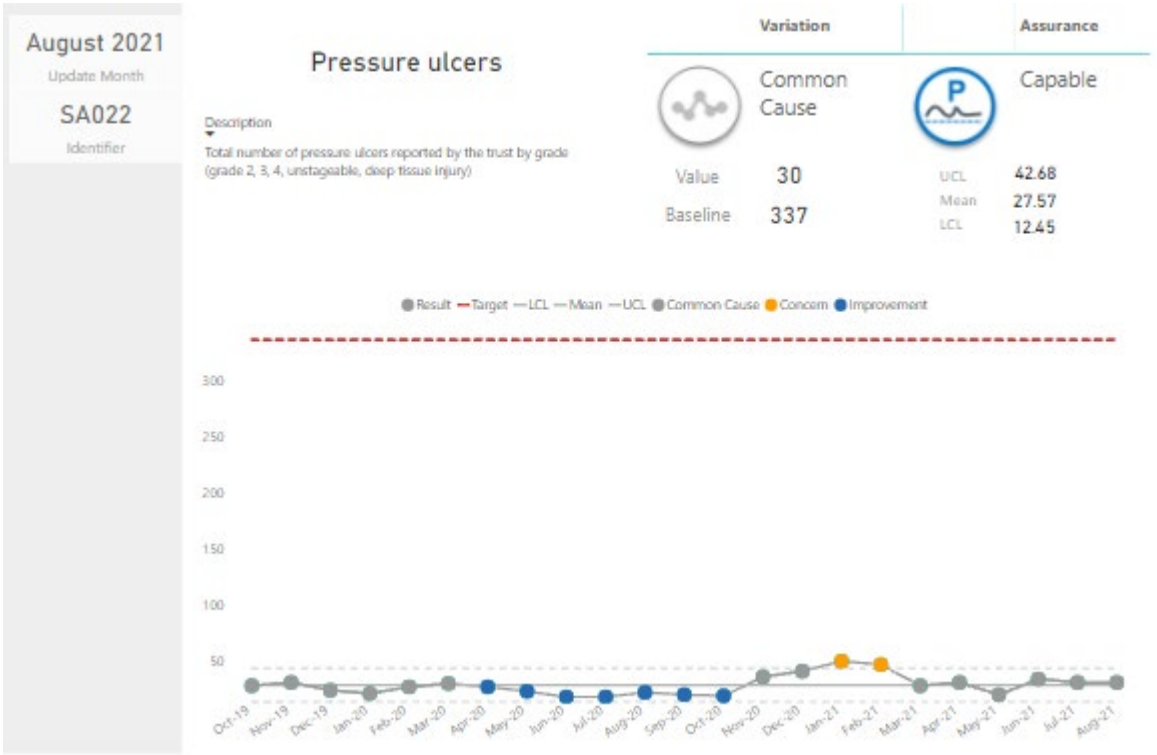
Pressure Ulcers



Performance (Date)
Variance Type
Common Cause
Target/Plan
Board Escalation
Not Required

What the chart tells us	Issues	Actions	Mitigations
A total of 69 pressure ulcer incidents were reported in September, 52 were reported as category 2 pressure damage, and 16 reported as DTI and 1 unstageable pressure ulcer. Following investigation/ validation currently 31 of the 69 incidents were not pressure damage. The majority of these being re coded as MASD or admitted to hospital with a pressure ulcer. Of the remaining 39, 28 have been finally approved the remaining 10 reported as are being reviewed.	There continues to be a significant number of investigations, (52%) that continue to breach the 14 day standard.	The Tissue Viability team are in the process of completing the TV fundamental standards across the organisation. Progress is good, with the aim to have all audits completed for December 2021. All audits results are fed back to the ward sister and real time teaching takes place if required at the time of the audit. The Tissue	

As there remains 10 incidents currently being reviewed, following investigation the total number of pressure ulcers may be less than the currently reported 39.	There has been x1 SID completed for a delay with removing a patient's leg dressing, which once removed showed a significant tissue loss.	Viability Team will work with the ward teams to formulate ward action plans, support with implementation and evaluate practice. Purpose T a new Pressure Ulcer Risk Assessment tool has been implemented across CHH in line with the digital roll out. Feedback from the ward areas has been mostly positive. HRI role out will initially use the paper version of Purpose T until full digitalisation takes place. Each Health Group to receive a monthly Tissue Viability report.	

Hull University Teaching Hospitals NHS Trust

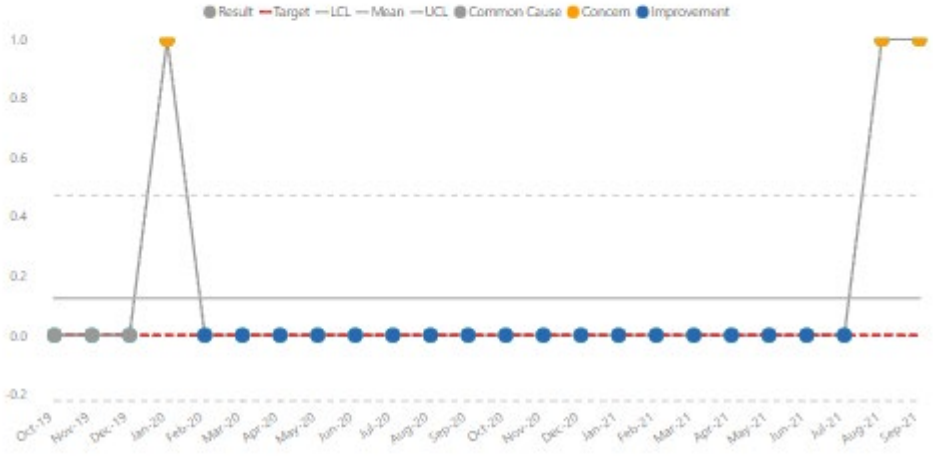
September 2...
Update Month

SA026
Identifier

Category 4 Pressure Ulcer

Description
Total number of pressure ulcers reported as grade 4

Variation		Assurance	
Concern (Low)		Unreliable	
Value	1	UCL	0.47
Baseline	0	Mean	0.13
		LCL	-0.22



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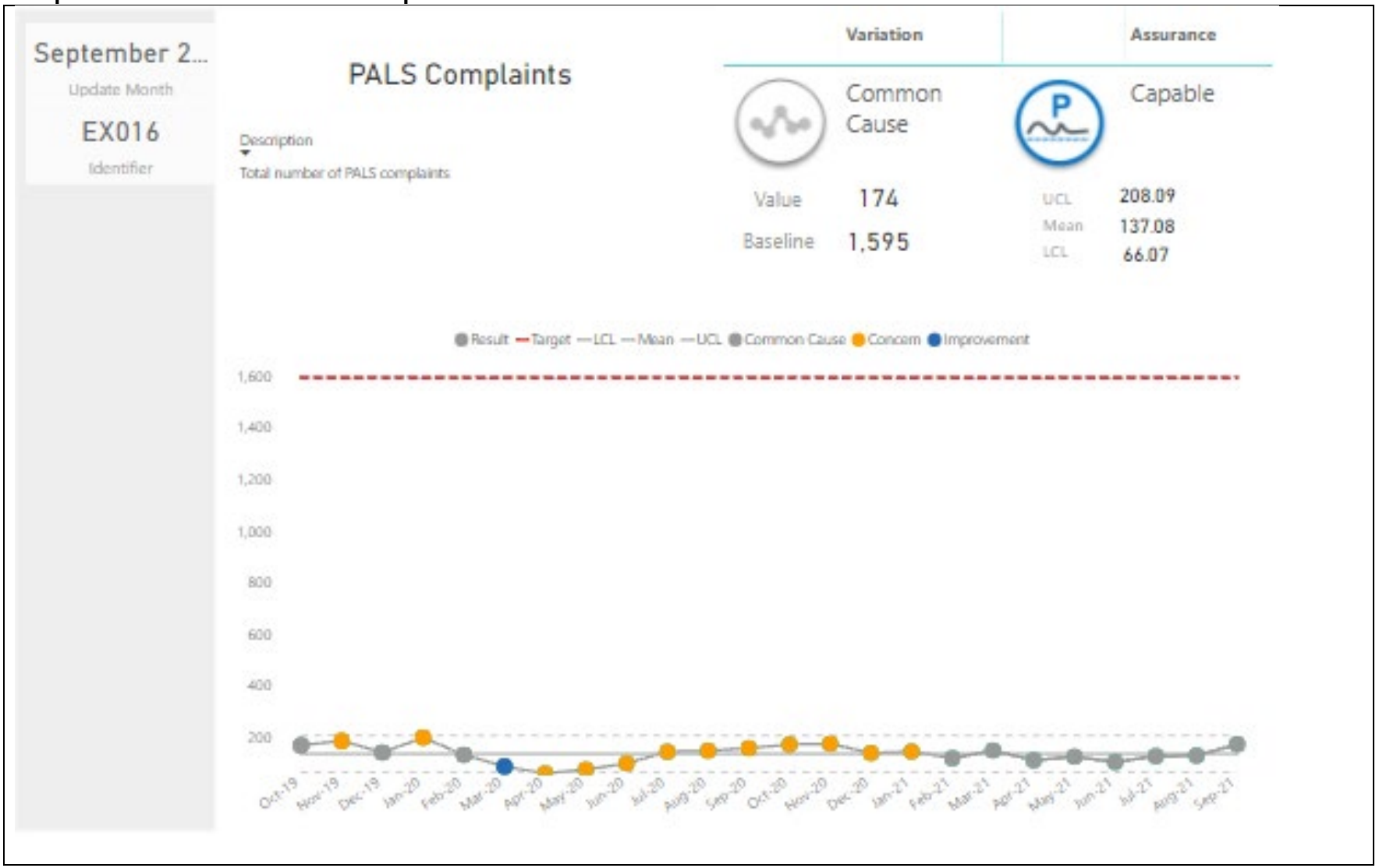
Complaints and PALS received in September 2021



Hull University Teaching Hospitals NHS Trust

What the charts tells us	Issues	Actions	Mitigations
See Appendix (Patient Experience Report)			

Well-Led
National Audits – CQC Queries
A number of queries were raised to the CQC by the National Clinical Audit Team for discussion and monitoring at a local engagement level.

National Audit	Current Position	Assurance	Required Action
National Lung Cancer Audit, 2021, alarm (3sd), Pathological confirmation in patients with stage I/II and performance, 1/1/18 - 31/12/18	This audit is flagging in the CQC Insight Report as performing 'Worse' than the England average and in March 2021, the Trust has received an outlier status from the NLCA 2019 Annual Report.	The outlier status was discussed with the Lung Cancer and there was a consensus opinion that due to the transition from a Cardio-thoracic service to a specialist Thoracic Surgery service during the cohort year would have caused the lower rate resulting in an alert. Increased numbers would be expected in the subsequent years. It is important to note that the service has also seen an increase in the use of Stereotactic Ablative Radiotherapy (SABR) during the last 2-3 years. They summarised that it was mostly down to SABR in patients with poor respiratory function, which the team feels is appropriate care. The mean national score of 85% seems quite high. Nonetheless the service are committed to improving the rate having recently started a local navigational bronchoscopy service. This will allow attempts at histology in some cases where it is difficult to access via CT guided percutaneous route and those with more marginal respiratory reserve.	The Clinical Lead is revisiting the data entry issues to address those failings and improve the collection and submission of data. Due to the pandemic the National Cancer Registration and Analysis Service (NCRAS), hosted by Public Health England (PHE), were unable to provide the standard dataset traditionally used in the NLCA report. This will be published in January 2022. However, As an alternative, NCRAS is providing a new Rapid Cancer Registration Dataset (RCRD) – this consists of 79 data items from the Cancer Outcomes and Services Dataset (COSD), Radiotherapy Dataset (RTDS), Systemic Anti-Cancer Therapy Dataset (SACT) and Hospital Episode Statistics (HES) dataset. While the RCRD has some limitations, a significant

			benefit is that the data are available quicker and so data from 2019 and 2020 will be included. This will be reviewed to identify any areas of improvement. In the meantime, the Clinical Lead and the Trust Lead Cancer Manager are exploring how the outcomes data can be extracted from the system to review and action before the national reports.
National Paediatrics Diabetes Audit, alarm level outlier 'Case-mix adjusted mean HbA1C'	This particular indicator from this audit is flagging in the CQC Insight Report as performing 'Much Worse' than the England average. The audit is out of date from 2018/19; however, the Trust has also received an outlier notification for the National Paediatric Diabetes Audit (NPDA) - Hull Royal Infirmary for 2019/20. Therefore, concerns remain current and the service has consistently performed much worse than national average for this indicator	FWHG presented on this to at the performance management meetings. There have been historic data issues that have been addressed. In addition to this, the HIP team have been supporting with pathway work with the aim of improving the mean HbA1c. The lead paediatrician presented to the Patient Safety Committee in June 2021 where the outstanding action of increasing the use of pumps for children and young people was discussed. The Clinical Lead has confirmed they have addressed this action and increased the use of insulin pumps. It should be acknowledged that for many of the other indicators in this national audit, the Trust is performing well.	The following steps have been agreed to improve the HbA1c of our cohort of children. The first four measures have been completed and the last two are in progress. 1. New High HbA1c pathway - complete 2. Carbohydrate counting from diagnosis - complete 3. Additional Nurse Dietitian clinics - complete 4. Increase use of technology (insulin pumps , continuous glucose monitoring) – complete 5. Lead nurse role (currently unassigned) issue to be

			addressed by nursing management 6. Health care assistant to support clinics to free up nursing time
National Bowel Cancer Audit: • 'Insufficient data - 30-day emergency readmission' outlier; • 'Insufficient data - 90-day mortality' outlier; and • 'Insufficient data - Two-year survival' outlier.	For 2018/19 HUTH were excluded from the risk-adjusted analyses of '90 day mortality', '30-day readmission rate' and 'Two year mortality' because overall data completeness was less than 20% or ASA grade and/or TNM stage was missing in more than 80% of patients included in the analyses.	• 88% of patients had complete pre-treatment staging. This is higher than the national average of 83%. • 96% of patients had a recorded number of lymph nodes which is higher than the national average of 91%. • The observed 30-day unplanned return to theatre rate at HUTH is 4.5%. This is considerably lower than the national average of 11.8%. • 56% of patients received pre-operative radiotherapy. This is higher than the national average of 32%.	The Trust is working with the Audit Co-ordinator at NHS Digital regarding this outlier. They have confirmed that the latest data confirms that the Trust will not be an outlier for 30-dat emergency re-admission; however, data issues remain with the missing ASA grades and TNM data which have prevented risk adjusted assessment in the 18-month stoma, and the 2-year mortality outlier measures. NHS Digital have stated that if the data can be corrected by the next database extract in the first week of November 2021, the audit will endeavour to add a foot note explaining the data was later completed and remove the service from the list of outliers. The Clinical Audit and Effectiveness Manager is working with the Clinical Lead to address this.

Quality Report – September 2021 – Patient Experience
LEAD: Beverley Geary, Chief Nurse

The purpose of the report is to inform the Quality Committee of the activities of the Patient Experience Team during the month of September 2021.

COMPLAINTS:

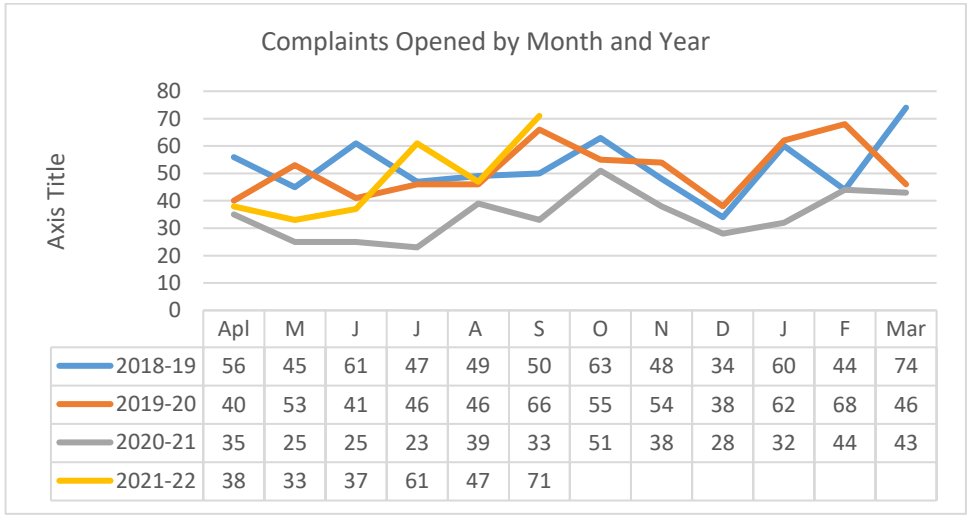
Complaints by HG and Subject (Primary)	General Advice	Attitude	Care and Comfort	Communication	Delay, Waiting Times and Cancellations	Discharge	Environment	Hotel Services	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	0	0	0	0	1	0	0	1	0	0	0	2
Clinical Support - Health Group	1	0	0	1	1	0	0	0	0	0	0	3
Emergency Medicine - Health Group	0	0	0	2	0	0	0	0	0	0	8	10
Family and Women's Health Group	1	2	2	1	1	0	0	0	0	0	9	16
Medicine - Health Group	1	0	4	2	1	1	0	0	0	0	8	17
Surgery - Health Group	0	0	4	3	2	1	0	0	0	0	13	23
Totals:	3	2	10	9	6	2	0	1	0	0	38	71

The table indicates the number of complaints by subject received by each Health Group during the month of September 2021. Treatment continues to be the subject receiving the highest number of complaints. The number of complaints received over the past 5 months is significantly higher than the same period in 2020.

Currently there are 150 complaints open (as of 13 October 2021) however; the team are now up to date with logging new cases. 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 is currently being prepared.

The Information Services team are currently arranging for up to date complaints information to be available on BI.

The standard is for 85% of complaints to be closed within 40 working days. Of the 45 complaints closed in September 2021, 17 (38%) were closed within 40 working days. The standard has not been achieved in the financial year 2020/21. The Patient Experience Team is working closely with the health groups to meet the standard.

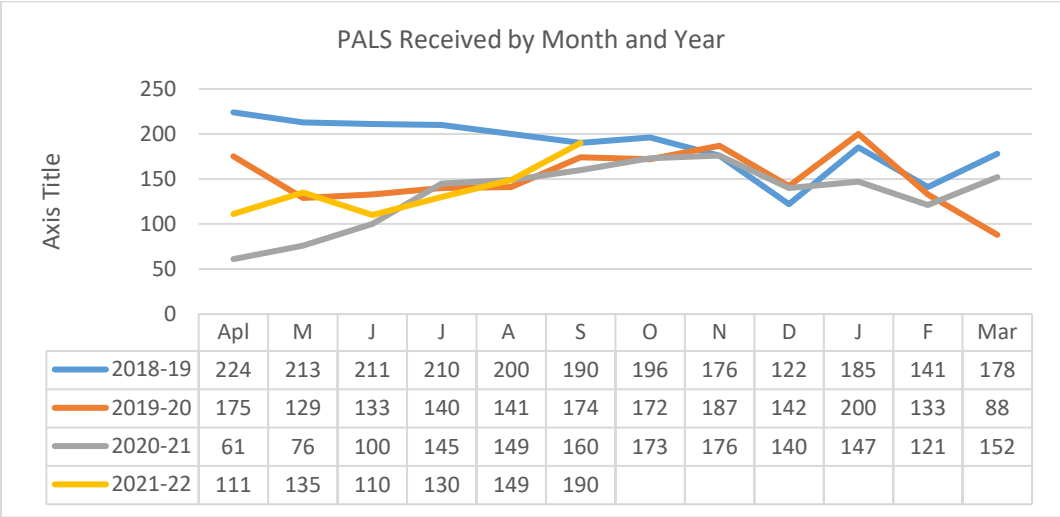


	Apl	M	J	J	A	S	O	N	D	J	F	Mar
2018-19	56	45	61	47	49	50	63	48	34	60	44	74
2019-20	40	53	41	46	46	66	55	54	38	62	68	46
2020-21	35	25	25	23	39	33	51	38	28	32	44	43
2021-22	38	33	37	61	47	71						

Complaints closed within 40 working days:					
Apl	May	June	July	Aug	Sept
54%	60.7%	73.6%	73.6%	53%	38%

June 2021 by HG	Nº Closed	Within 40 days	Upheld	Partly Upheld	Not Upheld	Not Inv	Re-opened
Corporate Functions	1	1 (100%)	0	1	0	0	0
Clinical Support	4	2 (50%)	1	2	1	0	0
Emergency Medicine	6	2 (66%)	0	3	3	0	0
Family and Women's	13	3 (23%)	2	7	4	0	1
Medicine	10	8 (80%)	1	8	1	0	1
Surgery	11	1 (9%)	1	2	8	0	0
Totals:	45	17 (38%)	5	23	17	0	2

Patient Advice and Liaison Service (PALS):



	Apl	M	J	J	A	S	O	N	D	J	F	Mar
2018-19	224	213	211	210	200	190	196	176	122	185	141	178
2019-20	175	129	133	140	141	174	172	187	142	200	133	88
2020-21	61	76	100	145	149	160	173	176	140	147	121	152
2021-22	111	135	110	130	149	190						

Contact with PALS has increased during September compared to previous months; however, the PALS team are turning the cases around quickly with support from the health groups.

The table below indicates the total number of PALS concerns by subject received by each Health Group during the month of September 2021 (190). Delays waiting times and cancellations was the subject with the highest number received (66), the majority relating to the waiting time for appointments, surgery or notification of results.

In addition to the concerns raised, there were 20 compliments, 2 comments and 11 general advice contacts received by the team during September 2021. 330 cases have been closed this month and there are currently (as of 13 October), 52 cases open.

PALS by HG and Subject (Primary)	General Advice	Attitude	Care and Comfort	Communication	Delays Waiting Times and Cancellations	Discharge	Environment	Hotel Services	Safeguarding	Special Needs	Treatment	Total
Corporate Functions	1	1	0	1	0	0	0	1	0	0	0	4
Clinical Support - Health Group	2	3	1	4	10	0	0	0	0	0	1	21
Emergency Medicine - Health Group	2	6	3	4	2	0	0	0	0	0	5	22
Family and Women's - Health Group	3	3	2	5	14	0	0	0	0	0	4	31
Medicine - Health Group	7	3	4	10	14	3	1	0	0	0	10	52
Surgery - Health Group	3	5	4	9	26	3	1	0	0	0	9	60
Totals:	18	21	14	33	66	6	2	1	0	0	29	190

Parliamentary and Health Service Ombudsman (PHSO):

The PHSO has advised that one case they have investigated has been partly upheld. This will be reported to the next PEEC meeting by the Surgery Health Group.

National Surveys:

ED is preparing an action plan following the results of the 2020 survey that will be presented at the PEEC meeting in November and will be monitored through that committee. Meetings have been arranged with F&WHG to review the Children and Young People's Survey 2020, and the Maternity Survey 2021 as the provisional results have now been received from Picker. The Inpatient National Survey for 2021 will take place in autumn this year and posters have been forwarded to all wards for display to advise patients in hospital during the survey period.

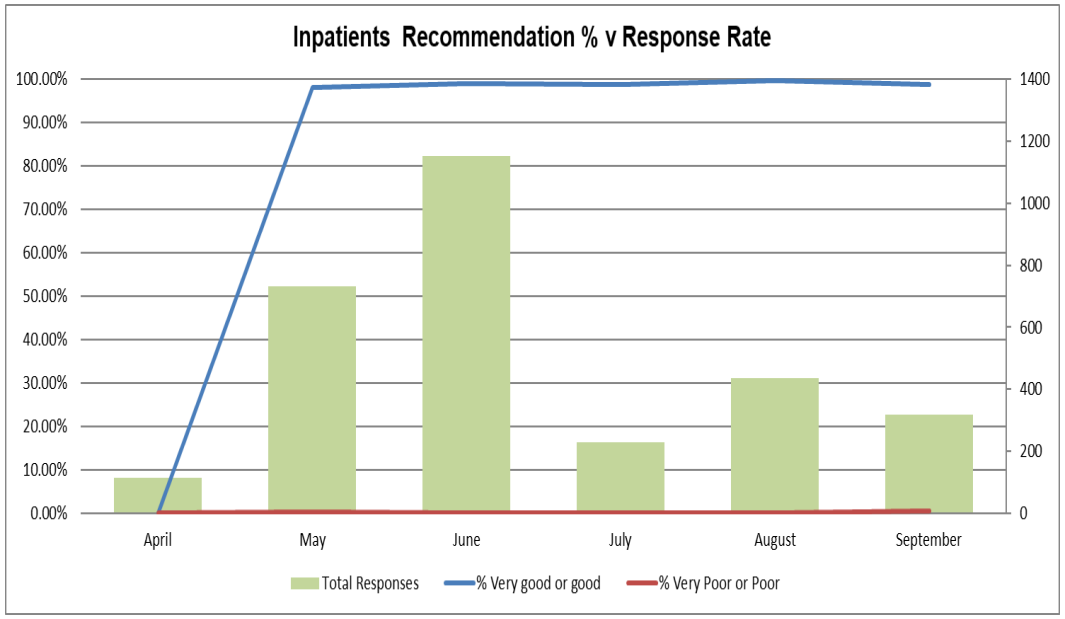
Interpreter Services:

During the month of August 2021, 950 telephone interpreters were used amounting to 15,194.8 minutes in 44 different languages. The top three languages were Romanian 279 calls, Polish 168 calls and Arabic 71 calls. 128 video interpreting sessions were held and 468 face to face sessions.

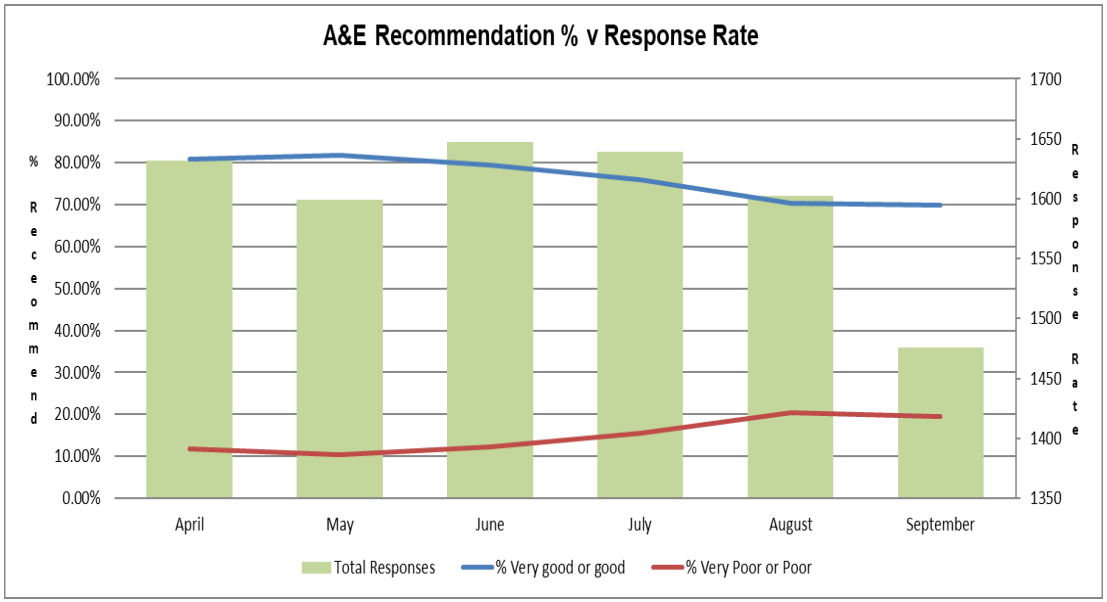
Friends and Family:

Friends and Family Test September 2021

The Trust's Friends and Family test for all areas, including the Emergency Department, had a lower number of responses for September 2021 with 2,206 patient feedback responses, compared to August 2021 when 3,072 were received. The September inpatient results indicate that 98.74% 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%. The patient experience team are working with the information analytics and business intelligence team to set up the new Friends and Family test, provided by Healthcare Communications and will go live at the end of October 2021 giving patients the option to leave feedback via many different new platforms.



Friends and Family Emergency Department (ED)
1,472 patients who attended the Emergency Department in September 2021 responded to the Friends and Family Test with 69.78% of patients giving positive feedback and 19.51% negative feedback. 1,602 patients that attended the Emergency Department in August 2021 responded to the Friends and Family Test with 70.29% of patients giving positive feedback and 20.47% negative feedback. The remainder were neither positive nor negative.



Voluntary Services:

HUTH volunteers have been helping Trust departments over the month of September 2021.
We have been active in re-engaging with our established volunteers and are slowly welcoming them back into the Trust. All volunteers will receive a relevant risk assessment and will be encouraged to participate in LAMP testing.

Meet and Greet volunteers have played a pivotal role in making sure visitors to the sites are keeping to safety measures and helping them to move around the hospitals. Volunteers have contributed 1500 hours in this role from June to August across all sites.

We currently have over 500 volunteers within the Trust.

It has previously bee reported that volunteers would be supporting the team at the new Complex Rehabilitation centre (Ward 1), this is now underway and support include a volunteer from our Young Health Champions.

As the new academic year approaches, we are well underway with plans for the Young Health Champions volunteering programme and continue to work with existing partnerships via local schools, colleges and training providers. We anticipate Voluntary Services will start to go out to give presentations, Q&A sessions and recruitment days with students in their place of learning from late September onwards (COVID permitting). We have a plan in place should we need to deliver virtually, however we feel there is a need to keep these activities as it supports our partnership working

Volunteer recruitment remains healthy for both young volunteers and adults. We have had over 70 applications submitted over the last few months. The recruitment process and interviews will start shortly. Volunteers will be able to participate in areas including Community Midwifery, General Outpatients and exciting new opportunities with HUTH Delivery a mobile shopping service brought from the HEY Volunteer shop.

The voluntary service team have been inviting volunteers to an information day, to talk to them about their experiences during COVID, and updating them on any changes within the Trust.

These sessions have been a good way of checking in with the volunteers and their health and wellbeing, all volunteers who have attended the voluntary information day have given good feedback to the team, we have spoken to them about their COVID boosters and the Lamp test and thanked them for all of their time and dedication to the Trust.

We are holding voluntary information days through the months of October, November and December 2021.

Youth & Adult Patient, Public & Carer Councils

The Youth Patient, Public & Carer Council had its introductory meeting on 5 October 2021 with 16 attendees. Regular meetings on a monthly basis have been organised with 21 young people now interested.

The Adult Patient, Public & Carer Council was reconvened on 12 October 2021 (we have six members). An advertisement campaign to recruit new members and a new chair will begin by end of October 2021.

Hull University Teaching Hospitals NHS Trust
IPC BAF Report for Trust Board

Agenda Item	7.3.2	**Meeting**	**Trust Board**	**Meeting Date**	09.11.2021
Title	IPC Board Assurance Framework (BAF) Update				
Lead Directors	Beverley Geary, Executive Chief Nurse Suzanne Rostron, Director of Quality Governance				
Author	Ernesto N. Quider, Associate Director of Quality *(on behalf of the IPC T&F Group and Subgroups members)*				
Report previously considered by (date)	This report has been previously considered at the Quality Committee on 25th October 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 recommended to: ▪ Receive the IPC BAF for assurance following on from review by the Quality Committee and to note the ongoing IPC improvement work by the IPC BAF task and finish group; ▪ Decide whether any further actions or information is required.

Hull University Teaching Hospitals NHS Trust
IPC Board Assurance Framework Update

1. Purpose of the Report

The purpose of the report is to inform the Trust Board the updates of the ongoing work of IPC Board Assurance Framework (BAF) task and finish subgroups, acknowledge the key actions received and review the actions taken to address identified risks as of this stage.

2. Background

The IPC Task and Finish (T&F) Group was organised on 8 September 2021 to address number of key actions at pace following the review undertaken by NHSEI. In order to ensure all BAF Goals are reviewed thoroughly with focused areas to undertake, IPC BAF subgroups have undertaken a full review against the ten IPC BAF goals. The sub groups have assessed the assurances and evidence available against each key line of enquiry within the goals and as a result identified any gaps in assurances and the required mitigating actions. Each key line of enquiry was then RAG-rated accordingly. The current IPC BAF is attached at Appendix A for Trust Board information.

3. Assessment Outcomes of IPC Board Assurance Framework

The table below (*see table 1, pages 4-6*) is a summary assessment of all IPC BAF goals based on the work undertaken by BAF sub-groups. The risks and other key themes arising from sub-groups review meetings were evaluated at the IPC T&F Group Confirm and Challenge meeting on Tuesday, 26th October 2021.

The assessment outcomes of note are as follows:

- BAF goals with red RAG Ratings (see Appendix A for further details):
  - Goal 1: Systems are in place to manage and monitor the prevention and control of infection,
  - Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection
  - Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people, and

- The majority of key lines of enquiry have been RAG-rated as significant assurance received (Green) or limited assurance received and confident improvements will be made within 3 to 6 months (Amber Green).
- Goal 1 is partially completed as the review is ongoing due to the depth and the risk of the goal notably the decision to re-evaluate risk assessment of non-clinical areas- require some more clarity from Silver / Directors (1.1), which was escalated to Director of Workforce.
- Two key lines of enquiry are rated as *Amber Red* (limited assurance received and confident improvements will be made within 6 months or more). These relate to following goals:
  - Goal 1.3 - Triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways, and
  - Goal 6.10 - Staff understand the requirements for uniform laundering where this is not provided for on site.
- Only three key lines of enquiry are rated as *Red* (low assurance – does not meet expectations). These relate to following goals:

- Goal 2.12 - Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and other national guidance and the appropriate precautions are taken,
- Goal 5.2 - Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidelines, and
- Goal 5.11 - To ensure 2 metre social and physical distancing in all patient care areas.

4. Next Steps

The Board will receive updates with a clearly outlined improvement plan to address all mitigating actions for next meeting. This T&F group will continue until all improvement actions are in place and the Infection Reduction Committee is providing sufficient assurance to the Patient Safety and Improvement Sub-Committee, Quality Committee and ultimately Trust Board.

5. Recommendations

The Trust Board is recommended to:

- Receive the IPC BAF for assurance following on from review by the Quality Committee and to note the ongoing IPC improvement work by the IPC BAF task and finish group;
- Decide whether any further actions or information is required.

Ernesto N. Quider
Associate Director of Quality
October 2021

(On behalf of the IPC Task and Finish group and subgroups members)

Table 1. IPC Board Assurance Framework
Sub-groups Assessments Summary

IPC BAF Goals Description	Key Actions Identified
Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	▪ Risk assessment of non-clinical areas- require some more clarity from Silver / Directors (1.1). ▪ On-going work needed for completion of BI report; Triage assessment & compliance audit (1.3). ▪ More evidences required to address actions related to monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice (1.8).
Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	▪ Compliance with cleaning elements missed including bed rails and tabletops. ▪ Evidence noted during IPCT audits that staff do not always decontaminate reusable equipment between patient use ▪ Concerns re. Supply of red bags in clinical areas. ▪ Ventilation was a risk to be held on the risk register.
Goal 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	▪ Largely compliant, form completed and returned. Evidence in the process of being submitted. No significant actions required.
Goal 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support of nursing / medical care in a timely fashion	▪ Started but more time required to work through all evidences to be completed. ▪ Key information required for public websites for visiting and updates and how we manage feedback from patients and carers regarding infection control issues.
Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	▪ SOPs in place but limited evidence to show compliance with these. Ongoing reviews in place for these policies/SOPs. ▪ Other actions required include new BI report of testing compliance to allow live monitoring of screening, update of risk register, robust triage tool and recording of patient risk in electronic records (5.2).

IPC BAF Goals Description	Key Actions Identified/ Progress Review
Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	▪ Lift lobby in HRI on restoration of visiting remains a challenge. ▪ SOP awaiting final approval regarding the audits undertaken - to be reviewed at the Matrons meeting at the end of October (6.5). ▪ Audits programme will be included as opportunity for improvements. ▪ Delayed escalation of positive cases noted resulting in transmission and nosocomial cases (6.12, 6.13)
Goal 7: Provide or secure adequate isolation facilities	▪ Designated red capacity is in place but the challenge on the Trust is maintaining and achieving green and amber pathways. Lack of cubicles on some wards creates additional challenges. Cohorting has been essential in some specialty areas. Contacts have also been cohorted where necessary (7.1). ▪ Social distancing on some wards especially on the HRI remain a challenge. ▪ Lack of cubicle capacity and toileting facilities on certain wards on HRI site remains a challenge (7.4).
Goal 8: Secure adequate access to laboratory support as appropriate	▪ Largely compliant, form completed and returned. ▪ Assurances and other supporting documentary evidences in the process of being submitted including but not limited to, BI reports review, TAT review, and policies updating.
Goal 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	▪ Largely compliant, form completed and returned. ▪ 9.4 - To confirm with procurement team regarding PPE supplies needs. Where clinical areas flip back excess PPE left. To check with supply chain regarding storage facilities for PPE and access to current PPE process including emergency stock; safe guard for PPE requisition; confirmation on/ clarification of out hours process; stock of body bags. ▪ Additional evidences in the process of being submitted.
Goal 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	▪ 10.1- Staff may not know they are in an 'at risk' group and are not identified unless a risk assessment is completed and regularly reviewed in light of changing health and/or working conditions. ▪ 10.3- No comprehensive central training records held for all staff, some records but in different places and incomplete. ▪ Additional evidences in the process of being submitted.

Hull University Teaching Hospitals NHS Trust

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
1.1	Local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;	COVID-19 Secure Risk Assessment for Non-Clinical areas are in place. Matron COVID-19 weekly compliance audit. IPC COVID-19 enhanced ward audit. Ventilation compliance audit.	COVID-19 Secure Risk Assessment for Non-Clinical areas requires update. Clinical areas do not have a bespoke risk assessment aligned with the Hierarchy of Controls	H&S team review & update latest COVID-19 Secure risk assessment congruent with Hierarchy of Controls. Monthly audits required. Clinical areas require bespoke risk assessments congruent with Hierarchy of Controls. High risk areas Neil Kaye to provide details of locations with regards ventilation. Database of all areas clinical & non clinical to be created.	Oct-21		AG		
1.2	The documented risk assessment includes: - a review of the effectiveness of the ventilation in the area; - operational capacity; - prevalence of infection/variants of concern in the local area	Review of operational capacity daily. CRIP report presented weekly providing information on prevalence and variants under investigation. Ventilation Risk Assessment completed. COVID-19 Surge Plan cognisant of current estate limitations	Every Action Counts' still requires application and use across the Trust. Risk assessment for clinical areas requires development utilising the Hierarchy of Controls. Patient specific risk assessment required.	IPCT to lead on dissemination of 'Every Action Counts' resources. Neil Kaye to provide clinical areas with information about Estates & Facilities risks. Develop risk assessment for clinical areas and patient group versus surge planning.	Oct-21		AG		
1.3	Triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways	Emergency Department / Admission pathway triaging and testing policy in place. Surgical pre-admission triaging and testing policy in place. Direct admission areas e.g. CAU / Cardiology / CMU and Urology and GP streaming on 6th floor triaging and testing policies in place. Direct admissions via clinic	Triage not cognisant of previous COVID-19 positive history, contact status and COVID-19 vaccination status. Some POCT missed in ED in spite of decision to admit Negative POCT rather than clinical picture dictates patient transfer. There is not a single unified triage template that is used for all admissions that is then recorded in the patient records. Admissions staff ask triage questions but this is not usually recorded especially with regards COVID-19.	BI report for screening compliance in progress/ Review and update required of triaging template.	Oct-21		AR		
1.4	When an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be given	Extended use FFP3 face masks applied during increased activity on inpatient areas of COVID-19 infections	No policy in place	Advice provided by IPCT / Incident meeting convened and advises accordingly dependent on risk profile. Consider development of policy and inclusion of KLOE 1.4	Oct-21		AG		
1.5	Infection risk is assessed at the front door and this is documented in patient notes	Patients streamed via ED / AMU/ACU and infection risk assessed and documented. Triaging & screening as per NHSE/PHE guidance. All patients screened on decision to admit irrespective of previously positive result. COVID-19 suspected on CXR/ CTAP will be managed as suspected case, irrespective of screening result. Other infection risks assessed and documented e.g. D&V Evidence includes: • ED Triage template • POCT SOP • Results of patient notes review/ audit	Triage not cognizant of previous COVID-19 positive history, contact status and COVID-19 vaccination status. Some POCT missed in ED in spite of decision to admit Negative POCT rather than clinical picture dictates patient transfer. There is not a single unified triage template that is used for all admissions that is then recorded in the patient records. Admissions staff ask triage questions but this is not usually recorded especially with regards COVID-19.	BI report for screening compliance in progress/ Review and update required of triaging template.	Oct-21		AG		
1.6	There are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative.	Patient pathways in place with regards COVID-19 positive status and/or patients suspected with COVID-19, irrespective of screening result e.g. CXR/CTAP. Wards H36 – H38 direct admission route. Patients not suspected with COVID-19 and negative on POCT admitted via AMU and/or direct to base ward. For AMU/ base wards, ideal to admit to cubicle and await days 3 & 5-7 screen but not always possible due to the constraints of the HRI estate, resulting in admission to bedded bays increasing the transmission risk Evidence includes: • COVID-19Surge Plan/ COVID-19 screening at every 72 hrs or 48hrs if increased positive activity/ dynamic risk assessment by Senior Nursing Team.	Cubicle capacity on HRI site creates pathway risk	Dynamic risk assessment by senior nursing team. COVID-19 screening at every 72 hrs or 48hrs if increased positive activity. Regional hospital transfers process further mitigates risk. SOP	Oct-21		G		

Hull University Teaching Hospitals NHS Trust

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
1.7	That on occasions when it is necessary to cohort COVID-19or non-COVID-19patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	COVID-19 Surge Plan provides opportunity to create dedicated COVID-19 positive wards negating the need for wards to have mixed COVID-19or Non-COVID-19patients. The exception to this would be clinical speciality areas e.g. H7, Major Trauma, Cardiothoracic and Neurosurgery. Where wards identify COVID-19 positive cases dependent upon timing of screens, patients are managed appropriately e.g. transferred to COVID-19 positive ward if clinically indicated or isolated on base ward and affected bay closed. Affected bays/ ward areas are closed by the IPCT and clinical teams on receipt of a positive COVID-19 result and communicated to staff, patients and visitors. Documented in IPC database. As patients are transferred or discharged cleaning of bedded area and/or cubicle escalated via OCS helpdesk and booked as an amber clean (full Tristel clean with curtain change). Full ward cleans have been booked as purple cleans (UV and/or HPV). Daily monitoring by IPCT. Weekly COVID-19 compliance audits by Senior Matrons. Discussed at bed meetings throughout the day chaired by Site Team and at respective Command meetings. Evidence includes: • COVID-19 Surge Plan • COVID-19 BI report • COVID-19 spreadsheet • IPCT database entry/ IPC Enhanced ward audit • OCS Helpdesk Report	Inconsistencies in audit processes / over-reliance on Cayder to undertake contact tracing no robust ward based / IPC process to facilitate contact tracing effectively	IPC Matron Audit against national standards BI reporting/ scoping Lorenzo bed management for contact tracing capacity	Oct-21		AG		
1.8	Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice - staff adherence to hand hygiene? - patients, visitors and staff are able to maintain 2m social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE - staff social distancing across the workplace - staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) clinical b) non-clinical setting	**Staff Adherence to Hand hygiene:** Staff adherence to hand hygiene (HH) is monitored at ward / department level by link practitioners / ward sisters / charge nurses, with monthly 5 moments of HH audits completed along with annual HH assessments. HH also monitored by IPCT/ Senior Matrons via IPC enhanced ward audits and Senior Matron assurance booklets. Census audits completed by practice development team inclusive of HH compliance. HH posters demonstrating technique both for handwashing and decontaminating hands with alcohol gel. Supplies of HH products monitored via ward top up and via Supplies team to ensure supply meets demand given increased demand.	Inconsistencies in HH audit processes	IPC Matron Audit against national standards. IPC audits - ward/Senior Matron/ IPC focus audits being reviewed and updated with electronic versions for ease of completion	Oct-21		AG		
		Staff social distancing across the workplace: In clinical environments staff socially distance within workplace and wear PPE when delivering patient care which precludes social distance measures. In non-clinical areas in wards signage denoting minimum numbers displayed for office areas Wards and departments local ownership of hands/ face/space and fresh air IPCT daily visit to monitor and challenge as and when necessary. Non-COVID-19Secure areas risk assessed previously and monitored to ensure key messages continue to be followed. Staff encouraged whilst on duty but on breaks 'off premises' smoking on the perimeter of the Trust site when removal of facemask necessitates the ability to smoke, to maintain social distancing.	COVID-19Secure Risk Assessment for Non-Clinical areas requires update. Clinical areas do not have a bespoke risk assessment aligned with the Hierarchy of Controls	H&S team review & update latest COVID-19 Secure risk assessment congruent with Hierarchy of Controls. Monthly audits required. Clinical areas require bespoke risk assessments congruent with Hierarchy of Controls.	Oct-21		AG		
		Staff adherence to wearing fluid resistant surgical facemasks (FRSM): Staff required to wear FRSM in all Trust settings to wear a fluid repellent facemask Compliance with FRSM monitored and adherence evident in clinical settings as per audit / Census results. In non-clinical settings FRSM are required in shared office spaces irrespective of the staff group occupying that space and/or when moving from a single occupancy office into a shared office space. Contractors working on Trust site required to wear a face mask / face covering. Supplies of facemasks monitored via ward top up and via Supplies team to ensure supply meets demand given increased demand.	Good uptake and compliance amongst staff but lack of evidence to demonstrate - COVID-19 Secure Risk Assessment for Non-Clinical areas requires update. Clinical areas do not have a bespoke risk assessment aligned with the Hierarchy of Controls.	Continued reminders required at ward / departmental level along with challenge of non compliance at individual level. H&S team review & update latest COVID-19 Secure risk assessment congruent with Hierarchy of Controls. Monthly audits required. Clinical areas require bespoke risk assessments congruent with Hierarchy of Controls.	Oct-21		AG		
1.9	Monitoring of compliance with wearing appropriate PPE, within the clinical setting, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Practice and compliance audits completed by Senior Matrons and IPCT. Additional walk around completed by IPCT and also Executive Team. Census audits also completed by Practice Development team. Feedback provided to staff at time of monitoring/ audit findings. Role of PPE champion role applied in non-clinical settings when maintaining COVID-19 secure to good effect. Evidence includes: • PPE poster in clinical environments • IPC audits • Senior Matrons audits • Census audits • Monitoring audits of environments where PPE champion role has been applied	Clinical areas not fully adopted role of PPE guardians	Wards and departments / HGs to identify PPE guardians	Oct-21		AG		

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
1.10	Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace	LFT testing rolled out across the Trust during November 2021, initially to high risk areas and then to all clinical areas and departments. (non-clinical/ clinical). LFT Trust supply withdrawn and replaced with LAMP testing for staff rolled out on the 1st June 2021 across both hospital sites and for all staff. Staff submit once weekly LAMP tests. In addition to required LAMP testing staff order LFT testing kits via Government link to supplement testing for peace of mind. Evidence includes: • LAMP portal providing evidence on staff compliance with testing • LAMP progress report tabled at Silver	Poor uptake of LAMP testing amongst staff	All additional measures to increase uptake taken. Trust to support both LFT and LAMP testing for staff and to adopt changes on asymptomatic staff screening processes as they arise	Oct-21		AG		
1.11	Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control / Public Health team	During outbreaks and increased incidence in wards and clinical departments the ESR helpdesk has attended outbreak meetings and facilitated additional mass testing of staff groups who are implicated. More recently LFT testing / LAMP testing has assisted with staff screening, providing further assurance. Evidence includes: • Staffing screening results • IIMARCH outbreak report forms • Outbreak meeting minutes	Capacity issues identified especially out of hours for rapid staff screening	Option scoped and costed to facilitate and deliver staff screening out of hours on the HRI site - rapid screening for staff to enable prompt assessment and return to work as appropriate	Oct-21		AG		
1.12	Training in IPC standard infection control and transmission-based precautions are provided to all staff	IPCT and Practice Learning Team delivered training to respective teams in situ on the wards. Videos with regards donning and doffing along with posters disseminated to wards and departments Tools and reminders on Pattie, also training packages delivered at induction and via Big Blue Button training . Evidence includes: • Mandatory training records and compliance	Mandatory training is only delivered face to face every 3 years via H&S training via Big Blue Button	E&D to work in partnership with IPCT to scope and deliver IPC training annually	Oct-21		AG		
1.13	IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	Big Blue Button virtual training available for staff along with eLearning packages for induction and mandatory training with the inclusion of IPC recommendations for COVID-19. Information provided to junior doctors with regards IPC measures reinforcing key messages via virtual training. Induction information is inclusive of COVID-19 key messages. Evidence includes: • Mandatory training records and compliance • Induction training records/ Lets Get Started training packages • Junior doctors induction records	Mandatory training is only delivered face to face every 3 years via H&S training via Big Blue Button	E&D to work in partnership with IPCT to scope and deliver IPC training annually	Oct-21		AG		
1.14	All staff (clinical and non-clinical) are trained in - putting on and removing PPE; -know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Previous videos demonstrating donning and doffing along with PHE visual guide to PPE provided to both clinical and non-clinical staff. Standardisation of poster designed by ICD and disseminated to wards and departments, clearly demonstrating what PPE is required and when. Supplies of PPE monitored via ward top up and via Supplies team to ensure supply meets demand given increased demand. During outbreaks and increased incidence of infections, the need for the standard use of FFP3 for staff delivering clinical care is reviewed, in line with updated national guidance – implemented in situations with increased aerosol generated procedures. Evidence includes: • Demonstration videos • Posters • Audit of clinical environments • PPE usage report from Supplies team	Limited evidence of training records	Clinical staff to be provided with additional 'refreshed' information on PPE e.g. what to wear and when / donning & doffing.	Oct-21		AG		
1.15	There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	Posters have been updated at regular intervals throughout the pandemic – current posters reinforce the national key messages with regards 'space, face and hands and fresh air/ventilation. Recent posters reinforcing importance of the continued wearing of facemasks. Evidence includes: • Posters • Billboards • Social media messages • Key messages via Pattie and global email e.g. Director of Workforce email	HUTH website not updated with current information	Need for HUTH website to be reviewed and updated for the general public	Oct-21		AG		

Goal 1: Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
1.16	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	National guidance received by the Trust via numerous sources and disseminated accordingly by ICD/ IPCT / DIPC, Head of Emergency Planning. National guidance reviewed and changes to policy disseminated and gap analysis undertaken. Changes to guidance communicated to staff via Pattie, E-News, Daily Updates and via face to face discussions. Utilising a risk assessment process (Hierarchy of Controls) the IPCT under the direction of the DIPC & ICD development of speciality based risk assessments e.g. specialist surgery to ensure safe patient admission, flow through the organisation and reduced risk of nosocomial COVID-19 infections. Evidence includes: • Update via Silver Command • Via dedicated Pattie page • Global email to staff • Changes to posters if required • Hierarchy of control example provided on Pattie for staff to apply	'Every Action Counts' still requires application and use across the Trust	IPCT to lead on dissemination of 'Every Action Counts' resources.	Oct-21		AG		
1.17	Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	National guidance received by the Trust via numerous sources and disseminated accordingly by ICD/ IPCT / DIPC, Head of Emergency Planning. National guidance reviewed and changes to policy disseminated and gap analysis undertaken. Tabled via OIRC/ SIRC/ Quality Committee and then Trust Board with any risks and actions highlighted. Evidence includes: • Board minutes • SIRC & Quality Minutes • Silver control meeting minutes	Nil identified	Nil required	Oct-21		G		
1.18	Risks are reflected in risk registers and the Board Assurance Framework where appropriate	Health Group Risk Registers reviewed at HG Governance Meetings. IPC Risk Register tabled at Operational Quality Committee & Strategic IRC. COVID-19Risk Register – tabled at Command Structure meetings and latterly COVID-19Steering Group.	IPC risks included in departmental / HG and Corporate risk registers - BAF providing collation of additional risks	Stand alone IPC risk register being drafted by Quality & Risk Team	Oct-21		AG		
1.19	Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Each reported HCAI and pathogen results triggers a response by the IPCT, delivery of a care plan and advice on ongoing management e.g. isolation. This is documented in the IPCT database. In some cases it may result in contact tracing and an incident meeting to discuss a single case. Evidence includes: • IPC monthly summary report • Monthly HCAI Quality Report • Laboratory data with regards non COVID-19 infections and pathogens/ Hospital onset HCAIs reported via DATIX. Hospital onset HCAIs require RCA investigation by ward and HG	Not all hospital onset HCAIs reported via DATIX. Delay in RCA processes results in a lost opportunity to learn from incident in a timely manner	DATIX compliance report to be tabled at OIRC. RCA documentation reviewed and updated. RCA training to be scoped and delivered to key members of HGs	Oct-21		AG		
1.20	That Trust CEO, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	Daily data submissions approved by Execs but not personally signed off. Trust Business Intelligence (BI) reporting team providing daily BI report with an additional spreadsheet of newly reported cases awaiting submission to the daily nosocomial sitrep sent to the IPCT for assurance. Evidence includes: • BI report • Additional BI report of nosocomial cases sent to DIPC/ICD and IPCT	Nil identified	Nil required	Oct-21		G		
1.21	This Board Assurance Framework (BAF) is reviewed and evidence of assessments are made available and discussed at Trust Board	Yes, as and when national updates of the BAF has occurred or when changes in policy have precluded an updated BAF. IPC Task & Finish Group coordinating response and output and scrutinised at SIRC	Nil identified	Nil required	Oct-21		G		
1.22	Ensure Trust Board has oversight of ongoing outbreaks and action plans.	Yes via Command Structure, via Strategic IRC and Operational Quality Committee either via Monthly Reports or stand-alone reports. IIMARCH reports emailed to Execs Evidence includes: • Silver Command Minutes • SIRC minutes • OQC minutes • IIMARCH reports	Closing the loop of lessons learnt / action plan review	Outbreak review to be tabled at OIRC by HG with lessons learnt and action plan so monitoring in place	Oct-21		A/G		
1.23	There are check and challenge opportunities by the executive / senior leadership teams in both clinical and non-clinical areas	Walk around completed by Nurse & Medical Directors along with Exec Team members in both clinical & non-clinical areas Evidence includes: • Feedback from walk-around	Opportunities to feedback formally at either OIRC / SIRC not currently in place	Feedback added as agenda item for November 2021 OIRC	Oct-21		A/G		

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
2.1	Designated teams with appropriate training are assigned to care for and treat patients in COVID-19-19 isolation or cohort areas	As per previous surge plan, wards and teams identified to manage suspected and confirmed cases. Additional support and input provided by ID consultants. In reach from IPCT. Evidence includes: COVID-19 Surge Plan Redeployment list for staff identified to provide clinical care to COVID-19 patients Donning and doffing training compliance Generic IPC training compliance from HEY 24/7 3 yearly FIT testing compliance	None identified		Oct-21		G		
2.2	Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19-19 isolation or cohort areas	OCS (Domestic Services Contractor) provided with appropriate training on wearing PPE by their designated trainer, and also FIT testing for OCS staff in the early stages of the pandemic. Support provided by IPCT with regards training. OCS aware of the need to use Tristel and disposable microfiber cloths which is actioned for any HCAI identified in the Trust. OCS has allocated cleaning teams to COVID-19-19 and non COVID-19-19 wards. Evidence includes: OCS reports tabled at ORIC Operational OCS meeting attended by IPCN FIT testing compliance reports	None identified		Oct-21		G		
2.3	Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance	Yes with Tristel and disposable microfiber cloths and by OCS staff wearing appropriate PPE. OCS identify and segregate Cleaning Action Team to COVID-19-19 and non COVID-19-19 wards/ depts. When completing terminal decontamination. Evidence includes: RAG rated cleaning charts PHE cleaning standards • Cleaning records • Monitoring records • OCS Helpdesk records	PHE cleaning standards may be changing in the short term.		Oct-21		G		
2.4	Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	Cleans are requested via the OCS Helpdesk (amber cleans) by the ward/department. The request is sent to a mobile device by the Helpdesk for action by the Rapid Response Team. Upon completion of the task a member of the nursing team checks that the cleaning has been completed to the appropriate standard. The Rapid Response Team alerts the Helpdesk of completion via mobile device and closes off the task as completed. Facilities monitoring team and OCS supervisory team will also audit the tasks to ensure cleaning standards a met. All Helpdesk requested tasks are reported at the monthly contract meeting as part of the contract KPI's. Evidence includes: • OCS Helpdesk records Terminal clean SOP Terminal clean sign off sheet • OCS Operational Meeting minutes • OCS reports tabled at OIRC	Out of hours ward./department clean are not currently signed off by a nurse as the wards may be empty and therefore no-one available to sign off the completed clean.	Consider if Site Matron are able to tackle on this role and function.	Oct-21		AG		
2.5	Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance and other national guidance	The current contract with OCS states that twice daily cleaning is required and in place as per the National Cleaning Standards. In addition to this, further enhanced and touch point cleaning has been implemented on all high risk areas as per discussions with IPCT and in accordance with the PHE guidance. High risk areas are COVID-19 wards or any area that has an infection outbreak. Evidence includes: • OCS reports tabled at OIRC • Cleaning schedules	None identified		Oct-21		G		

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
2.6	Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local Infection Prevention and Control Team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	The use of neutral detergent has been discussed with OCS. Currently looking into the practicalities of how this can be dosed/measured. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses. Tristel Fuse contains a surfactant which acts as a neutral detergent and is the Trust's cleaning/ disinfectant product of choice. Previous Trust cleaning regime using Microfiber and water and Tristel Fuse for infective environments/ areas contaminated with blood and bodily fluids. OCS during pandemic have reverted to using Tristel Fuse as standard across clinical environments across the Trust site Evidence includes: • Cleaning schedules • Confirmation in writing with regards Tristel Fuse efficacy against COVID-19-19 OCS Monitoring outcomes PHE Guidance	Revised standards may change current practice. Low risk areas only use water and microfiber cloth, this may increase to use of neutral detergent.		Oct-21		G		
2.7	Manufacturers' guidance and recommended product "contact time" must be followed for all cleaning / disinfectant solutions / products as per national guidance	This is followed as per the recommended product guidance. Tristel Fuse used according to manufacturer's guidance including making up, storage and contact time. OCS will notify the clinical team once the cleaning of a room/area has been completed. Evidence includes: • Tristel Fuse usage guidance • Tristel Fuse posters • OCS and Facilities monitoring	None identified		Oct-21		G		
2.8	'Frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables & bed rails, should be decontaminated more than twice daily & when known to be contaminated with secretions, excretions or body fluids.	OCS / Nursing team 'shared' responsibility in clinical areas with the clinical team. Currently OCS adhere to the 2 metre rule when cleaning a bed space that is occupied with a COVID-19-19 patient so would not clean the over bed table and bed rails until the patient was discharged, in these circumstances the nursing team clean the bed table and bed rails with Clinell. This can be implemented in all non COVID-19-19 areas at a frequency of 2 full cleans and 1 check clean daily or by an agreed frequency following discussion with the IPCT team. This would not be required in low risk pathway areas with OCS & ward/ departments reverting back to normal cleaning checklists and frequencies. Evidence includes: • OCS monitoring • Cleaning checklists • IPCT audits	Due to reduced nurse staffing, compliance with cleaning elements missed including bed rails and table tops	Need to scope additional support to wards and departments such as ward hygienists and ward housekeepers if these are not already in place	Oct-21		AG		
2.9	Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily.	Staff in wards and departments are cleaning electronic equipment at least twice daily with Clinell wipes and in some areas wipes specific for mobile phones, IPODS and IPADS. In non-clinical areas, staff are encouraged and provided with Clinell wipes to clean electronic equipment which has been personally used at the beginning and end of the working day. Guidance provided on cleaning equipment safely and appropriately. Specific wipes for touch screens available in certain clinical areas Evidence includes: • OCS monitoring • Cleaning checklists • IPCT audits Ward IPC assurance audits	Practices in non clinical areas.		Oct-21		AG		
2.10	Rooms/areas where PPE is removed must be decontaminated, ideally times to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Arrangements already in place with ward team – housekeeping staff. OCS implemented increased frequency cleaning regime to all 'lobby's/reception areas where donning and doffing takes place under the guidance of the IPCT team. Prudent communication between ward/ department and domestic services teams Evidence includes: • OCS monitoring • Cleaning checklists • IPCT audits	Need to check theatres at end of morning lists etc. as only cleaned by OCS in the evenings.		Oct-21		AG		
2.11	Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol - before inspection, servicing or repair equipment	The current practice on wards and departments is to wipe down equipment and place a green sticker on this to notify the state of cleanliness. Evidence includes: Fundamental standards audit Ward assurance IPC audit Ward cleaning checklists	Evidence noted during IPCT audits that staff do not always decontaminate reusable equipment between patient use	Senior Matron and Senior Sisters to ensure education of staff to ensure decontamination is in place as per guidance.	Oct-21		AG		

Goal 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections										
Key line of enquiry/Systems and processes are in place to ensure:		**Evidence/Assurance**	**Gaps in Assurance**	**Mitigating Actions**	**Date last reviewed**	**Q1**	**Q2**	**Q3**	**Q4**
						Assurance RAG			
2.12	Linen from possible and confirmed COVID-19-19 patients is managed in line with PHE national guidance and other national guidance and the appropriate precautions are taken	Yes, treated as infectious linen as per Trust and national guidance. National guidance advocates the tagging of linen bags. Evidence includes: • OCS monitoring • Linen contract and linen usage report	Concerns re supply of red bags in clinical areas.	Supply to be confirmed with stores.	Oct-21		R		
2.13	Single use items are used where possible and according to Single Use Policy	Yes – areas managing suspected/ positive patients are strongly advised to use single use items and/or single patient use items as per Trust policy which can then be disposed of when the patient either gets discharged or dies. Evidence includes: • IPCT audit • Fundamental standard audit • Single use equipment usage report from Supplies team	Check how many areas are ordering single use items.	Contact with Debbie Sutton to check.	Oct-21		AG		
2.14	Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Reusable equipment is cleaned in between patient use with Clinell wipes and/or Tristel, if contaminated with blood and bodily fluids. Equipment is cleaned as per ward/ departmental cleaning checklist. Evidence includes: • IPCT audit Fundamental standards audit • Cleaning checklist • Single use equipment usage report from Supplies Team			Oct-21		G		
2.15	Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Monitoring continuing in both clinical and non-clinical areas by Trust facilities staff and OCS. Failed elements documented and in some cases photographed. Monitoring report provided to ward sister/ charge nurse and/or departmental manager . Monitoring is scheduled twice yearly in non clinical areas. Evidence includes: • OCS monitoring			Oct-21		AG		
2.16	Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	Improved compliance following reminders of the importance of good ventilation but during colder weather less inclination to open windows due to patient comfort so reassurance provided to clinical teams. Some waiting areas of the Trust are internal waiting areas and not immediately serviced by windows, therefore other options scoped and piloted such as free standing air purification machines. 'Fresh air' and good ventilation included on IPC measures poster. Evidence includes: • Ventilation Meeting minutes • Trust ventilation report	Ventilation within the Trust especially the Tower Block is still not fully understood and appreciated. Areas thought to be well serviced by ventilation whether mechanical or natural is not fully known until completion of ventilation survey is completed	Continuation of ventilation survey Need to formally assess and evaluate the efficacy of free standing air purification machines piloted in the Trust	Oct-21		R		
2.17	Monitor adherence environmental decontamination with actions in place to mitigate any identified risk	Compliance is checked via environmental ward audits (fundamental standards) and weekly Senior Matrons audits. Monthly IPC ownership audits complete at ward level by ward team. IPCT also conducting enhanced ward audits. Facilities monitoring team and OCS Supervisory team monitor as standard. Evidence includes: • OCS monitoring • Cleaning checklists Fundamental standards Ward ownership audit tool • IPCT audits • Reported via OCS Operational Meeting and via OIRC			Oct-21		G		
2.18	Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	Compliance is checked via environmental ward audits (fundamental standards) and weekly Senior Matrons audits. Monthly IPC ownership audits complete at ward level by ward team. IPCT also conducting enhanced ward audits. Facilities monitoring team and OCS Supervisory team monitor as standard. Equipment cleaning matrix in place that itemises cleaning responsibilities and frequencies. Evidence includes: • OCS monitoring • Cleaning checklists Fundamental standards • IPCT audits • Reported via OCS Operational Meeting and via OIRC	Green stickers should be in place, but aware these are not always in place.		Oct-21		AG		

Hull University Teaching Hospitals NHS Trust

Goal 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance									
Key line of enquiry/Systems and processes are in place to ensure:		**Evidence/Assurance**	**Gaps in Assurance**	**Mitigating Actions**	**Date last reviewed**	**Q1**	**Q2**	**Q3**	**Q4**
						Assurance RAG			
3.1	Arrangements around antimicrobial stewardship (AMS) are maintained	The Trust has a standing antimicrobial stewardship committee led by the Infection Department and Pharmacy teams (ACAT Advisory Committee on Anti-microbial Therapy). This meets bi-monthly to review all pertinent aspects associated with antimicrobial use in the Trust. This includes updating local polices/guidelines in line with best practice evidence and guidance, review of audits and antimicrobial consumption data and oversight of some local susceptibility data. The ACAT committee and pharmacy team also inputs into CQUINs related to antimicrobial stewardship, and reviews the results of these. Evidence includes Agenda and minutes of ACAT meetings Antimicrobial stewardship report to OIRC and SIRC Health group antimicrobial reports sent to nurse and medical directors, pharmacist and quality lead Indication and duration audit reports Total antimicrobial consumption reports Guidelines and policies on Pattie New guideline compliance audits Root cause analysis / Post Infection review templates CQUIN / National indicators submissions	No assurance on actions taken on indication and duration report or evidence of improvements fed back from HGs Lack of evidence of actions taken to improve compliance with prescribing in accordance with local guidelines Anecdotal evidence of poor usage of guidelines could be supported by antibiotic website usage data. Need more robust and regular communication of antimicrobial guideline changes and updates to clinical teams. Lack of oversight of completion of actions from RCA/PIR process and no formal regular sharing of lessons learned. RCA process currently under review. Benefits from achieving CQUIN compliance are not obtained within the area that has improved quality There is a lack of regular, robust review of all key susceptibility data due to insufficient IT/admin support within the AMS and IPC teams. The impact of this on patients	Development of process for HGs to report back actions taken on receipt of reports Development of process to allow HGs to feedback quality improvements taken due to poor compliance with guidelines Report of guideline usage data to be submitted to ACAT meetings quarterly Investigation of options for more readily accessible, user friendly multi-platform solutions for guidelines Development of process for HGs to share on lessons learnt from RCAs and PIRs at OIRC Business case for admin support for IPCT/AMS to collate key data including epidemiology and susceptibility data	Oct-21		AR		
3.2	Mandatory reporting requirements are adhered to and boards continue to maintain oversight	Currently (2021-22) the only mandatory requirement is that total antimicrobial consumption data is submitted from DEFINE database nationally. This is done, although there is no financial penalty attached. This data is also reviewed locally at ACAT and SIRC.	No gaps in assurance	No mitigating actions required unless new requirements are introduced.	Oct-21		G		

Hull University Teaching Hospitals NHS Trust

Goal 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support of nursing / medical care in a timely fashion

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
4.1	Implementation of national guidance on visiting patients in a care setting	As per updated guidance visiting would be permitted in the Low and Medium risk pathways but restrictions would apply in high risk settings e.g. increased prevalence of an infection/ outbreak and be limited to only essential visitors. This would also apply to designated COVID-19 wards. One household member/ NOK identified to visit and provided with a designated time slot as agreed with the ward sister/ charge nurse. Visiting with no restrictions remains in place for EOL and/or special circumstances. Evidence includes: • Visiting Policy • Visiting information on Trust website www.hey.nhs.uk/visiting and https://www.hey.nhs.uk/COVID-19/ and https://www.hey.nhs.uk/maternity/faqs-COVID-19/ • News releases as necessitated by changes in policy e.g. https://www.hey.nhs.uk/news/2021/08/10/please-wear-your-mask-when-visiting-hospital-buildings/ and https://www.hey.nhs.uk/news/2021/07/15/COVID19-restrictions-remain-in-force-at-hull-hospitals/ • Social media posts (these provide more generic advice but include face masks, handwashing, social distancing)	When you search for visiting, some of the results which are generated point the reader to specific ward leaflets / information with info on visiting which is contradictory and makes no mention of COVID19 because it was created and published pre-pandemic e.g. Neonatal ward HEY805/2016. Posters across Trust but these need standardising and refreshing. Easy read posters required. The Trust webpage needs to be kept updated on changes.	Nominated person to review generic Visiting and Maternity website content on a regular basis to ensure it remains in line with national guidance Add a banner at top of 'Getting to our hospitals' page and 'Patient information leaflets' to direct people to the latest advice on visiting during the COVID-19 pandemic/say this supersedes any leaflets dated pre-pandemic. Operationally effective with regards to visiting and communications are sent via the daily updates as required from the Trust Silver meetings with any changes.	Oct-21		AG		
4.2	Areas in which suspected or confirmed COVID-19 patients are being treated are clearly displayed with appropriate signage and have restricted access	Yes – door signs denoting whether an area is treating COVID-19 ward and the ward is a designated COVID-19 ward. Restricted access to wards denoted with a red line. In addition wards with increased prevalence and/or restricted access due to an outbreak loose COVID-19 Surge Plan BI COVID-19 Sitrep report. The BI report continues to be used to identify COVID-19 positive cases; if an area is identified as having a hospital attributed cases then an incident/outbreak meeting is held – restrictions to visiting is discussed/implemented at that meeting. However, this may be risk assessed & individual assessments can be made with regards to visiting if patients have extenuating circumstances. The IPC team continue to perform COVID-19 ward audits following the identification of an increased incidence or outbreak of COVID-19. Hospital attributed cases of COVID-19 have a Root Cause Analysis undertaken. The Outbreak policy (CP204) has been updated to reflect the national guidance regarding COVID-19 outbreak management this has been presented to the Operational IRC Committee for validation but the copy on Pattie has yet to be updated. The Trust reports outbreaks via by the submission of an IIMARCH report. The format of the Senior Matrons audit is currently being reviewed. Evidence includes: • Door signs • IPC audits • Senior Matrons audits		The current National guidance is in the process of being reviewed. There is a proposal that the 3 distinct COVID-19 care pathways (high, medium and low) are to be removed & one respiratory pathway applying transmission based precautions is to be introduced – which may have an influence on the poster information going forward. However the current Trust guidance should reflect the 3 tier guidance.	Oct-21		G		
4.3	Information and guidance on COVID-19 is available on all Trust websites with easy read versions	Visiting information on our website www.hey.nhs.uk/visiting includes a link through to the Mencap website which contains easy read information on general COVID-19 issues such as handwashing, face coverings, vaccination etc. Due to the limited information in easy read this will help direct people whilst awaiting feedback from PHE. For all other information - versions are available on Pattie, and also sent out via global email and news bulletins. Information is also available on patient and staff internet/ intranet websites. Evidence includes: • Trust websites (including audio and alternative text versions) • Pattie • Social media including twitter, Facebook and Instagram	Easy ready version required.	PHE contacted with regards to the latest Easy Read information. Browse aloud functionality allows audio as an option.	Oct-21		AG		
4.4	Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Yes – infection status and status with regards possible infection in the absence of a positive screen e.g. suspicion via CT and/or CXR. Notification of status also via Nerve centre, Lorenzo and via IDLs. Evidence includes: • Transfer information • IDL • Liaison with respective clinical / IPCT team, site matron team, discharge team/MDT • Repatriation patients	None identified	None identified	Oct-21		G		

Hull University Teaching Hospitals NHS Trust

Goal 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support of nursing / medical care in a timely fashion

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
4.5	There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Yes – posters and patient information leaflets available in wards and departments Evidence includes: • Posters • Billboards • Patient information leaflet • Information letter sent out with hospital appointments • Entrance signage outside tower block, Minors and Children's ED entrances		Options for digital signage which would also help to reinforce this message are currently under review.	Oct-21		G		
4.6	Implementation of the supporting excellence in infection prevention and control behaviours implementation Toolkit has been considered	A number of the recommendations included in the document have been introduced within the Trust; including those relating Wellbeing and morale, Patients and visitors, & Staff / workforce.	Benchmark against all of the recommendations in an action plan and present to the Trust IPCC identifying any areas which require further work.	Examples of implementation of the toolkit are as follows: Clear messaging/posters with regards to •2m distancing – use of face masks/coverings •Staff masks & distancing when on breaks & guidance for outside of work. •Front door 'greeters' to ensure compliance with mask wearing volunteers introduced at the front door to further help explain the measures in place across the service, as well as providing direction and support within the building. Estate •Removable signage Consider developing signage that can be moved and flexed to the needs of the facility. One example of this could be a pull-up banner i.e. You are now entering a red zone. • Waiting room layout Some waiting rooms are not conducive to IPC compliance. Consider how chairs are spaced and restrict use of other chairs and surfaces between these spaces. Diagnostics waiting rooms were raised as a particular area for consideration. • Safety huddles Dedicated safety huddles focus on IPC and safety measures	Oct-21		AG		

Hull University Teaching Hospitals NHS Trust

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
5.1	Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	'Front door' assessment and triaging in line with national guidance on ED and admission units. YAS undertake clinical assessment prior to arrival in ED Resus and Majors and alert ED team of risks associated with COVID-19. ED able to direct admit to cubicle within Resus/Majors, with the exception of initial assessment. COVID-19 streaming undertaken in ED initial assessment and Paeds ED with COVID-19 streaming POCT pathway and allocation of cubicle as required. Screening including access to rapid PCR testing and POCT but assessment of risk also includes changes on CXR and CTAP in spite of a negative COVID-19 test with liaison with Resp & ID medical Teams for additional assessment. COVID-19 screening protocols in place, screening inpatients every 72 hours following negative POCT admission screen (every 48 hrs during periods of increased incidence). Other assessment areas e.g. H36 & AMU have screening/ triaging & admission pathway. Evidence includes: • ED Streaming POCT SOP/ H36 & AMU admission pathway/SOP • COVID-19 screening / results spreadsheet, COVID-19 inpatient screening protocol	Triage not cognizant of previous COVID-19 positive history, contact status and COVID-19 vaccination status. Some POCT missed in ED in spite of decision to admit Negative POCT rather than clinical picture dictates patient transfer. There is not a single unified triage template that is used for all admissions that is then recorded in the patient records. Admissions staff ask triage questions but this is not usually recorded.	BI report for screening compliance in progress/ Review and update required of triaging template.	Oct-21		AG		
5.2	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidelines	'Front door' assessment and triaging in line with national guidance on ED and admission units. YAS undertake clinical assessment prior to arrival in ED Rhesus and Majors and alert ED team of risks associated with COVID-19. ED able to direct admit to cubicle within Rhesus/Majors, with the exception of initial assessment. COVID-19 streaming undertaken in ED initial assessment and Paeds ED with COVID-19 streaming pathway in Emergency Care. H36 COVID-19 admission / assessment ward provided with 18 cubicles, 6 of which are lobbied with negative pressure. AMU admits patients with a negative COVID-19 POCT and symptoms not suggestive of COVID-19. Evidence includes: • POCT SOP/ Assessment areas SOP e.g. H36. ED Triage SOP	There is not a single unified triage template that is used for all admissions that is then recorded in the patient records. Admissions staff ask triage questions but this is not usually recorded. ED initial assessment (walk-in), ambulance initial assessment/ Atrium and GP streaming on H36 can result in over crowding	BI report for screening compliance in progress/ Review and update required of triaging template/ Estates & Facilities limitations to be added to IPC risk register	Oct-21		AR		
5.3	Staff are aware of agreed template for triage questions to ask	Staff are aware of key triaging questions with regards assessment of risk associated with COVID-19 and all patients requiring admission have POCT / PCR dependent upon clinical area.	Triage not cognizant of previous COVID-19 positive history, contact status and COVID-19 vaccination status. There is not a single unified triage template that is used for all admissions that is then recorded in the patient records. Admissions staff ask triage questions but this is not usually recorded.	BI report for screening compliance in progress/ Review and update required of triaging template	Oct-21		AG		
5.4	Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	YAS undertake clinical assessment as per YAS pathway prior to arrival in ED Resus and Majors and alert ED team of risks associated with COVID-19. ED/ Admission areas staff aware of key triaging questions and competent in the clinical case definition and will signpost a patient to the appropriate COVID-19 pathway. Evidence includes: • POCT SOP/ Assessment areas SOP e.g. H36. ED Triage SOP	Triage not cognizant of previous COVID-19 positive history, contact status and COVID-19 vaccination status. There is not a single unified triage template that is used for all admissions that is then recorded in the patient records. Admissions staff ask triage questions but this is not usually recorded.	BI report for screening compliance in progress/ Review and update required of triaging template	Oct-21		AG		
5.5	Face coverings are used by all outpatients and visitors	Clear advice provided to patients and visitors on the wearing of facemasks in both outpatient and inpatient settings, if clinical condition dictates. Where patients and visitors are classed as exempt alternatives are offered such as face visors. Mask dispensers available at main entrances and provided in OPD and ward settings. Patients and visitors provided with masks should they attend without one or face covering deemed inadequate. Evidence includes: • Outpatient depts. audits • IPCT audits • Senior Matron audits • Reminder posters 'face masks / face coverings still a must'/ Trust website updated with information about masks and face coverings when visiting the hospital sites	Inconsistent compliance noted across Trust by patients and visitors, in spite of reminders visual and verbal	Ongoing need to reinforce messages for maximum impact	Oct-21		AG		
5.6	individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation	Patients deemed immunocompromised e.g. oncology patients on active treatment or due to medical condition are identified and where possible isolated. Evidence: Medical & nursing records, Senior Matrons audits / IPCT audits/ Cayder bed management	Need for protective IPC measures not always initially recognised and managed effectively especially during peaks of high demand	Triage admission template/ SOP requires revision to include all circumstances	Oct-21		AG		
5.7	Face masks are available for all patients and they are always advised to wear them	Clear advice provided to patients on the wearing of facemasks in both outpatient and inpatient settings, if clinical condition dictates. Where practical staff should be encouraging patients to wear facemasks, if clinical condition dictates especially in ward inpatient areas and non-compliant patients reminded of importance and risk to others.. Mask dispensers available at main entrances and provided in OPD and ward settings. Evidence includes: • Patient information leaflet/ Reminder posters	Inconsistency of advice provided to patients whilst an inpatient, patients wearing masks when leaving wards for appointments and procedures/ tests but less so when walking around bedded area and visiting the toilet.	Additional visual reminders required for patients whilst nursed in bedded areas	Oct-21		AG		

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
5.8	Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care	Clear advice provided to patients on the wearing of facemasks in both outpatient and inpatient settings, if clinical condition dictates and non compliant patients reminded of importance and risk to others. Clinical staff reinforcing message of wearing facemasks when leaving bed space to patients. Patient information leaflet produced including use of facemasks. Mask dispensers available at main entrances and provided in OPD and ward settings. Evidence includes: • Patient information leaflet/ Reminder posters	Inconsistency of advice provided to patients whilst an inpatient, patients wearing masks when leaving wards for appointments and procedures/ tests but less so when walking around bedded area and visiting the toilet in a clinical environment.	Additional visual reminders required for patients whilst nursed in bedded areas	Oct-21		AG		
5.9	Monitoring of inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	Clear advice provided to patients on the wearing of facemasks in both outpatient and inpatient settings, if clinical condition dictates. Clinical staff reinforcing message of wearing facemasks when leaving bed space to patients. Patient information leaflet produced including use of facemasks and reminder posters available in clinical areas. Mask dispensers available at main entrances and provided in OPD and ward settings. Evidence includes: IPCT audits / Senior Matron COVID-19 compliance audits	Inconsistency of audit processes	COVID-19 compliance audit requiring update	Oct-21		AG		
5.10	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Screens and booths utilised both in inpatient and outpatients areas. Screens provided to reception staff or where staff working at desks in high foot fall clinical areas. Additional screens to aid social distancing utilised in waiting areas across the Trust especially in OPD settings. Inpatient areas e.g. EAU/ new ICU utilising Kwikscreens and areas scoping use of clear plastic curtains. High foot fall areas e.g. staff rooms, ward offices and dining areas risk assessed and maximum staffing numbers displayed. Evidence includes: Screens in place in some areas evident in IPC and facilities monitoring audits.	Limited evidence of documented compliance/ variation across the Trust	Estates and HS to provide evidence of compliance and adaptions applied wit regards screens	Oct-21		AG		
5.11	To ensure 2 metre social and physical distancing in all patient care areas	CHH site - compliant with recommendation and modern HTM requirements . HRI site due to existing estate and ward layout not compliant with HTM bed spacing requirements and recommendation with the exception of H36/ H37/ H38 & H500. Further compounded by a lack of floor to ceiling partitions between bays on some wards. Social distancing assessments of both outpatient and inpatient areas completed and documented accordingly scoping the use of physical barriers. Bed spacing risk assessments completed and recommendations tabled to the Executive Board. Decision taken that on balance of risk, the Trust is unable to remove beds to comply with this recommendation. Patient discharge lounge undertake risk assessment prior transfer and do not accept patients with known infections. Evidence includes: • Bed spacing risk assessment / Options appraisal paper to Execs	Beds within the HRI tower block non-compliant especially in 6, 5 and 4 bedded areas but especially 6 bedded bays which also conversely are poorly ventilated	Ventilation audit and recommendations/ dynamic risk assessment required if prevalence/ incidence dictate further review. Frailty assessment beds including discharge lounge SOP to be drafted.	Oct-21		R		
5.12	For patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	Yes process in place to escalate and manage – discussion with ID and IPCT for advice on patient management. Process includes management of symptomatic patient, PCR screening, isolation, if possible and contact tracing as necessary. Contacts screened as a precaution. Case by case assessments and treatment plans initiated. Evidence includes: Incident Meeting Record RCA for HAI	National guidance available although local pathway/ SOP beneficial to prompt and assist decision making	Symptomatic Patient Pathway/SOP required	Oct-21		AG		
5.13	Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	Yes process in place to escalate and manage – discussion with ID and IPCT for advice on patient management. Process includes management of symptomatic patient, PCR screening and contact tracing as necessary. Contacts screened as a precaution. inclusive of visitors of affected patient. Case by case assessments and treatment plans initiated. Evidence includes: IPCT database & spreadsheet/ BI Report, Laboratory record, Incident Meeting Record & RCA for HAI	National guidance available although local pathway/ SOP beneficial to prompt and assist decision making	Late onset COVID-19 Patient Pathway/SOP required	Oct-21		AG		

Goal 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
5.14	There is evidence of compliance with routine patient testing protocols in line with key actions - infection prevention and control and testing document	Yes – screening undertaken as per national guidance but with the addition of screening all inpatients every 72 hours to capture new asymptomatic cases and 48 hrs during periods of increased incidence Evidence includes: • COVID-19 screening protocol • Laboratory records/ BI reporting • Nursing records and Lorenzo record • IPCT database & spreadsheet/ audit of screens	Limited evidence to confirm compliance and no consistent Trust wide process - inpatient areas have developed systems and processes to capture screening compliance	BI report on patient screening compliance created for HGs to review screening compliance at ward level	Oct-21		AG		
5.15	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Patients who attend and continue to attend for appointments have been appropriately triaged, managed and signposted accordingly, if relevant to clinical need patients have been isolated and screened appropriately in dedicated area. OPD staff may escalate concerns to IPCT for further advice. If applicable screened during hospital appointment otherwise sent home and advised to contact 111 with advice on isolation and signposted if symptoms worsen. Evidence includes: • Documentation in patient's notes	Potential inconsistency in documentation in patient notes and escalation where relevant. Although embedded process in place no OPD triage policy/ SOP to underpin	OPD Triage policy/ SOP required	Oct-21		AG		

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection									
Key line of enquiry/Systems and processes are in place to ensure:		**Evidence/Assurance**	**Gaps in Assurance**	**Mitigating Actions**	**Date last reviewed**	**Q1**	**Q2**	**Q3**	**Q4**
						Assurance RAG			
6.1	Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	One way main entrance / exit at HRI site which is a challenge compounded by building work but safety mitigations have been adopted with clear signage and separate entrance in and out. Separate entrances/ exits to other departments including ECA and Paediatrics ED. Restricted access to communal areas e.g. staff restaurants enforced with clear markers and signage. CHH has multiple areas across a large site with entrances and exits but clear markers and signage in place Evidence includes: • Site plans • Estates & Facilities site visits • IPCT audits • H&S audits	Lift lobby in HRI on restoration of visiting remains a challenge	Estates and Facilities to maintain clutter free lift lobby area and ensure clear signage is in place and area at times policed by volunteers NK agreed with Ian Stanley to reapply floor markings out socially distanced spaces in the lift lobby and increase keep left signs OCS audit communal areas	Oct-21		AG		
6.2	All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other national guidance, to ensure their personal safety and working environment is safe	Staff received 'in house' training at ward/ departmental level to ensure personal safety and a safe working environment. Additional bespoke training has been delivered to individual teams by both ID and IPCT. Further training with regards facemasks and respirators has also been delivered. Health and Safety team involved in providing assurance with regards Trust environments. New starters to the organisation are captured a part of the induction programme and provided with appropriate training. Evidence includes: • Mandatory training records • Ward based training • IPCT audit • Senior Matron • COVID-19 Secure risk assessments • Posters • Information on Pattie • Band 7 meetings • Senior Matron meetings Induction training national fit testing algorithm received from the national fit testing team	Agreement for 3 yearly face to face and annual e-learning update	Proposal to change training frequency for clinical staff from 3 years to 1 year - to be agreed. The vast majority of Acute Trusts favour the current National Recommendations from Skills for Health with regards a yearly update National PPE & IPC training are currently on-line e-learning packages, which meet Core Skills Training Framework (CSTF) requirements, and have been updated to include reference to COVID-19. Managers to monitor new starter training that has to be completed within 4/6 weeks HYMS - Years 0,1,2 only attend hospital fully supervised, no COVID-19 areas. Patients are identified for them in advance so no known COVID-19 either. They are provided with scrubs and trained in handwashing but no other Trust stat mandatory training. Years 3 – 5 and Physician Associates (years 1 and 2). These students are all provided with scrubs and visors. They are allowed appropriate access to any area of the Trust. They receive all the same stat mandatory training as any member of staff. However, they are not FIT tested centrally. If they are required to be in level 3 PPE then it is the responsibility of the hosting department to FIT test them and provide appropriate PPE. This is not recorded centrally but should be recorded on a departmental level. Please note that year 3 and 4 students rotate clinical site (Hull, York, Grimsby, Scunthorpe, Scarborough) every 16 weeks and every 8 weeks in Year 5.	Oct-21		AG		
6.3	All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to don and doff it safely	Training video developed by IPCT. Pictorial guidance available and displayed in clinical areas IPCT and PDMs cascading training information to ward/ department teams. New starters to the organisation are captured a part of the induction programme and provided with appropriate training. Evidence includes: • Posters • Training video • Pattie PPE information	Unable to identify who has watched the donning and doffing video on HEY 24/7	Video on HEY247 can be monitored and names who have watched recorded. Key areas - staff to sign to say they have been trained.	Oct-21		AG		
6.4	A record of staff training is maintained	HEY24/7.		student nurses - the university will undertake a risk assessment and if student high risk or going to work in a high risk area they will be fit tested by the Trust and recorded	Oct-21		G		
6.5	Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	Yes – enhanced ward audits completed by IPCT. Daily and/or weekly Senior Matrons audits completed. Census audits completed. Evidence includes: • IPCT audits • Senior Matron audits • Census audits	Currently unsure as to what elements each audits cover	SOP awaiting final approval regarding the audits undertaken - to be reviewed at the Matrons meeting at the end of October 2021	Oct-21		AG		
		Hand hygiene facilities including instructional posters: Access to hand hygiene sinks and alcohol gel at entrance to ward and within the clinical environment provided along with instructional posters		Posters displayed	Oct-21		G		

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
6.6	Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19-19 transmission such as: - hand hygiene facilities including instructional posters - good respiratory hygiene measures - staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care - staff maintain social distancing (2m+) when travelling to work including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace - frequent decontamination of equipment and environment in both clinical and non-clinical areas - clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	**Good respiratory hygiene measures:** All staff and visitors entering Trust premises wearing facemasks/ face protectors including contractors. Clinical staff required to wear FFP3 do so when delivering patient care and if risk assessment dictates use. Patients are reminded of good cough etiquette and provided with tissues as needed. Patients are also encouraged to wear a face covering /mask, if tolerated both in outpatient and inpatient settings, especially in multi occupancy bays and when mobilising around the clinical environment. Nursing staff reinforcing need as necessary with non-compliant patients. Visitors must wear face coverings/ masks unless even if exempt when visiting patients in clinical environments and be encouraged to social distancing at pre-booked visiting slot.			Oct-21		G		
		Staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care: **COVID-19-19 SECURE: NON-CLINICAL ENVIRONMENT CHECKLIST (offices etc.)**		Assurance received that Clinical Skills adhere to 2m social distancing unless there is a specific clinical procedure, in which case they would wear the relevant PPE as in a clinical setting. They are still adhering to 2m distancing in Suite 22 and MEC and reduced room capacity as a result. New guidance on 1 meter distancing - https://www.gov.uk/government/news/ukhsa-publishes-new-recommendations-for-COVID-19-19-infection-prevention-and-control HYMS - not for Trust to advise but there is the following guidance "There are no longer restrictions on the approach to teaching and learning in higher education (HE) providers as a result of COVID-19-19. There is no requirement for social distancing or other measures within in person teaching" https://www.gov.uk/government/publications/higher-education-reopening-buildings-and-campuses/higher-education-COVID-19-19-operational-guidance	Oct-21		G		
		Staff maintain social distancing (2m+) when travelling to work: As above but staff also reminded of social distancing measures required within work, travelling to and from work but away from the workplace. Key messages and reminders on the 'do's and don'ts' provided to staff with staff side representatives involved. Reminders with regards the prudent use of social media reinforced.		The current national guidance with regards travelling on public transport is available at https://www.gov.uk/guidance/coronavirus-COVID-19-19-safer-travel-guidance-for-passengers#travel-safely-during-the-coronavirus-outbreak With regards to the use of public transport social distancing rules (2 metres or 1 metre with additional mitigations) are lifted; This is not the case with the health care environment as "Physical distancing of 2 metres remains in place as standard practice in all health and care settings, unless providing clinical or personal care and wearing appropriate PPE" https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/COVID-19-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations (Sept 2021) Current guidance advises that you should wear face coverings in crowded and enclosed areas, such as on public transport, where you come into contact with people you do not usually meet. It is also recommended you wear a face covering when travelling in a private vehicle with people you do not usually meet. The current UK IPC Guidance published by Public Health England is in the process of being revised to ensure that the	Oct-21		G		

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
		Frequent decontamination of equipment and environment in both clinical and non-clinical areas: Cleaning checklists utilised in clinical and non-clinical settings. Enhanced cleaning provided by OCS in clinical settings in addition to cleaning undertaken by ward housekeepers/ hygienists. Clinell wipes provided to staff to facilitate quick and easy cleaning of clinical and admin work areas e.g. computer keyboards and phones. Reminders provided to staff to clean work stations after use		Enhanced OCS cleaning in high risk areas	Oct-21		G		
		Clear visually displayed advice on use of face coverings and facemasks: Trust A10, A3 & A4 posters demonstrating mask use and correct wearing of masks 'do's and don'ts' displayed across the Trust, including non-patient facing areas		Posters displayed	Oct-21		G		
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions	5 moments HH audits and IPC ownership audits completed by respective wards and departments on a monthly basis. Enhanced audits completed by IPCT to ensure staff remain compliant with both standard infection prevention & control precautions (SICPs) and transmission based precautions (TBPs). Daily, weekly and monthly Senior Matron assurance booklet audits completed determined by COVID-19-19 activity and outbreaks in clinical areas all of which include SICP & TBP's. Regular Census audits completed by practice development matrons again includes SICP & TBP's Evidence includes: • IPCT audits • HH audits • Senior Matron audits • Census audits			Oct-21		AG		
6.8	The use of hand dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	Locations of hand dryers reviewed by Estates and Facilities. Hand dryers switched off in admin areas (suites) because originally thought to be a vector for transmission prior to change in guidance and hand towel dispensers erected. Risk assessment undertaken as hand driers were also located in toilets adjacent to ED waiting areas. Paper towels were not originally in these areas due to used sharps been disposed of in waste bins and a risk to domestics. Evidence includes: • Estates and facilities audit • IPCT audit • Monitoring audit			Oct-21		G		
6.9	Guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Posters available and displayed. Evidence includes: • Posters • IPCT audits		Posters displayed and monitored though IPC audits	Oct-21		G		
6.10	Staff understand the requirements for uniform laundering where this is not provided for on site	Guidance and information provided to teams/ departments via Trust communications. Evidence includes • Pattie staff information • Global email		The Trust posted guidance regarding the wearing of uniforms during the Pandemic on Pattie Advice for staff regarding the washing of uniforms was posted on Pattie: "It is also recommended that work uniforms and scrubs worn in clinical areas should be washed on a high temperature cycle." The current Gov.uk COVID-19 guidance links to the attached Uniform & Work wear guidance document https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/COVID-19-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations This advises • a ten minute wash at 60ºC is sufficient to remove almost all microorganisms. In tests, only 0.1% of any Clostridioides difficile spores remained. Microbiologists carrying out the research advise that this level of contamination on uniforms and work wear is not a cause for concern.	Oct-21		AR		

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Key line of enquiry/Systems and processes are in place to ensure:		**Evidence/Assurance**	**Gaps in Assurance**	**Mitigating Actions**	**Date last reviewed**	**Q1**	**Q2**	**Q3**	**Q4**
						Assurance RAG			
6.11	All staff understand the symptoms of COVID-19-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	Staff advised to contact the ESR helpdesk to report their own symptoms and that of their household contacts. Consideration being taken with regards innocuous mild symptoms and Trust identified anosmia as a key localised symptom of COVID-19-19 prior to being nationally recognised. Symptoms listed to inform staff and also that of ESR helpdesk Evidence includes: • Staff information via Pattie, Global email and Director of Workforce information • Staff testing guidance • Absence rates and reasons monitored . Staff asked to undertake twice weekly lamp testing		Monitored through silver command Changes in national guidance has seen the implementation of staff screening protocols to reduce the risk the risk of asymptomatic transmission. The staff help desk has been set up to provide advice to Trust employees. An incident/outbreak meeting is held If an area is identified as having two or more than Hospital attributed cases (outbreak policy) – required actions are discussed/implemented at that meeting. It would be difficult to provide evidence that poor staff compliance with regards to screening directly contributed to an outbreak, given the relatively long incubation period of COVID-19. However, staff screen results are considered at an outbreak meeting & any factors identified as contributing to an outbreak are documented. The details of the outbreak is reported by the Trust via the submission of an IIMARCH report. An Enhanced COVID-19 audit is undertaken by the IPC team after an outbreak has been declared which would identify areas of non-compliance with Trust policy/guidance.	Oct-21		G		
6.12	A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Virtual meetings held with PHE/ Local Authority and CCG representatives with data shared across agencies. Meetings recorded and minutes circulated and dashboards circulated by respective teams. Virtual attendance at HCAI ICS meeting and Trust attendance at LRF meeting Evidence includes: • Silver Command • CRIP report • Feedback from local regional and national meetings		Review and disseminate learning from outbreaks via completion of RCAs and outbreak IIMARCH from Board to Ward DIPC & ICD reinforced importance to IPCT and Site Team (out of hours) of need to escalate on the reporting of two or more cases in line with national guidance Daily Trust BI report available and is crossed checked on a daily basis by the IPC with the labs and RCA forms are completed online and outbreak policy has recently been	Oct-21		AG		
6.13	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	IPCT complete a colour coded spreadsheet highlighting cases which are screened positive following admission. BI reporting team also produce a separate report which highlights cases of 8 days or more to the IPCT. In addition the IPCT complete a review of laboratory 'TEL' list inclusive of weekends to assess cases who have screened positive on admission but whom have been recently being inpatients but have been readmitted via ED with a positive result. Two or more cases are triggered utilising these processes along with prudent communication by clinical teams esp. if suspicion on CXR/ CT. Evidence includes: • IPC spreadsheet • BI COVID-1919 report		Review and disseminate learning from outbreaks via completion of RCAs and outbreak IIMARCH from Board to Ward DIPC & ICD reinforced importance to IPCT and Site Team (out of hours) of need to escalate on the reporting of two or more cases in line with national guidance Daily Trust BI report available and is crossed checked on a daily basis by the IPC with the labs and RCA forms are completed online and outbreak policy has recently been reviewed The BI report continues to be used to identify COVID-19 positive cases; & COVID-19 positive cases are reported on the Lab system – "Tel list". The IPC team follow up positive COVID-19 cases daily, contacting the area concerned to provide appropriate IPC advice.	Oct-21		AG		

Hull University Teaching Hospitals NHS Trust

Goal 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection										
Key line of enquiry/Systems and processes are in place to ensure:		**Evidence/Assurance**	**Gaps in Assurance**	**Mitigating Actions**	**Date last reviewed**	**Q1**	**Q2**	**Q3**	**Q4**
						Assurance RAG			
6.14	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording or outbreak meetings	Infection Prevention & Control Outbreak and Incident Policy reviewed and updated in light of COVID-19-19 activity and approved at OIRC. An incident/ outbreak meeting is convened both for HCAI's and COVID-19-19 and where relevant PHE and System Partners invited with agenda, minutes and action trackers recorded Evidence includes: • Infection Prevention & Control Outbreak and Incident Policy • Outbreak meeting minutes and action trackers • IIMARCH report .		Review and disseminate learning from outbreaks via completion of RCAs and outbreak IIMARCH from Board to Ward DIPC & ICD reinforced importance to IPCT and Site Team (out of hours) of need to escalate on the reporting of two or more cases in line with national guidance Recruited into IPC secretary post Daily Trust BI report available and is crossed checked on a daily basis by the IPC with the labs and RCA forms are completed online and outbreak policy has recently been reviewed - JC to submit policy as evidence The Outbreak policy (CP204) has been updated to reflect the national guidance regarding COVID-19 Outbreak management this has been presented to the Operational IRC Committee for validation but the copy on Pattie has yet to be updated	Oct-21		AG		

Goal 7: Provide or secure adequate isolation facilities

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
7.1	Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	Yes in place but reviewed in line with prevalence, incidence alongside capacity and flow. COVID-19 surge plan in place. New wards H36, H37 and H38 designated COVID-19 wards with further surge wars identified as necessary. Patients tested on admission and every 3 days thereafter to ensure isolation where necessary. Elective green pathways protected where possible. Physical barriers put in place in OPD to segregate patients. Also increase in use of virtual clinics. Visiting policy in place. Evidence includes: • COVID-19 Surge Plan Visiting policy	Designated red capacity is in place but the challenge on the Trust is maintaining and achieving green and amber pathways. Lack of cubicles on some wards creates additional challenges. Cohorting has been essential in some specialty areas. Contacts have also been cohorted where necessary.	Bed modelling proposal to be drafted. Regular updating of the COVID-19 surge plan to reflect local infection rates and admission numbers. Scoping wards which from an IPC perspective provide safer environments with regards ventilation/ social distancing	Oct-21		AG		
7.2	Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Wards designated as COVID-19-19 positive wards negating the need for physical barriers. Patients nursed in other ward areas such as bays and cubicles that are treated with COVID-19-19 have restricted access to the bays/ cubicles with signage on the door. Some wards have 'amber' pathway patients who are managed in cubicles and although negative on admission screen will require day 3 screen prior to movement elsewhere on ward. In SHG Red rooms utilised to further assist with segregation and to facilitate flow. In outpatient areas, signposting and guidance provided to patients/ staff and visitors with 'meet and greet' at entrance to ward/department to assess patient risk with additional physical barriers utilised to assist with social distancing . Separate entrance ways have been designed in the Tower block and Women's and Children's Hospital to reduce contact. All wards are only accessible by key. OPD and other waiting areas have had single seating installed to maintain social distancing. Evidence includes: • IPCT audits • Monitoring audits • Senior Matron audits Outbreak policy Posters on ward entrances Visiting policy			Oct-21		G		
7.3	Patients with suspected or confirmed COVID-19-19 are isolated in appropriate facilities or designated areas where appropriate	Wards H36 – H38 direct admission route for COVID-1919 positive patients. Patients managed in either cubicles and/or bays.in other ward setting. Patients who screen positive for COVID-19-19 but whom need ongoing specialist care on base ward to remain on base ward but isolated with dedicated toileting facilities or access to their own commode. Separate red and green ICH and respiratory HDU. Patient testing every 3 days to ensure early identification of infection. Evidence includes: • COVID-19 Surge Plan • IPCT audits Minutes of outbreak meetings	Social distancing on some wards especially on the HRI remain a challenge, especially if capacity and acuity does not allow for the removal of beds Lack of cubicle capacity and toileting facilities on certain wards on HRI site remains a challenge	Bed modelling proposal to be drafted Scoping wards which from an IPC perspective provide safer environments with regards ventilation/ social distancing Ongoing need to evaluate the use of Red rooms in areas where space is compromised	Oct-21		AG		
7.4	Areas used to cohort patients with suspected or confirmed COVID-19-19 are compliant with the environmental requirements set out in the current PHE national guidance	Partially compliant – on the HRI site toileting facilities are inadequate for the ward bed base when managing COVID-19-19 cases less so on wards H36- H38. Evidence includes: • Negative pressure cubicles SOP for prioritisation of cubicle use	Lack of cubicle capacity and toileting facilities on certain wards on HRI site remains a challenge Social distancing not possible between beds in the tower block. Ventilation issues Lack of designated donning and doffing areas	Bed modelling proposal to be drafted Scoping wards which from an IPC perspective provide safer environments with regards ventilation/ social distancing Ongoing need to evaluate the use of Red rooms in areas where space is compromised New ICU facility on HRI site.	Oct-21		AG		

Hull University Teaching Hospitals NHS Trust

Goal 7: Provide or secure adequate isolation facilities										
Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
7.5	Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Patients who have additional healthcare associated infections are being managed as per Trust policy with review from the IPCT both in COVID-19-19 and non-COVID-19-19 areas, with priority for appropriate isolation e.g. patient with Clostridium difficile. Evidence includes: • Lorenzo • IPC Database • Relevant IPC policies • Alert Organism Care Plans Outbreak policy Fundamental standards audit Isolation policy			Oct-21		G		

Goal 8: Secure adequate access to laboratory support as appropriate									
Key line of enquiry / Systems and processes are in place to ensure:		**Evidence/Assurance**	**Gaps in Assurance**	**Mitigating Actions**	**Date last reviewed**	**Q1**	**Q2**	**Q3**	**Q4**
						Assurance RAG			
8.1	Testing is undertaken by competent and trained individuals	POCT: Training forms in place (Q-Pulse); Lab: Kay A to assess T&C status of MVI lab in line with UKAS requirements Yes – both within patient admission areas, wards and departments. Staff that facilitate staff testing have also been trained and deemed competent by IPCT and ID. POCT introduced in ED and dedicated swabbing team introduced and trained by POCT Team Laboratory staff trained in processing respiratory samples. Increase in working/ processing hours within laboratories. Journey of swab' developed to ensure staff aware of process of screening a patient and a result being reported. Training records held in the lab and in line with UKAS accreditation. • Swabbing / screening protocol • How to take and submit a swab poster • POCT training information • POCT SOP • Laboratory training records	Training and competency records for staff undertaking swabbing	Incorporate documentation of swabbing training in nursing competencies	Oct-21		AG		
8.2	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Patient: All Pts on admission, 72hrs thereafter, during the LOS, patients moving to different wards, pre-discharge checks (if referred to care home)- policy; monitoring measures; POCT testing interface; STAFF: symptomatic testing; asymptomatic (LAMP until Dec) Yes – screening undertaken in line with PHE and national guidance. Processed locally and when capacity dictates samples are sent off to regional labs for processing and variant typing. Rapid PCR processes are also available for patient and staff screening. POCT introduced in ED and dedicated swabbing team introduced and trained by POCT Team Staff screening is undertaken within 48 hours of staff reporting symptoms to dedicated ESC reporting line. Staff in-house and household screening available and co-ordinated by Trust screening POD and the staff T&T team.	No over-arching SOP on inpatient screening	Produce SOP on inpatient screening	Oct-21		AG		
8.3	Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	TAT reported daily to PLACER (national database); KPI data review in business team meeting; IPC review meeting within CSHG (TATs, issues, updates); In ED/ assessment areas such as H36 and very high risk areas e.g. H36 ICU settings rapid testing capacity is available with an allocation of swabs provided. A priority sticker system is in place in ED with a daily allowance of swabs available. Monthly report of turnaround times from receipt to reporting reported by Pathology to NHSE/I – Quality Assurance lead. As from 26th April 2021 POCT available in ED with four POCT machines in place to enable prompt screening of patients with a decision to admit	Current TAT monitoring based on time in laboratory, not time taken from the patient to time result -to be escalated to Microbiology lab business team meeting to review parameters for TAT.	1. TAT parameters to be consider in lab audits programme; 2. IT to establish TAT reports	Oct-21		AG		
8.4	Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Lab process and SOP are in place in line with national guidance. Patients are screened on decision to admit, day 3, days 5-7 and discharge planning screen. All wards applying regular screening protocol with wards and departments e.g. every 3 days. Evidence in some wards and departments patients who previously screened positive were being incorrectly screened but in line with mass screening for previously negative patients. This has now been corrected. Compliance randomly monitored on wards and fed back to clinical teams if deviation from Trust screening protocols Laboratory also introduced a 'presumptive' result due to other diagnostic methods and this was communicated to staff across the Trust BI reporting team report cases via national COVID-19 sitrep – evidence emerged during March 2021 of previously positive cases being reported as hospital onset cases BI team met with DIPC and rectified by adding in prompts and sending a line listing to IPCT for scrutiny prior to upload Lab process and SOP are in place in line with national guidance.	Where are the results of the screening compliance audits reported – doing the audit isn't what is requested, it is the monitoring of the results	1. EQ to ask further clarification re. identified cases? COVID-19 specific?	Oct-21		AG		

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Goal 8: Secure adequate access to laboratory support as appropriate									
Key line of enquiry / Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
8.5	Screening for other potential infections takes place	Screening for other potential infections as per National guidance & IPC policies e.g. MRSA, CPE, CDI. - policy to check by DW? Mandatory HCAI reporting in line with National guidance. SSI surveillance for hips / knees /spinal surgery ongoing. Evidence: Trust IPC screening/testing policies for MRSA, CPE, VRE and other multi-drug resistant organisms	No assurance on compliance with policies	Audit of compliance with IPC screening policies	Oct-21		AG		
8.6	That all emergency patients are tested for COVID-19 on admission	As 5.13 admission screening is included in emergency pathways. Processes in place for COVID-19 testing as 1.1 & 5.13 & 8.2 All patients with a decision to admit are screened for COVID-19. In ED/ assessment areas such as H36 and very high risk areas e.g. H36 ICU settings rapid testing capacity is available with an allocation of swabs provided. A priority sticker system is in place in ED with a daily allowance of swabs available. As from 26th April 2021 POCT introduced in ED with four POCT machines in place to enable prompt screening of patients with a decision to admit As 5.13 admission screening is included in emergency pathways. Evidence includes BI report on screening compliance	No over-arching SOP on inpatient screening	Produce SOP on inpatient screening	Oct-21		AG		
8.7	That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise	Rapid PCR screen any newly suspected COVID-19 patient who is not isolated. PCR test any isolated patient when symptoms arise. All hospital onset cases investigated by IPCNs All patients who develop symptoms inclusive of mild symptoms or who have changes on CXR/ CT-AP are screened for COVID-19. BI report set up and disseminated to key staff.	No over-arching SOP on inpatient screening Screening compliance monitoring	Produce COVID-19 patient screening SOP Audit of screening compliance Monitoring of BI report on missed screens	Oct-21		AG		

Goal 8: Secure adequate access to laboratory support as appropriate									
Key line of enquiry / Systems and processes are in place to ensure:		**Evidence/Assurance**	**Gaps in Assurance**	**Mitigating Actions**	**Date last reviewed**	**Q1**	**Q2**	**Q3**	**Q4**
						Assurance RAG			
8.8	That those emergency admissions which test negative on admission are retested on day 3 of admission and again between 5-7 days post admission	As previous 5.13. Emergency COVID-19 pathway screening is day 0, 3, 5, 12 and weekly for duration of stay unless tested positive during that time. Screening at days 3 & 5-7 embedded process within Trust, for all inpatients, including elective and emergency - further simplified by requesting wards to follow updated protocol of screening every 72hrs As previous 5.13. Evidence includes BI report as above • Screen to be Green daily update email Regular communications regarding patient screening sent out via email and on Pattie	No over-arching SOP on inpatient screening Screening compliance monitoring	Produce COVID-19 patient screening SOP Audit of screening compliance Monitoring of BI report on missed screens	Oct-21		AG		
8.9	That sites with high nosocomial rates should consider testing COVID-19 negative patients daily	Nosocomial COVID-19 rates closely monitored. If rates were deemed high screening requirements would be reviewed and discuss amongst IPCT, GOLD command to confirm any changes to practice. During periods of high incidence experienced within wards on both HRI & CHH site, we have screened COVID-19 negative patients every 3 days. The Trust did not introduce daily screening because of existing demands on laboratory services but have since introduced every 48hrs during active outbreaks/ increased incidence of COVID-19 infection. Nosocomial COVID-19 rates closely monitored. If rates were deemed high screening requirements would be reviewed and discuss amongst IPCT, GOLD command to confirm any changes to practice. Evidence • Outbreak management minutes / IIMARCH report forms	No over-arching SOP on inpatient screening Screening compliance monitoring	Produce COVID-19 patient screening SOP Audit of screening compliance Monitoring of BI report on missed screens	Oct-21		AG		
8.10	That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	Screening requirement included in Trust guidance for pt. management and pathways. Patients discharged to nursing homes are screened in line with National guidance. COVID-19 positive patients are discharged/ transferred appropriately. Discharge liaison team involved, liaison with system partners/PHE/ social care and residential care. Discharge is planned and patients are screened as necessary – with discharge/ transfer dependent upon results. Screening is undertaken 48 hours prior to discharge to allow sufficient time to receive results back to aid discharge planning. Notification of status also via Nerve centre, Lorenzo and via IDLs. COVID-19 positive patients and/or contacts of positive cases are identified and discharge is planned in collaboration with family and System Partners. Gaps in effective and safe discharge planning are escalated and monitored via the respective HGs and Executive Team Screening requirement included in Trust guidance for pt. management and pathways. Patients discharged to nursing homes are screened in line with National guidance. • IDLs • DTOC list • Screening protocols	Lack of assurance of level of compliance with stated requirer	Produce COVID-19 patient screening SOP Audit of screening compliance Monitoring of BI report on missed screens	Oct-21		AG		

Goal 8: Secure adequate access to laboratory support as appropriate										
Key line of enquiry / Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
8.11	That those being discharged to a care facility within their 14 day isolation period should be discharge to a designated care setting, where they should complete their remaining isolation	COVID-19 status communicated and supported with the discharge liaison team COVID-19 positive patients are discharged/ transferred appropriately. Discharge liaison team involved, liaison with system partners/PHE/ social care and residential care. Discharge is planned and patients are screened as necessary – with discharge/ transfer dependent upon results. Screening is undertaken 48 hours prior to discharge to allow sufficient time to receive results back to aid discharge planning. Notification of status also via Nerve centre, Lorenzo and via IDLs. COVID-19 positive patients and/or contacts of positive cases are identified and discharge is planned in collaboration with family and System Partners. Gaps in effective and safe discharge planning are escalated and monitored via the respective HGs and Executive Team COVID-19 status communicated and supported with the discharge liaison team • IDLs • DTOC list • Screening protocols	Lack of assurance of compliance	Produce COVID-19 patient screening SOP Audit of screening compliance Monitoring of BI report on missed screens	Oct-21		AG		
8.12	That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	Elective pts are pre-assessed, advised to self-isolate and COVID-19 screen performed 3 days prior to admission. All elective patients are appointed via pre-assessment and screened for COVID-19 72hrs prior to admission. All patients instructed verbally and in writing to self-isolate prior to admission following this screen for the respective 72hrs. Patients undergoing major surgery where they would be disproportionally at risk of COVID-19 are advised to self-isolate for 14 days prior to admission and are screened for COVID-19 prior to admission. Surgical specialities appointing elective patients do so following national guidance Elective pts are pre-assessed, advised to self-isolate and COVID-19 screen performed 3 days prior to admission. • Pre-assessment of surgical patient pathways • Screening protocols • Written advice provided to patients	Lack of assurance of compliance	Produce COVID-19 patient screening SOP Audit of screening compliance Monitoring of BI report on missed screens	Oct-21		AG		

Hull University Teaching Hospitals NHS Trust

Goal 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms	Yes – IPCT providing in reach along with ID team. Care plans provided to ward teams on the management of patients with alert organisms. Follow up of patients with resistant organisms and Clostridium difficile and advice provided on ongoing management. Additional support provided by Medical & Nurse Directors along with Senior Matrons. Evidence includes: • Lorenzo • IPC Database • Relevant IPC policies • Alert Organism Care Plans - Staff Bulletins - Patient experience and patient feedback (complaints / PALs/Friends & Family Test) - Datix	Some Trust IPC policies currently being updated. Lab systems / IT currently under review and need updating. Gaps in escalation to Health Groups about alert organisms. Datix for organism reporting - new introduction and lack of compliance. **Staff out of date with IPC training requirements level 1 & 2 and are being picked up in BAF 2 & 7 for change in practice.**	Laboratory IT system update due to introduce LIMS in Spring 2022 - demo for IPC team and micro team at the end of 2021, planned launch in 2022, which will allow new system to cascade/ communicate with other IPC systems. Action date: To be completed by end of April 2022 Updating fundamental audit tools to ensure this captures the required information, i.e. patient, care plan, isolation, management plan in place. Patient notes and care plans. Make care plans available online, via IPC Pattie page, for clinical areas. Action date: To be completed by end of April 2022 Adherence to IPC practices with meet and greet volunteers at entrances to buildings on site - keep a record of times and placement of these volunteers. Action Complete. Completion of hand hygiene audits. Enhanced audits during Covid outbreaks. Permission to challenge in place around the Trust - further empowerment work recommended. Action date: To be completed by end of April 2022 (3-6 months)	Oct-21		AG		
9.2	Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Yes – via HUTH command structure, previously dedicated PPE group. Information disseminated via global email, daily updates & Pattie. Discussed at Operational IRC and respective ward/ department meetings. Posters demonstrating correct PPE available within wards and departments Evidence includes: • PPE posters • Global email • Pattie updates /Bulletins - DIPC Nurse Alerted PHE regarding changes (information disseminated through Operational and Strategic IPC committee - Good command structure (Tin, Bronze, Silver, Gold) evidence through meeting minutes etc.	New updates ensuring IPC changes from PHE Note - lessons from deviation from PHE guidance in second wave of pandemic in terms of visors for green, amber, red pathways.	IPC team to review current PHE guidance in line with policies to ensure practices are current, communicate any changes.	Oct-21		G		
9.3	All clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with national guidance	Yes – waste handled, stored and managed as Category B waste. Yes, treated as infectious linen as per Trust and national guidance. National guidance advocates the tagging of linen bags. Evidence includes: • OCS monitoring • Linen contract and linen usage report • Soiled Linen Policy • Waste management Policy • Waste management compliance audits	Clinical areas not tagging linen, however are double bagging - meets national guidance / trust policy on this. Linen goes off site to be laundered and meets with the requirements for the contractor - infected linen is segregated, handled through correct PPE procedure and has pre-wash prior to usual processing.	confirmation of policy and guidance first. If this is an issue in terms of the linen - to do communications exercise to provide update for Trust staff. Double bag linen in line with waste management policy. Clinical waste is tagged.	Oct-21		G		
9.4	PPE stock is appropriately stored and accessible to staff who require it	A regular review of stock levels, PPE supplied to areas as needed. Identifying critical levels of consumables and PPE and escalating/ liaison via Supplies. Previous use of dedicated HUTH PPE global email Evidence includes: • National PPE meeting • Stock level records / dedicated store area on both sites / stock rotation - Procurement evidence	Assurance required regarding out of hours access to PPE, & body bags.	Assurance required regarding out of hours access to PPE; supply services to provide an update regarding storage facilities for PPE and ward access to PPE/Emergency stock. Action date: To be completed by end of April 2022 (6 months)	Oct-21		AG		

Goal 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
10.1	Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and psychological wellbeing is supported	Staff in 'at risk' groups identified. Measures in place to support staff who are shielding at home due to existing health conditions, providing support to work from home with regular in reach by managers. Pregnant staff either shielding and or re-deployed to low risk environments again with manager support. Other staff that are not shielding but are still 'at risk' redeployed to low risk areas. Staff who are working in both COVID-19 and non COVID-19 areas offered and provided with both physical and psychological support. Staff advised to make their manager aware of concerns with regards their health. Utilise a risk assessment tool to assess risk and determine process to follow to ensure staff safety is maintained. Evidence includes: • ALAMA COVID-19 risk assessment • Occupational health staff record • HR / Workforce report • Staff absence record	Staff may not know they are in an 'at risk' group and are not identified unless a risk assessment is completed and regularly reviewed in light of changing health and/or working conditions	Risk assessment prompt to be added to on staff member's HEY24/7 education/appraisal page and link to risk assessment provided for both individual and line manager. Individual staff member and line manager to take responsibility and ownership of process via HEY24/7. Risk assessment to be revisited every 2 years and/or in light of changing health and/or working conditions	Oct-21		AG		
10.2	That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	Staff in 'at risk' groups e.g. pregnant staff, shielding groups and BAME have a risk assessment completed by their respective manager to assess the suitability and practicalities of returning to work, continuing to work and/or require modifications to their work environment and/or practices. Staff advised to make their manager aware of concerns with regards their health. Utilise a risk assessment tool to assess risk and determine process to follow to ensure staff safety is maintained. Evidence includes: • ALAMA COVID-19 risk assessment • Occupational health staff record • HR / Workforce report • Staff absence record	Lack of compliance and assurance that all staff groups who are 'at risk' and/or BAME have had a risk assessment completed, notably amongst medical staff and lack of visibility/ ownership of risk assessment by individual and line manager	Risk assessment prompt to be added to on staff member's HEY24/7 education/appraisal page and link to risk assessment provided for both individual and line manager. Individual staff member and line manager to take responsibility and ownership of process via HEY24/7. Risk assessment to be revisited every 2 years and/or in light of changing health and/or working conditions	Oct-21		AG		
10.3	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	All staff required and likely to undertake AGPS and wear FFP3 reusable respirators, identified and provided with fit test training and training on care of a respirator. Record of training available on Pattie and via HG records. Various options available dependent on fit testing methods and failure. Other mask options available e.g. full face mask/ powered respirators should staff fail on other mask options Evidence includes: • SOP on use of reusable respirators provided to staff.	No comprehensive central training records held for all staff, some records but in different places and incomplete.	During September 2021, IPCT & H&S to revisit fit testing processes with the support of the National Fit Testing Team Centrally held training record to be established and maintained. Fit testing record to be recorded on staff member's HEY24/7 education/appraisal page Lead to be appointed and business case for dedicated team to be developed	Oct-21		AG		
10.4	Staff who carry out fit test training are trained and competent to do so	Fit testers across the Trust include members of the IPCT, clinical nurse educators, senior matrons and ward/ department managers/ link practitioners, all of whom have been trained to fit test either by an external company fit to fit test accredited trainer or members of the IPCT. Evidence includes: • Accredited training record via Full Support Centrally held record of approved fit testers	Centrally held training record established and maintained although record not complete as multiple fit testers responsible for training who did not document training and outcome No staff designated as 'train the trainers'	During September 2021, IPCT & H&S to revisit fit testing processes with the support of the National Fit Testing Team National Fit Testing Team to facilitate Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams	Oct-21		AG		
10.5	All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Staff fit tested to the model of FFP3 in use. Trust decision due to the unreliable delivery of disposable FFP3 face masks to order and supply reusable FFP3 face masks. Staff are therefore fit tested on these models (3M 6000/7500) and staff issued with personal use mask along with SOP and cleaning/ maintenance instructions Evidence includes: • Fit testing record • SOP on use of reusable respirators provided to staff • H&S team fit testing proposal paper • Centrally held record	Turnaround of staff e.g. junior doctors and need to fit test, as per national guidance to 3 different FFP3 facemasks will result in significant pressure on existing staff to fit test clinical workforce	During September 2021, IPCT & H&S to revisit fit testing processes with the support of the National Fit Testing Team National Fit Testing Team to facilitate Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams Accredited	Oct-21		AG		
10.6	A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	A fit testing certificate is provided to the trainee by the fit tester. If the fit testing is held at ward/ departmental level the certificate is held by the ward sister/ departmental manager, with a copy of the certificate provided to the trainee. A record is also held centrally by the IPCT Evidence includes: • Fit testing record • Centrally held record	Centrally held training record established and maintained although record not complete as multiple fit testers responsible for training who did not document training and outcome	During September 2021, IPCT & H&S to revisit fit testing processes with the support of the National Fit Testing Team National Fit Testing Team to facilitate Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams. Fit testing record to be recorded on staff member's HEY24/7 education/appraisal page	Oct-21		AG		

Goal 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection									
Key line of enquiry/Systems and processes are in place to ensure:		Evidence/Assurance	Gaps in Assurance	Mitigating Actions	Date last reviewed	Q1	Q2	Q3	Q4
						Assurance RAG			
10.7	For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	Yes completed by the IPC team member and/or fit tester in respective departments. Fit testing completed utilising qualitative processes but subjective and open to bias therefore any repeat fails on this method staff member is retested utilising quantitative methods with a higher pass rate. Testing certificate provided to trainee and held centrally by IPCT. Evidence includes: • Fit testing record • Centrally held record	Centrally held training record established and maintained although record not complete as multiple fit testers responsible for training who did not document training and outcome	During September 2021, IPCT & H&S to revisit fit testing processes with the support of the National Fit Testing Team National Fit Testing Team to facilitate Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams. Fit testing record to be recorded on staff member's HEY24/7 education/appraisal page	Oct-21		AG		
10.8	For members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	If a staff member fails fit testing, other options are scoped prior to decision to be redeployed; these include reusable masks, powered respirators and hoods. The inability to safely fit test and provide a solution prompts a discussion with the individual staff member and the staff member's manager and to ensure a risk assessment is completed. Following this HR and Occupational Health are involved with regards ongoing discussions and redeployment plans with advice sought from IPCT if required. Evidence includes: • Fit testing record • Centrally held record • Redeployment policy • Risk assessment	Trust process not using national agreed algorithm although Trust process in place but not consistent	Source nationally agreed algorithm and undertake gap analysis of Trust process against algorithm to identify any changes/ updates required	Oct-21		G		
10.9	A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	Documented record completed by ward manager/ HR & Occupational Health and copy provided to staff member. Evidence includes: • HR policy • Employment records			Oct-21		G		
10.10	Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	Discussion between IPCT, Occupational Health and Human Resources with regards staff who are required to wear an FFP3 due to working environment and/or outcome of risk assessment but whom are unable to do so with all reasonable adjustments scoped. Redeployment offered as per national algorithm Evidence includes: • Redeployment policy • Risk assessment	Trust process not using national agreed algorithm although Trust process in place but not consistent	Source nationally agreed algorithm and undertake gap analysis of Trust process against algorithm to identify any changes/ updates required	Oct-21		AG		
10.11	Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	IPCT and fit testers throughout the organisation provide fit testing for all staff that are required to wear a FFP3 facemask due to clinical reasons or following a risk assessment which determines the need for FFP3 facemask. Fit testers complete a fit testing record which is provided to the staff member and/or held at ward level with the ward sisters/ charge nurses. In addition the IPCT complete a centrally held record once a fit testing record is received. Letter received by the Trust from NHSE/I advising Trusts to fit test staff to three FFP3 masks to document staff fit testing record. Evidence includes: • Fit testing record • Centrally held record	Centrally held training record established and maintained although record not complete as multiple fit testers responsible for training provided fit testing certificate to but did who did not document training and outcome Results not robustly reviewed by Trust Board Letter received by the Trust from NHSE/I advising Trusts to document staff fit testing record	During September 2021, IPCT & H&S to revisit fit testing processes with the support of the National Fit Testing Team National Fit Testing Team to facilitate Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams	Oct-21		AG		
10.12	Consistency in staff allocation is maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	Current activity allowing for consistency in staff allocation in COVID-19 and Non-COVID-19 areas Evidence includes: • E.roster • Bank & Agency bookings	Staffing levels impacted by increased staff absence due to COVID-19 and self-isolation, potentially resulting in increased staff movement to cover shifts but were possible staff working on COVID-19 positive areas not moved to non COVID-19 areas	Staff working on COVID-19 positive areas not moved to non COVID-19 areas	Oct-21		AG		

Goal 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection									
Key line of enquiry/Systems and processes are in place to ensure:		**Evidence/Assurance**	**Gaps in Assurance**	**Mitigating Actions**	**Date last reviewed**	**Q1**	**Q2**	**Q3**	**Q4**
						Assurance RAG			
10.13	All staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	This KLOE is negated as all staff are still required to wear a facemask unless working alone in single office. Yes – clinical staff in ward/ departmental encouraged to observe social distancing. To consider office / admin spaces in assessing the ability to socially distance. In non-clinical areas staff encouraged to observe social distancing and if due to team size this would prove difficult alternative ways of working reviewed and implemented. Under this KLOE need to acknowledge the topic of smoking on the perimeter of Trust premises by staff who are reminded of the importance of social distancing when on smoking breaks. Security teams policing the perimeter and reminding staff of social distancing. Estates team providing markers and signage to serve as reminders for staff. Global email sent to Trust staff, piece on Pattie with regards importance of maintaining COVID-19 measures. Respective contactors employed on site also reminded via management structures of same. Evidence includes: • Updated posters across the Trust including grounds and perimeter • Key messages via Pattie • Key messages via Trust wide email • Director of Workforce key messages • COVID-19-secure risk assessments • COVID-19-secure monitoring audits • Audits of clinical environments – IPCT/ Senior Matron • Security detail inclusive of Trust perimeter	Previous COVID-19 Secure risk assessments now out of date.	Non-clinical areas to be reassessed by departmental managers/ COVID-19 Secure champions, utilising the COVID-19 Secure Risk Assessments.	Oct-21		AG		
10.14	Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	COVID-19 Secure risk assessments completed initially by the H&S team with a risk assessment tool and aide memoire provided to managers who wish to undertake their own risk assessments as a dynamic process. Advice is provided to clinical areas by the IPCT and senior team members to ensure clinical areas reduce risk where practical Evidence includes: • Posters • Global email • Pattie • COVID-19 Secure risk assessments • Monitoring records	Previous COVID-19 Secure risk assessments now out of date.	Non-clinical areas to be reassessed by departmental managers/ COVID-19 Secure champions, utilising the COVID-19 Secure Risk Assessments.	Oct-21		AG		
10.15	Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	Yes – implemented in both clinical and non-clinical areas. Reinforced to all staff groups via Pattie, global email and E-News. Evidence includes: • Posters • Global email • Pattie • COVID-19 Secure risk assessments • Monitoring records	Previous COVID-19 Secure risk assessments now out of date.	Non-clinical areas to be reassessed by departmental managers/ COVID-19 Secure champions, utilising the COVID-19 Secure Risk Assessments.	Oct-21		AG		
10.16	Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	Yes – staff are advised to contact the ESC helpdesk who support and sign post staff accordingly including arranging testing. Helpdesk also liaises with managers of individuals who report sickness and/or need to self-isolate. Evidence includes: • ESC helpdesk • Occupational health data • HR information • Feedback sort from affected staff member • Return to work process	No gaps identified	Nil actions required	Oct-21		G		
10.17	Staff that test positive have adequate information and support to aid their recovery and return to work.	Yes – staff are supported by the ESC helpdesk, HR and the staff member's manager. Staff advised to report if their symptoms alter or worsen. Evidence includes: • ESC helpdesk • Occupational health data • HR information • Feedback sort from affected staff member • Return to work process	No gaps identified	Nil actions required	Oct-21		G		

Agenda Item	7.3.3	**Meeting**	Trust Board	**Meeting Date**	25 October 2021
Title	IPC – 6 Month Update				
Lead Director	Beverley Geary, Chief Nurse				
Author	Greta Johnson, Director of Infection Prevention and Control				
Report previously considered by (date)	The Report has been considered at the Quality Committee in October 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	

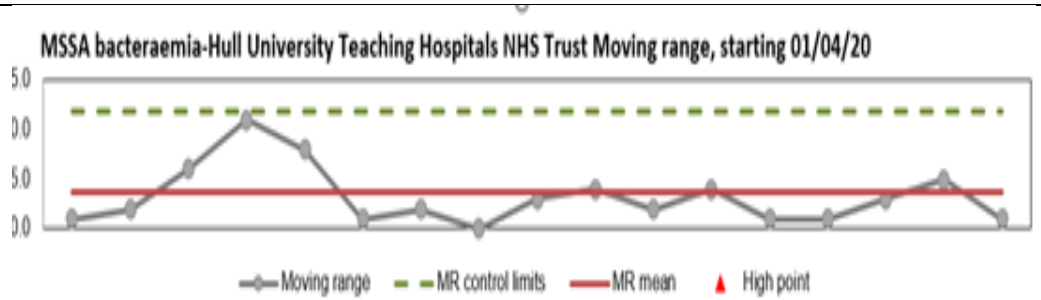
Key Recommendations to be considered:

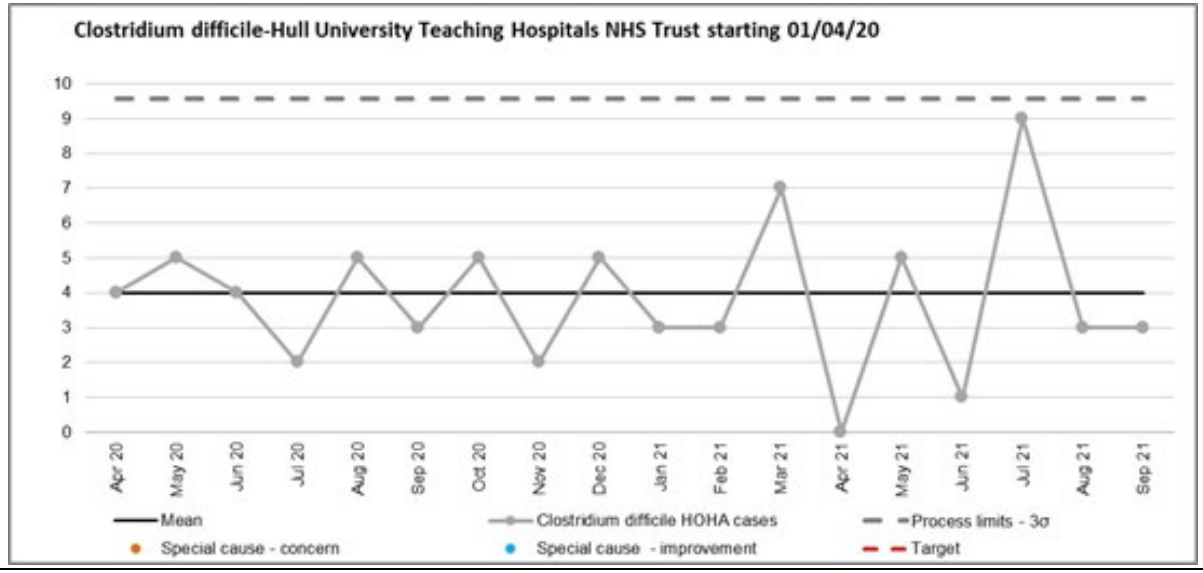
The purpose of this report is to provide information and assurance on matters relating to the prevention and control of healthcare associated infections (HCAIs) and opportunistic infections for the month of September 2021 and for the first six months of the financial year.

The Board is asked to accept the report and advise if any further information or assurance is required.

Healthcare Associated Infections Report		
Purpose of the Report		
The purpose of this report is to provide information and assurance on matters relating to the prevention and control of healthcare associated infections (HCAIs) and opportunistic infections for the month of September 2021 and for the first six months of the financial year.		
Items for Escalation at close of September 2021		
MRSA Bacteraemia	No hospital or community onset cases reported for September 2021. From April – September 2021 one hospital onset MRSA bacteraemia was reported on the 20th May 2021. The patient had a complex medical history and as a result of the multi-agency Post Infection Review (PIR) investigation the case was deemed unavoidable	**Health Group Reported Cases 2021/22** 1 Trust apportioned cases reported, deemed unavoidable 0 Community apportioned cases reported ***(April – September 2020 no reported cases)***
MSSA Bacteraemia	During September 2021, two hospital onset MSSA bacteraemia cases were reported. Both cases were in the Surgery Health Group. The case reported on C15 represents a patient admitted in urinary retention requiring bilateral nephrostomies with stenting secondary to advanced prostate malignancy and insertion of a suprapubic catheter, post operatively developed a pyrexia, case under investigation by clinical team. The case reported on H6 represents a patient admitted with a bowel obstruction requiring a laparotomy and admission to ICU post operatively. Developed aspiration pneumonia secondary to a history of latent TB with MSSA identified in bronchial lavage sample suggesting respiratory as the source. CVC tip also cultured MSSA but nil evidence of a line infection at time of bacteraemia. In addition, one community onset healthcare associated cases was reported and are under investigation. From April – September 2021, a total of 29 hospital onset MSSA bacteraemia have been reported alongside 9 community onset healthcare associated (COHA) cases. 13 reported in Medicine Health Group, and 13 in Surgery Health Group and the remaining three in Clinical Support Health Group occurring in the first quarter only. Reviewing causation for these bacteraemia there are a number of trends to report: discitis, pneumonia, skin & soft tissue infections many of which are unavoidable, however, peripheral cannulas (PVCs) continue to be reported where no other source has been	HOHA cases: Medicine Health Group - 13 cases Surgical Health Group - 13 cases Clinical Support Health Group – 3 cases Families & Women's Health Group - 0 cases COHA cases: Medicine Health Group - 5 cases Surgical Health Group - 1 cases Clinical Support Health Group – 3 cases Families & Women's Health Group - 0 cases ***(April – September 2020 – 27 HOHA cases)***

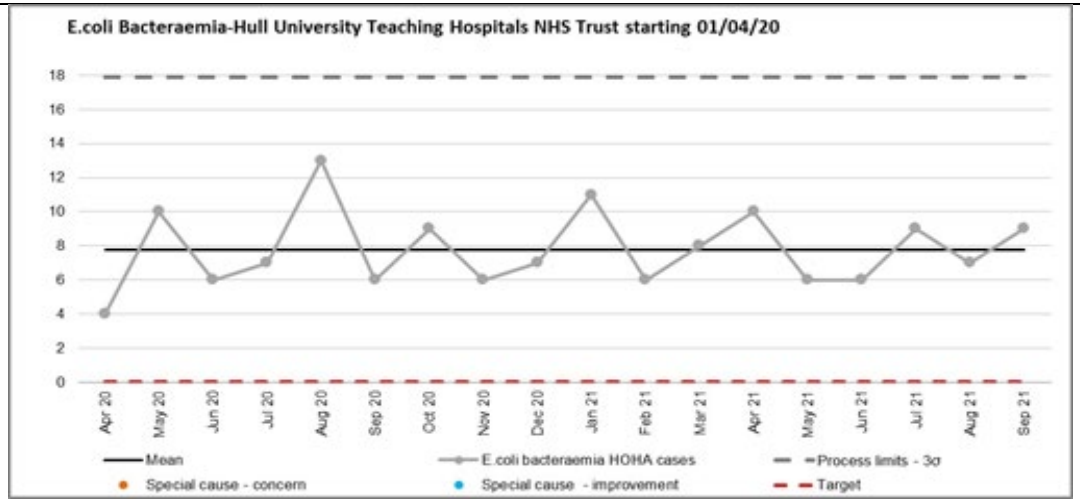
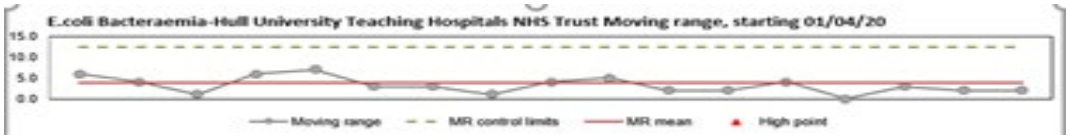
	identified and in this time period at least one MSSA bacteraemia linked to central venous access (CVC). All Trust apportioned cases are investigated using a root cause analysis (RCA) process with final RCAs tabled at Operational Infection Reduction (OIRC) and exception reporting to Strategic Infection Reduction Committee (SIRC). Mitigating actions: • From the 23rd August 2021 Health Groups are required to report HCAI HOHA and COHA cases via DATIX. Compliance will be monitored via OIRC and escalated to SIRC as and when needed. The Risk Team will provide a monthly compliance report to the IPCT. • RCA process reviewed and electronic version being scoped for use • Training on conducting an IPC RCA to be rolled out to Senior Matrons, Band 7s and Medical Teams.  	

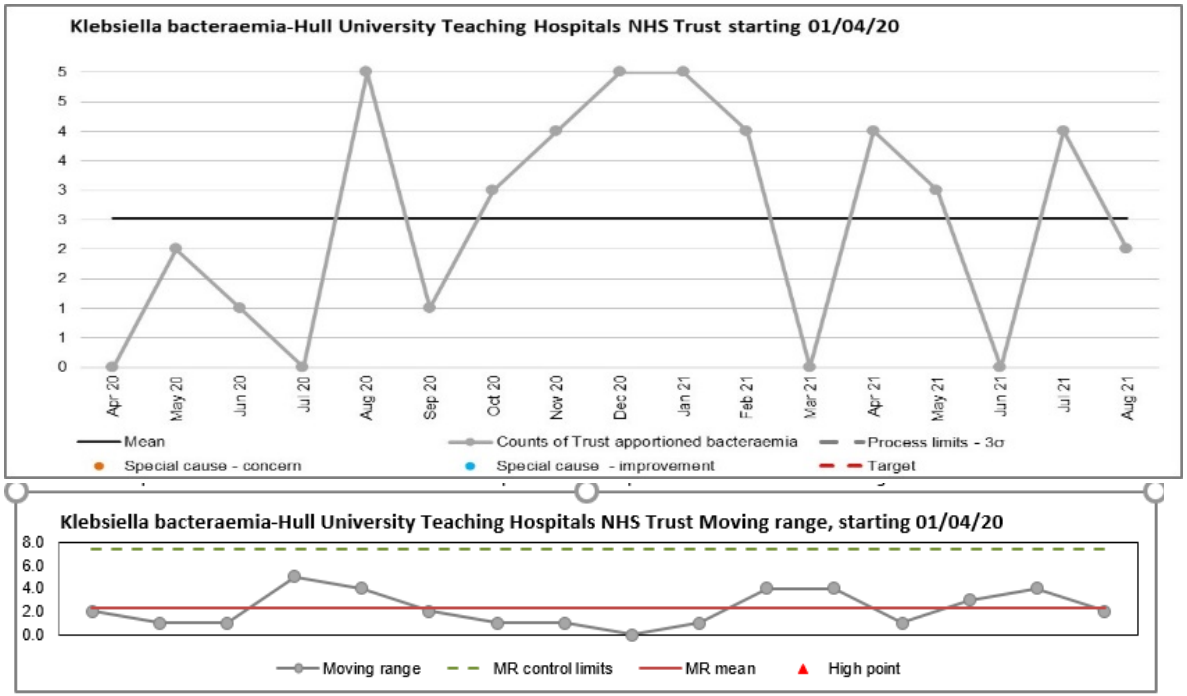
		
***Clostridium Difficile* (*Clostridioides difficile*)**	During September 2021, three Trust apportioned and one community apportioned *C difficile* cases were reported. All reported samples are sent automatically for ribotyping. Of the three cases, two are reported in the Medicine Health Group and one in the Surgery Health Group. A review of reporting and assurance around the investigation of Clostridium difficile by both the IPCT and HGs is underway but RCAs are required for all HOHA and COHA cases with RCAs sent to the respective HGs for completion. From April – September 2021, a total of 21 hospital onset *C difficile* cases have been reported alongside 10 community onset healthcare associated (COHA) cases. Eight within the Medicine Health Group, seven within the Surgery Health Group and the remaining six in Clinical Support Health Group with no cases reported for Families & Women's Health Group. All Trust apportioned cases are investigated using a root cause analysis (RCA) process with final RCAs tabled at Operational Infection Reduction (OIRC) and exception reporting to Strategic Infection Reduction Committee (SIRC). Over the last six months a review of RCA processes identified a delay in timely reporting, completion of RCA investigation and 'closing the loop' on the findings and subsequent learning. Of the RCAs completed and returned the majority are no lapses in practice, however, an increasing number are linked to suboptimal antimicrobial prescribing and not following Trust guidance. Mitigating actions:	HOHA cases: Medicine Health Group – 8 cases Surgery Health Group – 7 cases Clinical Support Health Group – 6 cases Families & Women's Health Group - 0 cases COHA cases: Medicine Health Group – 2 cases Surgery Health Group – 5 cases Clinical Support Health Group – 3 cases Families & Women's Health Group - 0 cases ***(April – September 2020 – 22 HOHA cases)***

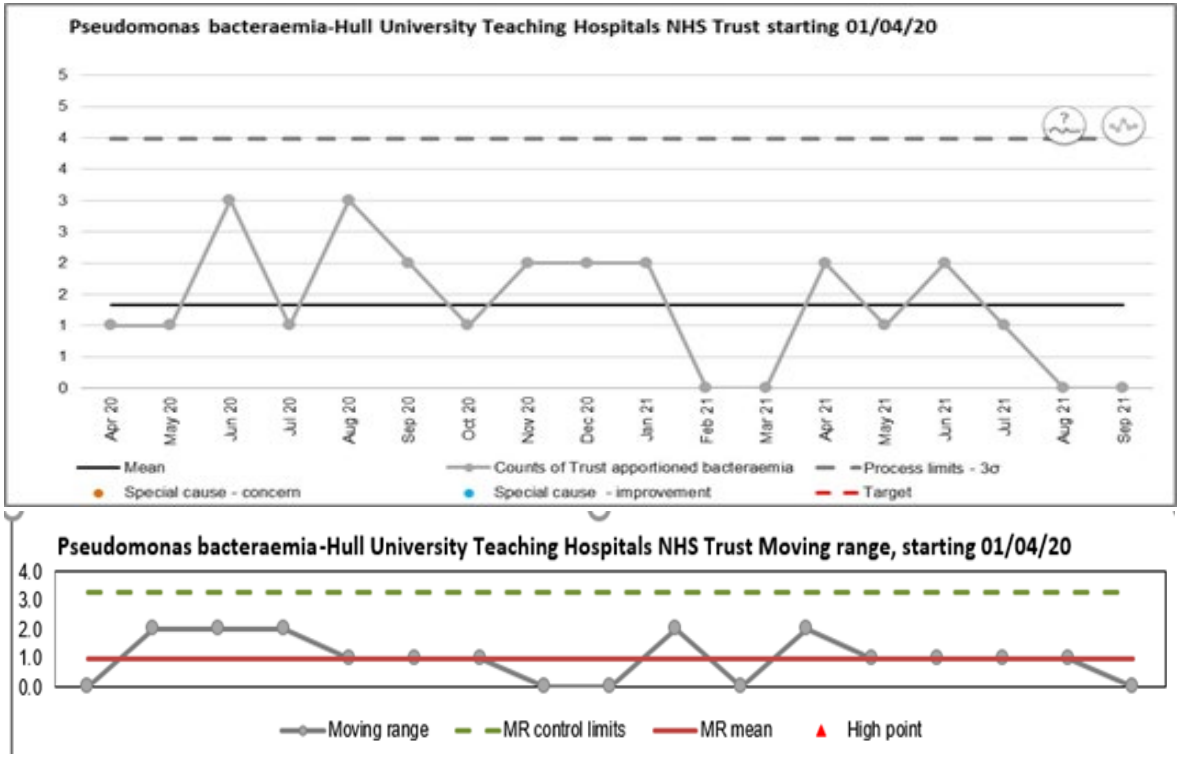
	• From the 23rd August 2021 Health Groups are required to report HCAI HOHA and COHA cases via DATIX. Compliance will be monitored via OIRC and escalated to SIRC as and when needed. The Risk Team will provide a monthly compliance report to the IPCT. • RCA process reviewed and electronic version being scoped for use • Training on conducting an IPC RCA to be rolled out to Senior Matrons, Band 7s and Medical Teams. • Pharmacy Team are undertaking indication & duration audits as standard but with the addition of an audit examining compliance against Trust prescribing guidance and treatment advice to clinicians from the Infectious Diseases Team and/or Consultants Microbiologists. This is reported via ACAT, OIRC & escalated to SIRC as needed. 	

		
E.coli Bacteraemia	In September 2021, nine Trust apportioned E. coli bacteraemia were reported, demonstrating a slight increase in cases but within normal limits. Of the nine cases, four were identified in the Surgery Health Group on wards H6, H60, H7 and HICU. A further four cases reported in the Medicine Health Group on wards HEAU, CMU and two of the four on H11 but on investigation not linked. The remaining case was identified in Clinical Support Health Group on ward C33. Each case is subject to a review by the IPCT and if lapses in practice are identified then a RCA is required. The same trends and sources of infection continue to be identified, being biliary, urinary and respiratory. From April – September 2021, a total of 47 hospital onset E.coli bacteraemia cases have been reported alongside 38 community onset healthcare associated (COHA) cases. 22 within the Medicine Health Group, 7 within the Clinical Support Health Group, eighteen within Surgery Health Group and the remaining one in Families & Women's Health Group. All Trust apportioned cases are investigated by the IPCT utilising a GNBSI review form, this was formally re-implemented from April 2021 following challenges with regards team capacity alongside COVID19 activity and outbreaks. If the bacteraemia on review is deemed avoidable then a root cause analysis (RCA) process is requested by the IPCT of the respective clinical team, with final RCAs tabled at Operational Infection Reduction (OIRC) and exception reporting to Strategic Infection Reduction Committee (SIRC). Over the last six months a review of IPC investigations/ RCA processes identified a delay in timely reporting, completion of RCA investigation and 'closing the loop' on the findings and subsequent learning. Of the reviews completed and returned the majority are unavoidable with no lapses in practice. However, there appears to be a theme with regards urinary catheter related infections (CAUTIs), for patients who have been admitted with a long-term catheter from the community and those patients who require a urinary catheter during the course of their admission.	HOHA cases: Medicine Health Group – 22 cases Surgery Health Group – 18 cases Clinical Support Health Group – 7 cases Families & Women's Health Group – 1 case COHA cases: Medicine Health Group – 9 cases Surgery Health Group – 10 cases Clinical Support Health Group – 18 cases Families & Women's Health Group – 1 case ***(April – September 2020 – 49 HOHA cases)***

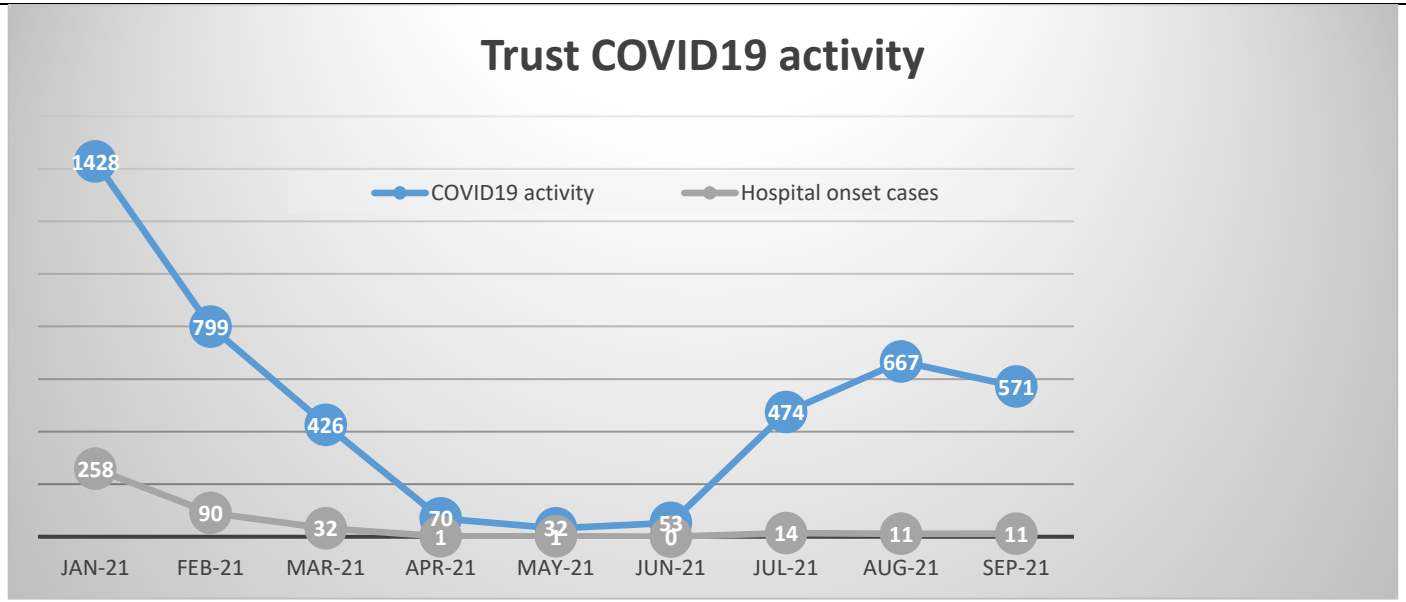
	Mitigating actions: • From the 23rd August 2021 Health Groups are required to report HCAI HOHA and COHA cases via DATIX. Compliance will be monitored via OIRC and escalated to SIRC as and when needed. The Risk Team will provide a monthly compliance report to the IPCT. • IPC review form & RCA process reviewed and electronic version being scoped for use • Training on conducting an IPC RCA to be rolled out to Senior Matrons, Band 7s and Medical Teams. • To understand the burden of urinary catheter usage in the Trust the IPCT are undertaking an audit of patients currently admitted to a ward who are currently catheterised, regardless of when and where the urinary catheter was inserted. The IPCT are reviewing as to whether a catheterised patient is being managed on a urinary catheter care bundle and that its ongoing usage is reviewed and documented with removal planned as soon as possible, clinical condition permitting. They are also assessing the prevalence of urinary tract infections in this group of patients. The outcome of this audit will be presented to OIRC in November 2021. • The Supplies Team are reviewing urinary catheter usage and associated products across the Trust and liaising with Community Teams across Hull & East Riding of Yorkshire to ensure patients on discharge have provision of community approved products to provide seamless care, for either patients with long term urinary catheters or those waiting for referral to urology for trial without catheter (TWOC).	

	 	
Klebsiella Bacteraemia	During September 2021, six Trust apportioned cases were identified which is a marked increase in cases. Four were reported in Surgery Health Group, one on ward H100, two on H6 and the fourth case on C27, the remaining two in the Medicine Health Group on wards CMU and C26. Given the commonality in geographical location for some of the cases the IPCT have undertaken a deeper dive and to date no links have been identified, although this is pending a further review of the medical and nursing notes. Each case is subject to a review by the IPCT and if lapses in practice are identified then a RCA is required. The same trends and sources of infection continue to be identified, being urinary, respiratory and intra-abdominal. From the 1st July 2021, the IPCT will focus on GNBSI, including Klebsiella and undertake a deeper dive especially regarding bacteraemia linked to urinary catheter related infections and those deemed antibiotic resistant. From April – September 2021, a total of 19 hospital onset Klebsiella bacteraemia cases have been reported alongside 12 community onset healthcare associated (COHA) cases. Twelve within the	HOHA cases: Medicine Health Group – 6 cases Surgery Health Group – 12 cases Clinical Support Health Group – 1 cases Families & Women's Health Group – 0 cases COHA cases: Medicine Health Group – 3 cases Surgery Health Group – 1 cases Clinical Support Health Group – 7 cases Families & Women's Health Group – 1 cases

	Surgery Health Group, six within the Medicine Health Group, one within the Clinical Support Health Group and none in Families & Women's Health Group. Over the last six months a review of IPC investigations/ RCA processes identified a delay in timely reporting, completion of RCA investigation and 'closing the loop' on the findings and subsequent learning. Of the reviews completed and returned the majority are unavoidable with no lapses in practice, however, Klebsiella has the propensity to be resistant and result in harder to treat infections. The ID & IPCT team are working closely together to highlight concerns with regards resistant GNBSI and GNB infections an example of this is a recent incident meeting to discuss infections on NICU. 	***(April – September 2020 – 9 HOHA cases)***

Pseudomonas aeruginosa Bacteraemia	During September 2021, no Trust apportioned Pseudomonas aeruginosa bacteraemia cases were reported however, a community apportioned case was identified. Each Trust & community apportioned case is subject to a review by the IPCT and if lapses in practice are identified then a RCA is required. From April – September 2021, a total of 11 hospital onset Pseudomonas aeruginosa bacteraemia cases have been reported alongside 2 community onset healthcare associated (COHA) cases. Five within the Medicine Health Group, four within the Surgery Health Group, two within the Clinical Support Health Group and none in Families & Women's Health Group. 	HOHA cases: Medicine Health Group – 5 cases Surgery Health Group – 4 cases Clinical Support Health Group - 2 cases Families & Women's Health Group - 0 case COCA cases: Medicine Health Group – 1 case Surgery Health Group - 1 case Clinical Support Health Group - 0 cases Families & Women's Health Group - 0 cases ***(April – September 2020 – 11 HOHA cases)***

Outbreaks / Incidents of Infection	During September 2021, an outbreak of diarrhoea and vomiting was reported affecting patients on H8. The ward was closed to admissions on the 28th August 2021 due to patients affected with diarrhoea and vomiting in numerous bays on the ward. In spite of extensive sampling and testing no causative organism was identified. No staff affected during the course of the outbreak and the ward was cleaned and reopened on the 2nd September 2021. From April – September 2021, there have been, inclusive of the above ward closure, four ward closures due to D&V, one in May 2021 on Ward H200, two in August 2021 on Wards H12 & H90 and Ward H8 during September 2021. During these ward closures incidental isolated cases of C difficile were reported but no ward closures were due to confirmed Norovirus and in each of these scenarios very few staff were affected. During the same timeframe there has also been numerous bay closures all of which on the HRI site, again short lived with no causative organism reported in spite of extensive sampling.
Neonatal Intensive Care Unit (NICU)	A colonised neonatal case of Pseudomonas aeruginosa was identified on NICU on the 13th September 2021. The baby was isolated and additional screening on the unit did not find any additional cases. The isolate was sent for VNTR profiling which demonstrated the isolate was unique and not previously linked to any cases previously reported. Weekly screening continues for all neonates on the unit for both MRSA and Pseudomonas aeruginosa. Of note, however, is an increase in gram negative infections on the unit, with babies being initially colonised and then progressing to clinical infections (but not bacteraemia) caused by the organisms. Environmental sampling including water sampling and a review of clinical practice has been undertaken. Challenges remain on the unit with the existing blue room awaiting reconfiguration. An incident meeting was held on the 13th October 2021.
COVID-19	During September 571 patients were screened positive for COVID-19; the majority were patients screened with a decision to admit and/or in OPD settings, demonstrating a continued increase in reported cases – a decrease of 96 cases from the month before. There were six COVID19 clusters reported during September 2021 affecting C10/C11, H6, H9, H100, and H12 & HICU. Incident meetings were convened and held. Possible causes identified include: indirect transmission from positive index case via care giving activity and/or visitor. Poor compliance with regards PPE use especially amongst medical staff which was escalated immediately. Second affected patient had one visitor compliant with LFDs. No staff were affected during the course of the outbreak and by the end of the outbreak staff were either completing LFDs and/or LAMP testing. The ward was closed to visitors as a precaution. From April to September 2021, 1,867 COVID19 cases screened positive for COVID-19; the majority were patients screened with a decision to admit and/or in OPD settings, of the 1,867 cases 21 were hospital onset probable cases (8-14days) and a further 17 were definite hospital onset cases (>15 days) representing a 1.1% and 0.9% infection rate in this time period. The hospital onset cases were linked to reported outbreaks where community onset cases were admitted and nursed in bays resulting in contacts and subsequent positive cases.

	 Mitigating actions taken include improved asymptomatic testing and PCR testing for both staff and patients and a promotion of the covid booster vaccination.
Other relevant information	The report from the NHSI visits in June 2021 was presented to Quality Committee in September 2021 with an update on actions taken against recommendations. A Task and Finish group has been set up to do a root and branch review of the Board Assurance Framework and a review of the IP Risk Register. The revised BAF will be presented to Board in November A workplan to focus on improvement; will be devised to address feedback from external visits and internal audit findings. This will be monitored through Strategic Infection Prevention Committee.

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

Item: Leadership Programme	Level of assurance gained: Reasonable
Leadership programmes ran internally have been modulised to ensure that they are pandemic proof. A number of courses now established for staff within the organisation, along with some accredited courses being sourced.	
Item: Health and Wellbeing	Level of assurance gained: Substantial
Occupational Health Services remain the main route for staff to see support and help for a wide range of mental and physical challenges at work. The Trust continues to support staff via Focus Counselling, Occupational Health Team and the Pastoral and Spiritual Care Team for general mental wellbeing support. Wellbeing is also now included within staff appraisal and encourages a conversation around staff wellbeing. Up! Health and Wellbeing wider wellbeing programme is also beginning to expand again following the pandemic.	
Item: Non-Medical Education Progress Report	Level of assurance gained: Reasonable
New deputy Head of Learning has commenced in post and working on key priorities for the department. Work experience was paused during the pandemic but looking to reinstate the non-clinical work placements where safe and working with local schools to provide safe alternatives to clinical placements. Continuing Professional Development funding from Heath Education England spending plan has been signed off and part of the allocated funding received. Trust has looked to maximise funding and bring education across teams.	
Item: Responsible Officer Report	Level of assurance gained: Reasonable
Medical appraisals following the recommendation to be suspended in March 2021 was recommenced in April 2021. The Trust is looking to increase the number of appraisers.	
Item: Staff Survey QTR 2 Results	Level of assurance gained: Reasonable
NHS Mandated pulse survey to be taken quarterly, response rate for quarter two has been affected whilst transferring to a new provider and platform. During the pilot which was open 8 days there was a 19% response rate. Health Groups have submitted staff engagement plans which will be reviewed at quarterly performance meetings. The national survey is now live and runs October – November 2021. The next pulse survey will be February 2022.	
Item: Freedom to Speak Up Guardian	Level of assurance gained: Substantial
The Freedom to Speak Up Guardian has been promoting the role across the organisation raising the profile of the role. The new Guardian has continued to receive an increasing number of concerns, demonstrating that staff are aware of the Guardian role. A variation of concerns raised and actively being supported to resolve.	
Item: Consultant Job Planning	Level of assurance gained: Reasonable
Reported that the job planning for the Doctors across all 38 departments is underway, currently working towards 90% target. The Trust is implementing team job planning in some areas.	
Item: Nursing and Midwifery Staffing Report	Level of assurance gained: Substantial
Significant increase of number of registered nurses next month following the recruitment of newly qualified student nurses. Successful programme for the international nurses with a 97% retention rate and 100% OSCE pass rate, further cohort arriving in December 2021.	

Hull University Teaching Hospitals NHS Trust
Minutes of the Workforce, Education and Culture Committee
Held on 9 August 2021

Present:	Prof U Macleod	Chair
	Dr A Pathak	Associate Non-Executive Director
	Dr M Purva	Chief Medical Officer
	Mrs B Geary	Chief Nurse
	Prof M Loubani	Guardian of Safe Working
	Mrs S Rostron	Director of Quality Governance
	Miss H Cattermole	Director of Medical Education
	Mrs L Vere	Head of Education and OD
	Mrs H Knowles	Head of HR
	Mr A Barker	HR Intelligence Manager
In attendance:	Mrs R Boulton	Quality Governance Officer
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mr Nearney, Director of Workforce and OD.	
2	**Declarations of Interest** Prof Macleod declared that she was the lead for the Medical School.	
3	**Minutes of the meeting held 14 June 2021** Miss Cattermole advised that she had asked permission to include Dr Pathak on the Senior Leaders engagement session. Item 8.1 – Mrs Geary advised that this item related to all overseas nurses not just Pilipino nurses. Prof Loubani, Mrs Vere and Dr Pathak to be added to the attendance list. Following these changes the minutes were approved as an accurate record of the meeting.	
4	**Matters arising from the minutes** Dr Pathak asked if the funding from HEE had been made available and it was agreed that this would be discussed outside of the meeting with David Hepburn.	
5	**Action Tracker** Mrs Vere advised that she was reviewing the peer to peer bullying and civility sessions were being implemented. She advised that she would present back to the group. The e-Rostering item would be picked up in the Guardian of Safe Working report. ***The agenda was taken out of order at this point.***	

9.1 Talent Management

Mrs Vere presented the item and advised that there was a succession plan in place for senior management which had been postponed due to the pandemic. She also advised that Andrea Glover (leadership consultant) was speaking to individuals and attending meetings to gather information about the Trust's current state.

Talent management was to be incorporated into the non-clinical appraisals along with staff wellbeing.

Miss Cattermole asked about developing junior doctors and not just the doctors and Mrs Vere advised that she was attending the next Junior Doctor forum and would pick this up as a theme.

Prof Macleod was keen to ensure Equality, Diversity and Inclusion training was in place to ensure a fair talent management system was introduced.

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

10.1 Health and Safety Report

The Health and Safety Report was received for information. The report had been received at the Non-Clinical Quality Committee and the Board.

10.2 Occupational Health Report

Mrs Hunter presented the report and advised that the number of Occupation Health referrals had increased by 12% in the year. The referrals were due to work related stress from staff being re-deployed and having stress related health issues.

Mrs Hunter advised that she worked closely with Mrs Vere's team to manage staff support and the Trust had also appointed a psychologist working 2 days per week.

The flu vaccination programme was at 87% and the new programme was being planned for 2021/22. 200 vaccinators had been trained.

Dr Purva asked about needle-stick injuries and how the Trust was addressing the issues. Mrs Hunter advised that the majority of needle-stick injuries was the result of staff not following procedures. Each line manager of every injury receive a letter from Occupational Health to encourage further training for their staff.

Prof Macleod expressed her concern around the vaccination uptake amongst the doctors. Mrs Hunter advised that this was the same every year despite the encouragement by the Trust.

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

11.1 Medical Education Report

Miss Cattermole presented the report and highlighted issues around Junior Doctor disengagement relating to clinical leadership, Covid preparedness and communication.

The Health Education England contract had increased emphasis on quality standards and there was a contractual requirement for WIFI included.

Recovery of the training was ongoing and a SMART action plan was in place for each trainee. Dr Purva agreed that the recovery of trainees was the priority as they were tired and still had high service pressures.

Dr Purva advised that she contested some of the issues in the report and had not seen the report before the meeting. She advised that she would add some comments to Mrs Thompson after the meeting. She added that other Trusts were in a similar position.

Prof Macleod asked about additional opportunities and Miss Cattermole advised that there were a number of different ways of working being explored.

Dr Pathak asked what was happening with Phlebotomy and Dr Purva advised that a business case was in development for the appointment of a Phlebotomist and work was ongoing to train nurses to carry out phlebotomy.

Resolved:
The Committee received the report and took assurance from the recovery training plan.

11.6 Guardian Safe Working Report

Prof Loubani presented the report and highlighted the issue in Phlebotomy and the business case being developed to support it.

Prof Loubani stated that the Junior Doctors had felt disconnected from management for a while and that there had been lost training opportunities during the first and second waves of the pandemic.

A road map for all grades of junior doctors was in place to ensure rotas were available and in place. E-Rostering was at 37% and work was ongoing to improve this compliance. Engagement of clinical supervisors and medical directors working collaboratively was key to encourage use of the system.

Resolved:
The Committee received the report and required further assurance regarding the e-Rostering compliance.

11.2 Workforce Race Equality Standard

Mrs Knowles presented the report and advised that the standards were nationally set parameters and updated the Committee of the Trust's compliance and action plan.
Mrs Knowles highlighted BAME Staff relating to disciplinary, mandatory training and recruitment standards. She advised that the Trust was

developing a diversity recruitment scheme to ensure that a diversity specialist sat on the panel.

There was still work to do regarding the diversity of the Board.

New appointments include Dumbor Ngagge as the BAME network chair and Fran Moverley as the Freedom to Speak up Guardian.

The Trust had been shortlisted for a Healthcare People Award and was leading the way in the Integrated Care System.

Mrs Vere advised that work was ongoing with the GP Practices and receptionists to build a network of allies and have a strong approach in the ICS.

Resolved:
The Committee received the Workforce Race Equality Standards and gained good assurance from the work ongoing.

11.3 Workforce Disability Equality Standards

Mrs Knowles presented the paper and advised that the WDES was a more recent set of metrics and not as embedded as the WRES. Elaine Hillerby had recently set up the enabled network and the work being carried out would underpin the recommendations in the WDES.

One of the key issues was that a number of staff did not want to declare their disabilities for different reasons. An action plan had been developed and addressed, in particular, the current building works and disabled access.

Pattie was now promoting external programmes and Occupational Health was continuing their work with disabled staff.

Prof Macleod asked that gender issues were included in future reports.

Resolved:
The Committee received the report and took good assurance from the Disability Network being established.

11.5 Modern Slavery Statement

The Modern Slavery Statement was presented to the Committee and it was due to go to the Trust Board in September 2021 for approval.

Dr Pathak asked about child labour and any other non-ethical labour and how this was monitored by the Trust to ensure products did not enter the Trust. Mrs Knowles advised that she worked closely with Mrs Lumb in Procurement to make sure that all suppliers of the Trust were ethical.

Resolved:
The Committee received and accepted the Modern Slavery Statement.

13.1 Integrated Performance Report

Mrs Thompson presented the report which highlighted the new proposal for an Integrated Performance Report which moved away from Rag

Ratings and used SPC charts and control measures. The report would also give assurance levels for each indicator.

Mrs Thompson had listed the workforce indicators at Appendix 1 for the Committee to review. She advised that these could be changed or amended as the IPR evolved.

Resolved:
The Committee received the report and agreed with the indicators proposed.

7.1 People Performance Report

Mr Barker presented the report and advised that the Trust was in a good position regarding vacancies. Turnover was going up but this had been impacted by temporary staff (recruited during Covid) leaving.

Mr Barker advised that Covid absence had gone up sharply in recent months but had now started to come down. There were a lot of symptomatic staff in the Trust presently.

Statutory and Mandatory training rates were improving. Miss Cattermole advised that 2 extra days given for F1 trainees had resulted in 89% completing their training and 90% completing their VTE Prophylaxis training.

Resolved:
The Committee received the report and took good assurance from the training rates increasing and the sickness rates coming down.

8.1 Nursing Midwifery Staffing Report

Mrs Geary presented the report and highlighted the Care Hours Per Patient Days for May 2021 was 7.87 and June 2021 was 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. Mrs Geary added that it would reduce further in the next report due to staff sickness over the recent weeks.

The `Let's Get Started` induction programme for the new registrants has been reformatted this year based on the feedback from previous cohorts. The students felt that the programme was too long in length and the depth was not enough for their entry to staff nurse roles. This year the programme will therefore run for 3-5 days on subjects which they feel are essential to make the transition from student to staff nurse easier.

Resolved:
The Committee took good assurance and accepted the report.

8.2 Variable Pay Report

Mr Barker presented the report and advised that the Trust had spent £7.4m in Quarter 1 on Variable Pay. This was compared to the same period of time in 2019/20 and the cost was £200k less.

The Health Groups were overspent by £889k in Quarter 1 and this was mainly due to staff requirements and agency costs to aid the recovery phase.

Dr Pathak asked for a breakdown of non-clinical and clinical variable pay and Mr Barker agreed to review this outside of the meeting.

Resolved:
The Committee received and accepted the report.

13 Any Other Business

Prof Macleod thanked Miss Cattermole for her contributions as this was her last meeting and wished her well for the future.

Prof Macleod suggested that LGBTQ and Transgender issues should also be included in Trust reports in the future.

Prof Macleod congratulated the HR and OD Team on their Base Camp award.

Date and time of the next meeting:
Monday 11 October 2021, 10am – 12pm, via Teams

Hull University Teaching Hospitals NHS Trust

Trust Board and Committee Front Sheet

Agenda Item	7.4.1	**Meeting**	Trust Board	**Meeting Date**	09.11.21
Title	Our People				
Lead Director	Simon Nearney - Director of Workforce and Organisational Development				
Author	Simon Nearney - Director of Workforce and Organisational Development				
Report previously considered by (date)	This report has not been received at any other meeting.				

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

Key Recommendations to be considered:
The Trust Board is requested to note the content of the report and provide any feedback.

Hull University Teaching Hospitals NHS Trust

Trust Board

9th November 2021

Our People

1. Purpose

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

2. Background

At the previous Board meeting in September the Trust had 70 Covid-19 inpatients. As at 3rd November, 2021 the Trust has 59 Covid-19 inpatients. A slight reduction, but still a significant number. The Trust has H37 and H38 at HRI dedicated to Covid-19 patients and H36 remains an assessment area for possible Covid-19 patients. Community infection rates have steadied, but the Trust remains under extreme pressure continuing to fight the pandemic whilst attending to the high demands on our Emergency Department, continuing to reduce our overall waiting lists and deliver other essential services. The current pressures are exacerbated as staff continue to self-isolate if symptomatic. The guidance on self-isolation has changed late August, so more staff isolating are only absent for 2 or 3 days not 10 as they can return to work following a risk assessment. Staff are exhausted. Silver command and Executive team are monitoring and managing the position on a daily basis.

3. Key Issues

Staff Absence

The total staff sickness absence for the financial year 2020-21 was 3.51%. The total absence including sickness and Covid-19 for 2020-21 was 7.20%. The Trust attendance target for attendance is 96.1% (sickness not to be greater than 3.9%).

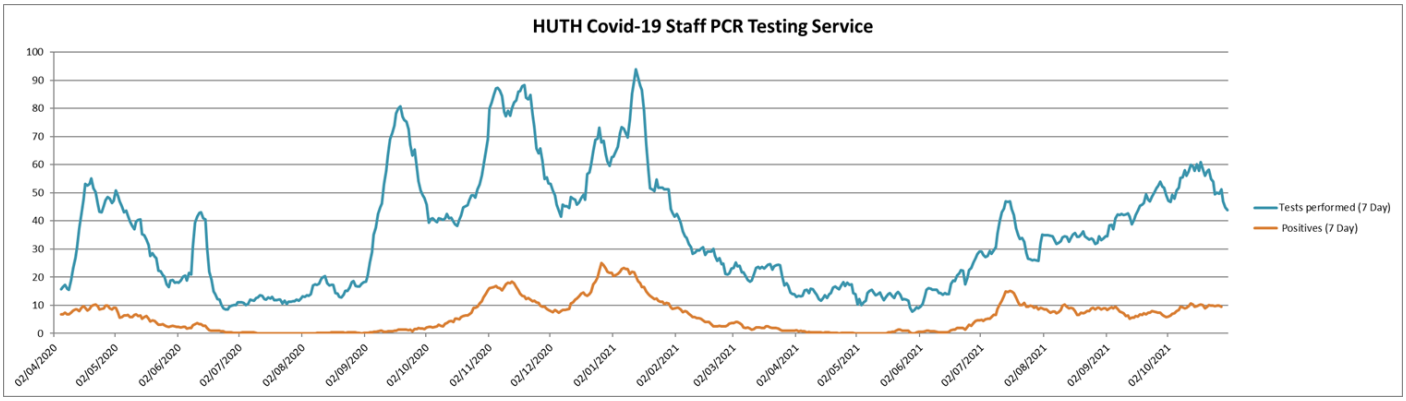
The Trust currently has 145 staff absent due to Covid-19 which is 1.39% of the workforce. Total sickness and Covid-19 absence is currently 3.9%. This is a decrease from 5.69% as at the last Board meeting in September.

4. Staff Testing

Symptomatic Testing (PCR)

The Trust continues to test symptomatic staff and family members for Covid-19 via a drive through facility which has been in operation since April 2020. If offers testing not only for HUTH staff, but also our 3rd party providers (OCS etc.) and also YAS, Humber FT and CHCP. Between April 2020-October 2021, we have tested 20,591 people, 16.25% of which were positive. The following graph shows the 7-day average of overall number of individuals tested and positive cases since the start of the programme.

In October 2021, 1637 people were tested and 17% were positive.



Asymptomatic Staff Testing (LAMP)
On Tuesday 1 June 2021, the Trust commenced LAMP testing via a partnership with the University of York and Capita. LAMP testing has been offered to all staff, clinical and non-clinical and was to replace lateral flow testing for most staff and is now encouraged twice per week. Further Trust communications, regarding the importance of LAMP, occurred in September 2021, however, uptake is still low, with only c.1,250 samples being tested weekly. Informal feedback is that the lamp test is more problematic / difficult to undertake than LFT and staff do not like 'to spit'.

Test and Trace
The NHS Test and Trace programme launched on Friday 5th June 2020 and continues today. Over the last 3 months 236 staff in August, 221 staff in September and 173 staff in October 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 Helpdesk
The Employee Service Centre Helpdesk, based in Suite 21 on the CHH site, continues to provide extended services to support the Trust with its response to the pandemic. Offering an extended 7 day service the helpdesk is the first port of call via which staff and their household members with Covid-19 symptoms can access a PCR test and/or obtain general Covid-19 advice and support. Between 1st April 2021 and 31st October 2021 the helpdesk received and responded to over 6000 Covid related calls.

5. Staff Vacancies

The Trusts overall vacancy position as at 30th September 2021 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1405.8	1415.7	71.3	0.0	0.0%
Add Prof Scientific and Technical	367.2	318.0	0.0	49.2	13.4%
Administrative and Clerical Staff	1640.9	1559.9	13.7	67.2	4.1%
Allied Health Professionals	487.5	473.2	3.5	10.8	2.2%
Estates and Ancillary	601.2	520.3	1.9	79.0	13.1%
Healthcare Scientists	330.8	303.8	0.0	27.0	8.2%
Medical & Dental - Consultant	499.5	452.2	16.1	31.2	6.2%
Medical & Dental - SAS	59.1	49.2	0.9	9.0	15.3%
Medical & Dental – Trainee Grades	662.8	682.2	15.5	0.0	0.0%
Nursing and Midwifery Registered	2393.0	2228.9	41.0	123.2	5.1%
Trust Total	8447.8	8003.4	164.0	280.4	3.3%

Overall the Trust vacancy position is 3.3%. The Consultant vacancy rate is 6.2%. Whilst our vacancy situation remains in a healthy position the Trusts recruitment plans during this financial year have been interrupted, but recruitment and retention remains a key priority.

The vacancy rate for Registered Nursing and Midwifery is currently 5.1% across the organisation.

The Trust has recently recruited 113 adult and paediatric student nurses predominately from the University of Hull.

There are currently 41 Registered Nursing Associates (RNA) with 11 more who have completed the programme but are just awaiting their PIN, making 52. The Trust has successfully recruited a further 23 TNA`s who commenced the programme in September 2021.
From the perspective of the Registered Nurse Degree Apprentices (RDNA) there are currently 32 in training. 12 of the 2018 cohort recently qualified in October and are awaiting their PIN. More RDNA's have recently joined the programme as well.

In relation to the Health Care Support Worker Apprentices, there are currently 14 in training. 9 recently completed their apprenticeship in October. 7 of these apprentices will transfer onto the RDNA programme with the other 2 onto the TNA programme. In conjunction with Hull College and the University of Hull the Trust has also recruited a further 15 HCSW to commence the programme in September 2021.

From an international perspective, the Trust has successfully recruited 240 international nurses mainly from the Philippines since October 2017. Of those 8 have left the Trust which is a retention rate of 97%. Of those that left 4 have relocated to be with family in the UK (3 in London and 1 in Brighton).

In response to the financial support offered by NHSE/I, the Trust plans to recruit a further 15 international nurses, by December 2021. There are also 9 existing Trust HCSW`s currently being supported through the OSCE process.

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 have been 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.

Trust staff involved in providing direct patient care, staff who are Clinically Extremely Vulnerable, (CEV) staff over 50 years of age and healthcare students on placement are eligible to have a Covid-19 booster. 45% cent of our entire staff have had a Covid-19 booster that is above the regional average of 39% and 57% of eligible staff have had theirs.

The flu vaccine is offered to all Trust staff on a priority basis starting with clinical and CEV staff. 52% of staff have had a flu vaccine so far which is the second highest number in the region. Trusts are being limited to the number of vaccines being delivered. We have had a 3 week gap without any vaccine but are planning to open up the programme again to all staff week commencing Monday 15th November.

In addition HUTH is also the lead provider for HCV ICS vaccination programme and as such the Trust has recruited a bank of vaccinators (both registered and unregistered) who are being deployed to Primary Care Networks, Community Pharmacies and Mass Vaccination sites across the Humber Coast and Vale area. Currently the bank hosts six Band 6 Clinical Supervisors, 280 Band 5 Vaccinators and 165 Band 3 Unregistered Vaccinators/Healthcare Assistants. The service

sits alongside the Nurse and Staff Bank and since its development in March 2021 has deployed staff to cover over 6000 shifts.

7. Communications and engagement

Staff Survey

As at the 3rd November the Trust has seen a 36% response rate to the national staff survey. This compares with a final response rate of 37% in 2020. The survey will close in the last week of November.

Communications strategy

The Communications team is prioritising four key areas over the next three years: Sustainability; Equality, Diversity and Inclusion; Research, Development and Innovation and Compassionate Care. These campaign areas will feature prominently in our reputation management, recruitment and retention and wellbeing work.

A full programme of digital development is also underway with a new platform for the Trust's intranet, Pattie, a rebuild of the Trust's website, a pilot scheme to test the efficacy of digital information screens and a Trust app in development.

The Zero30, sustainability campaign will launch in November 2021 with a focus on staff engagement.

8. National Pay Award

As per the national timetable, in September 2021 the payroll team facilitated the payment of the nationally agreed 3% pay award for substantive staff employed on Medical and Dental and Agenda for Change terms and conditions. Payments included arrears for the period 1st April 2021 to 30th September 2021.

9. Staff Support Arrangements

Occupational Health Services remain the main route for staff to access support and help for a wide range of mental and physical challenges at work.

The staff support service continues to work alongside our Occupational Health Service and offers an email and telephone hotline service. The Trust is promoting and advertising the Humber, Coast and Vale Resilience Hub widely for staff to access support. The Trust continues to support staff via Focus Counselling, Occupational Health Team and the Pastoral and Spiritual Care Team for general mental wellbeing support. An internal clinical Psychology service for staff is also available via Occupational Health. 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.

The 24/7 staff support hotline will continue to be available and is run by the Pastoral and Spiritual Care team. The OD team continue to monitor and signpost staff through the hyp-tr.staff.support@nhs.net email address. As Covid-19 number continue to rise the Staff Support MDT will adapt services to be flexible and line with the needs of staff.

The Quick Guide to Staff Support is available and updated regularly on Pattie to effectively signpost our staff to local and national services.

Supporting Teams with Psychological Debriefing:

Humber Coast and Vale Integrated Care System (HCV ICS) have funded across the ICS around 45 staff to undertake Critical Incident Stress Management Debriefing (CISM) training and we now have four members of HUTH Staff trained in this approach. Internally there are plans to also skill up key departments to internally be able to deploy these skills, with the focus initially on ED and ICU. There is funding in place to do this and the plan is to train 15-20 clinical staff (medics, nursing and AHP's), in Trauma Risk Incident Management (TRIM). This will enable us a Trust to embed the skills within these high stress departments, which allows for screening for those going beyond what you would expect to see as a normal response to a stressful or traumatic situation. This helps

build a culture of proactive support for mental wellbeing and also ensures we identify early any staff struggling so we can refer to our occupational health and wider staff support services if needed. The overall plan is to develop our in house psychological debriefing service alongside also contributing to ICS wide plans.

10. Learning and Organisational Development
Statutory and Mandatory Training - Core Skills Training Framework
The new Deputy Head of Learning is now in post and a key first task is a full review of all our statutory and mandatory training provision. This is being done to ensure that all our provision meets the guidance laid out by the Skills for Health Core Training Skills Framework (CSTF). By signing up to the Framework it means that the training is assured and is 'portable'. This means a member of staff who has just joined the organisation have done their fire training in a CSTF accredited Trust doesn't have to repeat it on arrival at HUTH. Equally our staff transferring out can also carry their training with them. This is especially helpful for our doctors in training rotations.

This review is also connecting with the accountable subject leads to ensure that we have the right content, targeted at the right people at the right intervals. We are also supporting to make sure training can be providing in the right setting or approach ranging from e-learning, live webinars and face to face (where appropriate in the current pandemic setting).

This review will inform and update both the Education Policy and the Statutory and Mandatory Training Policies.

Training Venues
Access to face to face training is being increasingly requested by both trainers and learners. Where is appropriate and essential this is being supported where capacity is available. MEC continues to be used as vaccination hub alongside the CHH lecture theatre. This has significantly reduced room availability across the whole Trust and HYMs and Clinical Skills are supporting medical education session as far as possible. Some sessions are having to be booked externally.

Until the social distancing rules change the room capacity we have remains a challenge and is impacting significantly on training such as resuscitation training capacity vs demand. We have been under increasing pressure to increase room capacity to below the 2m rules so more can be in the room e.g. lecture theatre but until we receive permission to change our set up locally and nationally we have to keep these measures in place.

Great Leaders Programmes
November sees the third post-pandemic cohort of Be Remarkable starting and the two other cohorts are accessing our newly designed modular programme to fit in with their work commitments and apply a flexible and accessible approach to senior leadership development.

Other key programmes running successfully are Rise and Shine and our Supervisors + programmes. The move to live webinars across all our programmes is working well and we make sure our learners are supported to access them in a quiet and appropriate space when their own work environments are challenging.

We are now advertising national Leadership Academy Programmes with funding attached for both Clinical and non-clinical staff. The focus at the moment is supporting staff to attend Mary Seacole (a programme for new/middle leaders).

11. 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

Agenda Item	8.1	Meeting	Trust Board	Meeting Date	9th November 2021
Title	Freedom to Speak Up Guardian report – November 2021				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Frances Moverley, Head of Freedom to Speak Up				
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	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 – November 2021

1. Purpose of the paper

To provide an overview of Q2 2021 - 2022 from the Freedom to Speak Up Guardian, an update on changes to the Guardian post and activities undertaken.

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 well-led domain of a CQC inspection.

2. Introduction

Following the Francis Review, all Trusts are required to have a Freedom to Speak Up Guardian (FTSUG) in place. This role acts impartially and provides staff with an option to raise concerns in a confidential manner.

The National Guardian's Office requires Freedom to Speak Up Guardians to be able to report directly to the Trust's Board. This report provides an update on concerns raised by staff through the Trust's Freedom to Speak Up Guardian.

There are a number of processes in place that allow staff to raise concerns. These include:

- Formal Raising Concerns and Whistleblowing Policy
- Staff Advice and Liaison Service (SALS)
- 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 such as the GMC's *Raising and acting on concerns about Patient Safety* (2012), which sets out the GMC's expectations that all doctors will, whatever their role, take appropriate action to raise can act on concerns about patient care, dignity and safety.

3. Changes to the Speak Up national Index

The National Guardian's Office publishes and annual 'Freedom to Speak Up' index measurement for all NHS Trusts, calculated on scores from specific questions within the previous NHS Staff Survey questions.

Nationally the Staff Survey questions have been changed in line with the People Plan and as a result some of the questions that comprised the Index have been removed. In light of this the National Guardian Office will no longer publish the Index.

The Staff Survey will continue to have a question asking whether workers feel safe to speak up and is accompanied by a new follow up question *"If I spoke up about something that concerned me, I am confident my organisation would address my concern".*

The National Guardian Office has invited Trusts to consider using this question as an indicator of their speaking up culture and arrangements. The National Guardian Office are also working

with to present the 2021 survey results on the Model Health System, to enable Guardians to use the tool to use the results in a similar way to the Index data.

4. Freedom to Speak Up Guardian – Trust Contacts

The Freedom to Speak Up Guardian reports on contacts received from members of staff to the Trust Board each quarter in the public board meeting. The data is also required to be reported to the National Guardian Office.

The Trust's figures are as follows:

From 1st July 2021 – 30th September 2021 (Q2), the FTSUG has been contacted as follows (in comparison to 1st July 2020 – 30th September 2020 (Q2)):

	Number of contacts	
Route of contact	**1st July 2021 – 30th September 2021**	**1st July 2020 – 30th September 2020**
Contacted via anti-bullying Tsar	0	0
Contacted directly by the member of staff	8	11
Requesting advice for a colleague	0	0
Contacted via SALS	1	1
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	1
Signposted by Trade Union contact	3	0
Total	**12**	**12**

From 1st July 2021 – 30th September 2021 (Q2),the FTSUG has been contacted as follows (in comparison to 1st July 2020 – 30th September 2020 (Q2)):

	Number of contacts	
Type of concern	**1st July 2021 – 30th September 2021**	**1st July 2020 – 30th September 2020**
Concerns about bullying behaviour	2	5
Concerns about HR process involving the member of staff – concerns about fair treatment	2	0
Concern about patient safety	0	1
Concern about worker safety*	0	N/A
Concerns about workload	0	0
Concerns about inappropriate behaviour	2	0
Concerned about role within the Trust	1	0
Concerned about issues directly relating to Covid-19	0	4
Concerns about service delivery	0	0
Concerned about poor working relationships within team	3	5
Unspecified – contacted for general support	2	1
Total	**12**	**12**

*New category introduced by the National Guardian Office

	YEAR TO DATE 1st April 2021 to 31st March 2022	TOTAL 1st April 2020 to 31st March 2021
Total number of contacts	17	24

Comments and learning:

- There has been an increase in the number of contacts received during Q2 (from 5 in Q1) and the majority of these cases are still live and in progress, requiring ongoing support and meetings with the individuals involved.
- The Guardian escalated (with consent) several cases during Q2 to the HR Department for clarification on HR policies and process.
- The reason for the concerns are varied; anecdotally the Freedom to Speak Up Guardian has observed a number of cases connected to poor working relationships and general rudeness from staff members. The Guardian will be involved in the future with a Civility and Inclusion project and will input the observations and learning.
- In one case, it was agreed with a staff member that anonymised feedback would be shared regarding their experience. The staff member reported experiencing rudeness from other staff members in several clinical areas and on a number of different occasions, an example being when handing over key patient information the other staff member turned their back, dismissing the handover and saying 'just write it in the notes'. This led to the staff member feeling disrespected, being told 'that's just what that ward is like' and worried about potential patient safety issues. This has sadly contributed to the staff member's decision to leave the Trust. The Freedom to Speak Up Guardian encouraged the staff member to complete an exit interview.

The Freedom to Speak Up Guardian attended a presentation from the Associate Director of Corporate Governance at Cambridgeshire Community Services NHS Trust, the Trust with the highest national Freedom to Speak Up Index score. The following learning was attributed to receiving the highest Speak Up Index score nationally:

- The Non-Executive Director responsible for Speaking Up is engaged and understands the process.
- Non-Executive Directors and Board Members visit service areas 'back to the floor' and there is high visibility of senior leaders on a regular basis. Observation of the services on the ground provides opportunities so Board members can experience what staff go through. This allows an opportunity for staff to relate to their leadership on a less formal basis and can raise challenges immediately.
- There is BAME representation on interview panels to ensure fairness and representation to candidates.
- There is a network of Champions embedded across services.
- People first approach – ensuring focus on what the member staff is going through, as well as the facts of the issue. Focus on support required by person throughout e.g. grievance policy.

5. Activities during Q2 2021 - 2022

The FTSUG has undertaken the following:

- Attended and provided a presentation of Speaking Up at the Enabled Staff Support Network, BAME Network and Junior Doctor Forum to raise awareness of the role and promote speaking up amongst members.
- Proactively linked in with the Non-Executive Director for Freedom to Speak Up, Head Chaplain and the Staff Support Psychologist to promote mutual referrals.

- Continued increasing the content on Pattie including creation of a blog and Frequently Asked Questions page.
- Led a Just Culture and Speak Up workshop at the Patient Safety Conference.
- Joint working with the Primary Care Dean at Health Education England to promote the Guardian role to GP Trainees and support the anti-racism work currently underway.
- Provided training to the FY1s as part of the Foundation Training programme. The feedback received included comments:
    - A topic that I previous had no idea about.
    - Nice interactivity to break up the lecture
    - Very useful information especially for those new to the Trust
    - Presenter was very engaging
    - I learnt a lot of new things from this teaching session.
    - It was a great teaching with good information.
    - I liked the use of polls. It should be done more often in these presentations

6. Planned Activities for Q3 2021 – 2022

- Promotion of National Speak Up month October 2021 including increased communications on Pattie and across the Trust, recording of video clips and a podcast explaining the importance of speaking up, attending team meetings and promoting completion of the Health Education England e-learning modules.
- Introductory meeting with the Acting Chair of the LGBTQ+ staff network.
- Joint working with the Volunteers Manager to include Freedom to Speak Up as part of the volunteers induction and ongoing education.
- Attendance at various team meetings to promote speaking up – including the Band 7 ward managers and the Chaplaincy team.
- Begin attending regular meetings with the Head of Workforce, HR Business Partner, HR Manager and HR Advisors across all Health Groups to share learning.
- Continuing to conduct a gap analysis and review of current speaking up processes and concluding recommendations.
- Start the recruitment of Freedom to Speak Up Champions; initially attending the Well-Being Champion network meeting to promote joint working.
- Participating in the stakeholder event for the recruitment of the new Chairperson.

7. 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
November 2021

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Digital Strategy Update

Presentation to HUTH Board November 2021

Dr Alastair Pickering, CMIO for HUTH & NLAG

Digital Strategy 2018-23

- Delivered the majority of previous 2018-23 Strategy (see Annex 1)
- Now entering a new world
  - ICS
  - Technology changes
  - Post Covid-19 NHS response

- Refresh Strategy to align with new Trust and ICS updates (Annex 2)

Current Digital Priorities 2021-22

- Short to medium term operational needs…
  - Elective Recovery
  - UEC pathways
- Delivering what we have to (contracts/funding)
- Working across organisations
  - ICS wide decisions
    - Maternity / Ophthalmology / Diagnostics
    - Intelligence & Insight collaborative / Future EPR planning
  - Local partnerships
    - PAS migration for NLAG (Digital Aspirant)
    - HASR enablement
    - Pathology / Radiology

Patients

- Single patient portal – PKB®
- NHS App
- Remote consultations
- Community Diagnostics support

Staff

- hDigital focus is to help staff through
  - Resilient systems that work
  - Faster & more secure connections
  - Simpler, more intuitive user interfaces
  - Collecting data once and sharing widely
  - Support for mobile & flexible working

- Support Safety and Quality
- Improve outcomes

Outpatient / Elective recovery support

Digital work ongoing at all stages

Hull University Teaching Hospitals NHS Trust

Input

- Referral management
- Decision Support

Throughput

- Productivity
- Patient Flow (SAFER) & Bed management
- Quality & Safety

Output

- GIRFT / PROMs
- Self-Management
- Proactive LTC monitoring

UEC Support work

- Direct Booking into ED
- UTC implementation on HRI site
- Front Door Streaming
  - SDEC service pathways
- Emergency Care Data Set (ECDS) extension
- Electronic communication
  - YAS Transfer of Care
  - YHCR uploads
  - Specialty Digital notes

Digital Aspirant funding -
HUTH & NLAG collaboration

Hull University Teaching Hospitals NHS Trust

- Shared PAS and EPR access
  - Technical links
  - PAS replacement at NLAG
- Shared Data warehouse
- Command Centre development
- Introduction of Robotic Process Automation (RPA)
- Electronic Document Management System

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HASR

Phases 1-3 (Current work from Digital to support programme)

Interim Clinical Plan (Phase 1)

- Neurology (Blueprint for single service model)
- Cardiology (Connected Health Network)

- Dermatology / Haematology / Oncology (service model support)

- Ophthalmology / ENT
- Gastro / Urology / Respiratory

Phase 2

- UEC
  - Massive interoperability work and pathway changes (ICS wide)
- Maternity
  - Regional Maternity system procurement
- Paediatrics
  - Interoperability, Data sharing, Safeguarding

Phase 3

- CAPITAL INVESTMENT
- Need to include appropriate Digital solutions
- Early planning and future proofing
- Infrastructure
  - Technical architecture mapping (whole ICS)
  - Shared Data warehouse & BI solutions
  - Regional Command Centre

Summary

- Wide reaching programmes of work
- Supporting all areas of Trust & ICS

- Prioritisation – need to know what is being planned
- Partnership – economies of scale are possible
- Strategic Refresh is underway (Annex 2)

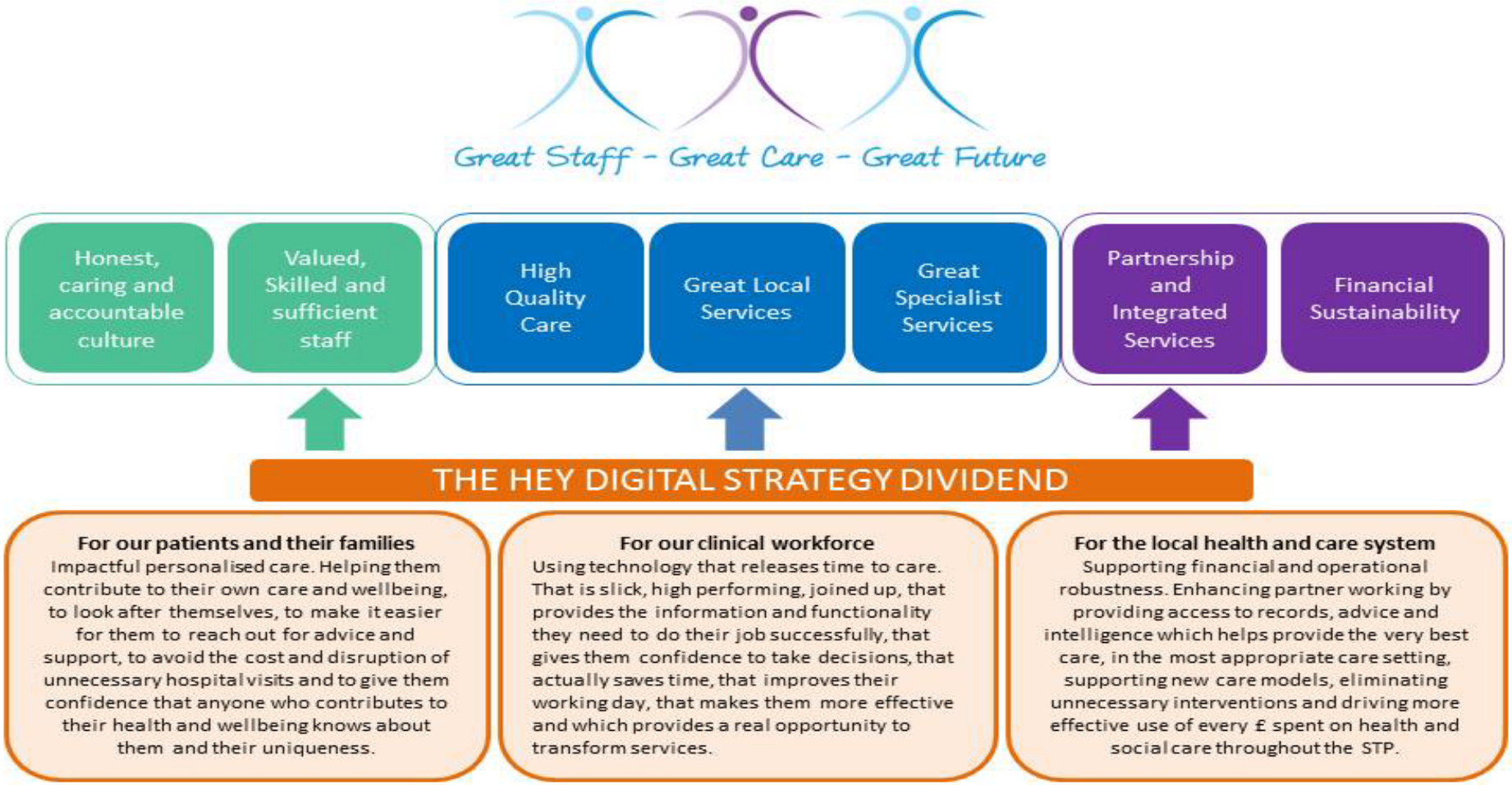
- **Transformation in how we work is required**

Hull University Teaching Hospitals NHS Trust

Annex 1

Delivery of Digital Strategy (2018-23)

Update on progress against previous strategic objectives


Great Staff - Great Care - Great Future
Honest, caring and accountable culture
Valued, Skilled and sufficient staff
High Quality Care
Great Local Services
Great Specialist Services
Partnership and Integrated Services
Financial Sustainability
THE HEY DIGITAL STRATEGY DIVIDEND
For our patients and their families
Impactful personalised care. Helping them contribute to their own care and wellbeing, to look after themselves, to make it easier for them to reach out for advice and support, to avoid the cost and disruption of unnecessary hospital visits and to give them confidence that anyone who contributes to their health and wellbeing knows about them and their uniqueness.
For our clinical workforce
Using technology that releases time to care. That is slick, high performing, joined up, that provides the information and functionality they need to do their job successfully, that gives them confidence to take decisions, that actually saves time, that improves their working day, that makes them more effective and which provides a real opportunity to transform services.
For the local health and care system
Supporting financial and operational robustness. Enhancing partner working by providing access to records, advice and intelligence which helps provide the very best care, in the most appropriate care setting, supporting new care models, eliminating unnecessary interventions and driving more effective use of every £ spent on health and social care throughout the STP.

The functional development and enhancement of Lorenzo is ongoing and, over the life of this Strategy, we will:

- *Complete the Trust wide deployment of Lorenzo Electronic Prescribing and Medicines Administration (ePMA) CHH live, HRI plan for early 2022*
- *Decommission CAYDER and adopt Lorenzo Advanced Bed Management (ABM) throughout the Trust. This will provide slicker, integrated and intuitive pathway management, from referral to discharge, integrated into the EPR, with actions visible, traceable and reportable. Our vision is to enable care partners from outside of the Trust to interact with ABM, enhancing coordinated care models and improving patient flow DEC 2021-JAN 2022*
- *Implement Lorenzo Task Management to improve oversight and accountability along the patient journey On Inpatient Programme roadmap for 2022*
- *Commit to Lorenzo Theatres, bringing theatres into the heart of the EPR, supporting integrated resource allocation, contributing towards GS1 compliance and enabling ORMIS to be decommissioned CHH Live, ongoing project*
- *Complete the roll-out of NerveCentre e-OBS throughout the Trust, positioning e-OBS alongside of Lorenzo through enhanced integration. CHH live, HRI rollout 2022*
- *Build on the digitisation 'proof of concept' initiatives in Breast, Cardiology and ED and drive paperless working throughout outpatients and inpatients ED live, ongoing project in 2022*
- *Continue to build a richer Lorenzo care record through integration of key 3rd party clinical systems, including the adoption of Fast Healthcare Interoperability Resources (FHIR) Standards Ongoing Dev work*
- *Support the wider data sharing across the STP community through promotion of the use of the enhanced Summary Care Record. Now feeding into YHCR*
- *Manage the transition process at the end of the Lorenzo Local Service Provider (LSP) Contract which expires in June 2021 Complete*

Over the life of this Strategy therefore, we will:

- *Complete the total replacement of the Trusts Data Network and Telephone across all Trust buildings and sites. Ongoing work with new Capital builds*
- *Roll-out patient Wi-Fi services, in line with national policy, to all areas of the Trust ongoing into 2022*
- *Complete the transition to a fully digital Trust wide unified voice and video service, supporting MDT's and virtual clinics Enhancement work ongoing*
- *Decommission the in-house Exchange service and transition to NHS Mail by 30th June 2018 Complete*
- *Procure and implement the Yorkshire and Humberside Public Sector Network (YHPSN) solution as a replacement for N3 Complete*
- *Procure and deploy a Single Sign-On 'one password' solution for staff, linked to Smart cards, using 'tap and go' to speed up access to spine authenticated systems (eg Lorenzo / SystmOne / ESR) Complete*
- *Deploy Windows10 across the desktop environment and continue to refresh our desktop estate to enable new applications to be successfully deployed. Complete*
- *Alongside of that we will commit to reviewing the costs and benefits of deploying a 'virtual desktop' solution to both support agile working and reduce the lifecycle replacement cost of desktops COVID-19 required rapid deployment of laptops at scale with widespread VPN access*
- *Review the opportunities and benefits of off-site cloud hosting services in line with emerging NHS Digital Policy ongoing*
- *Improve and evolve our Cyber Security approach; enhance our current technical defences to include software asset and security patch management; create a dedicated IT security management team ongoing*

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Annex 2 - Digital Strategy (Future)

Alignment, prioritisation and collaboration

Trust – Partners – ICS – Regional – National

Hull University Teaching Hospitals NHS Trust

Annex 2a
Digital Strategy (Future)

HUTH Digital Strategy *(in development)*

Alignment with Trust strategy on Strategic Delivery Framework,

Patient safety, Digital Maturity progression

Element	Strategic Ambition	Measures	Year 1 Objectives	Year 2 Objectives	Year 3 Objectives
Digital Development	We will become a digital first organisation	Successful implementation of Digital solutions for key operations and systems	Complete rollout of ePMA, eObservations and electronic nurse assessments	Complete rollout of electronic nursing assessments and digital referrals processes	Complete removal of paper clinical records with rollout of electronic notes
	We will play a key role in the development and delivery of the Humber and ICS Digital strategy and plans	Develop digital solutions that encompass all elements of the patient pathway, and align with Humber and ICS wide objectives	Support the transition of services as part of HASR Phase 1: Interim Clinical Plan to enable shared service models across the Humber region	Complete delivery of the Interim Clinical Plan for HASR; Support project delivery for ICS digital plans as a key acute provider	
	We will work in partnership with neighbouring organisations and systems to develop more streamlined digital capability	Implement digital solutions that support shared working with neighbouring organisations	Shared PAS with NLAG; Shared Data Warehouse and analytics team; Shared LIMS and Pathology service; Integration with regional shared care record to support patient pathways	Complete implementation of digital systems to deliver a working radiology network and imaging collaborative across Yorkshire	
	We will become a digitally mature, secure and resilient organisation	Compliance with National Cyber Security guidance on current and new systems and show improvement in our Digital Maturity	Meet DSPT standards and work towards Cyber Essentials plus compliance; Complete a baseline assessment of What Good Looks Like (WGLL) and continue improvement work against HIMSS digital maturity framework	Meet DSPT standards and Cyber Essentials plus; Identify priority work areas to improve on Digital Maturity including staff and patient digital engagement and literacy	Exceed DSPT standards; Demonstrate improvements in Digital Maturity assessments (e.g. WGLL, HIMSS)

Top 10 Digital Priorities for Patient Safety

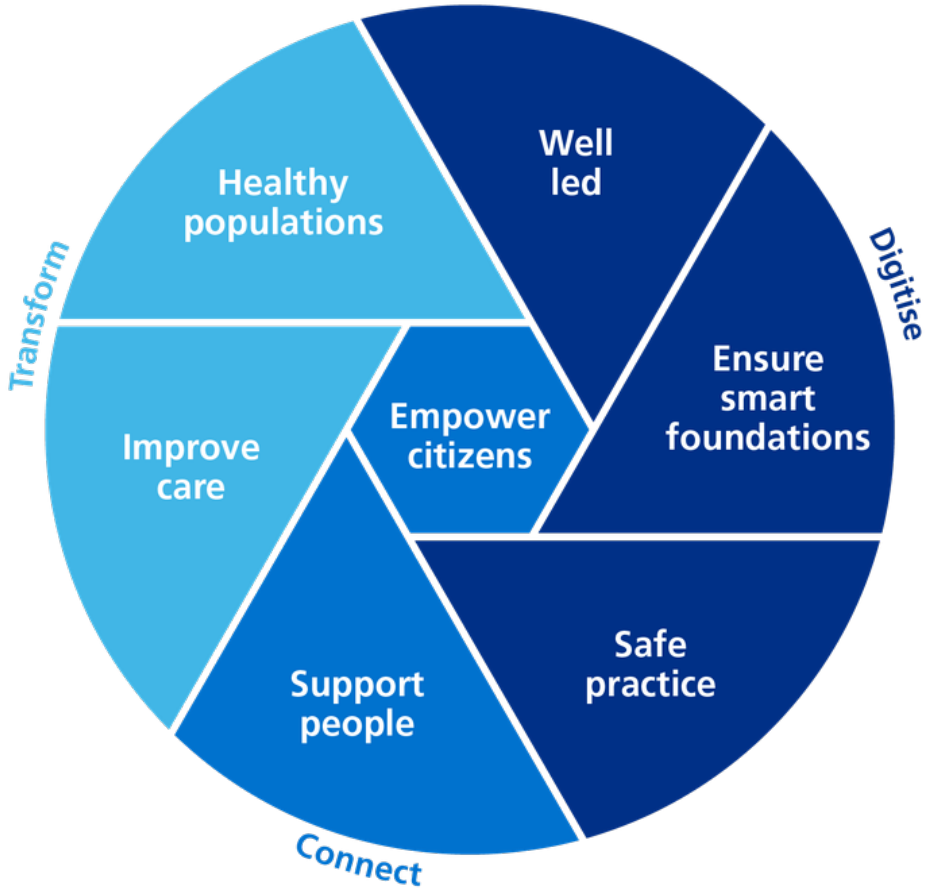
Hull University Teaching Hospitals NHS Trust

- Investment
- Automation
- Strengthen Digital Literacy
- Better access to centrally sourced & patient generated data
- Scanning multiple hospitals to enhance effect of new systems (blueprinting / benchmarking)
- Count what counts not what is easy to count
- Adopt patient safety standards and embed these into new technologies, especially AI
- Build safety more strongly into the user experience
- Patient safety maturity Index
- Faster deployment of key technologies

HUTH Clinical Digital Priorities

- Patient Safety, morbidity & mortality data
- Results management
- Image management
- Clinical Communications (bleep replacement)
- Shift to paperless records e.g.
  - IDL; ReSPeCT / EPaCCs; VTE recording
- System request backlog e.g.
  - G2; Endoscopy; Orthotics; ICU; Orthopaedics/Trauma

What Good Looks Like framework



Hull University Teaching Hospitals NHS Trust

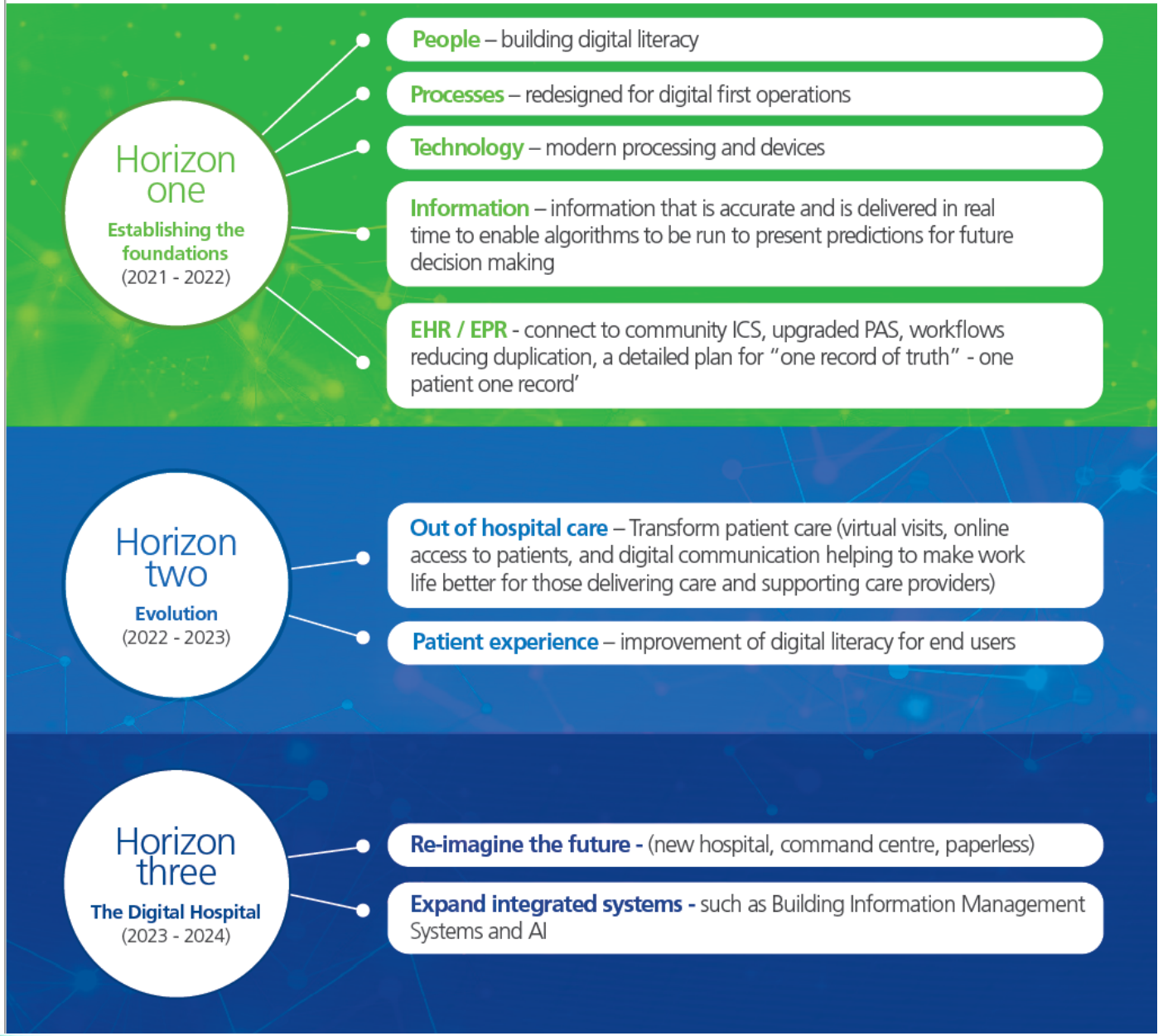
Annex 2a
Digital Strategy (Future)

NLAG Digital Strategy

Alignment to Trust Strategy, Clinical Priorities and high level roadmap


Strategic Framework
Vision
Committed to caring for you
Values
Kindness
Courage
Respect
Principles
Right care, right place, right time
Whole system thinking, whole system practice
Patient centred care
Transformation of services
Objectives
To give great care
To be a good employer
To live within our means
To work more collaboratively
To provide strong leadership
2024 priorities - NLaG will have:
Integrated urgent and emergency care
Transformed outpatient services
Worked in partnership with Primary Care Networks
Reconfigured specialities on to one site where appropriate
Restructured cancer services
Created a sustainable hospital at Goole
Digital Solutions

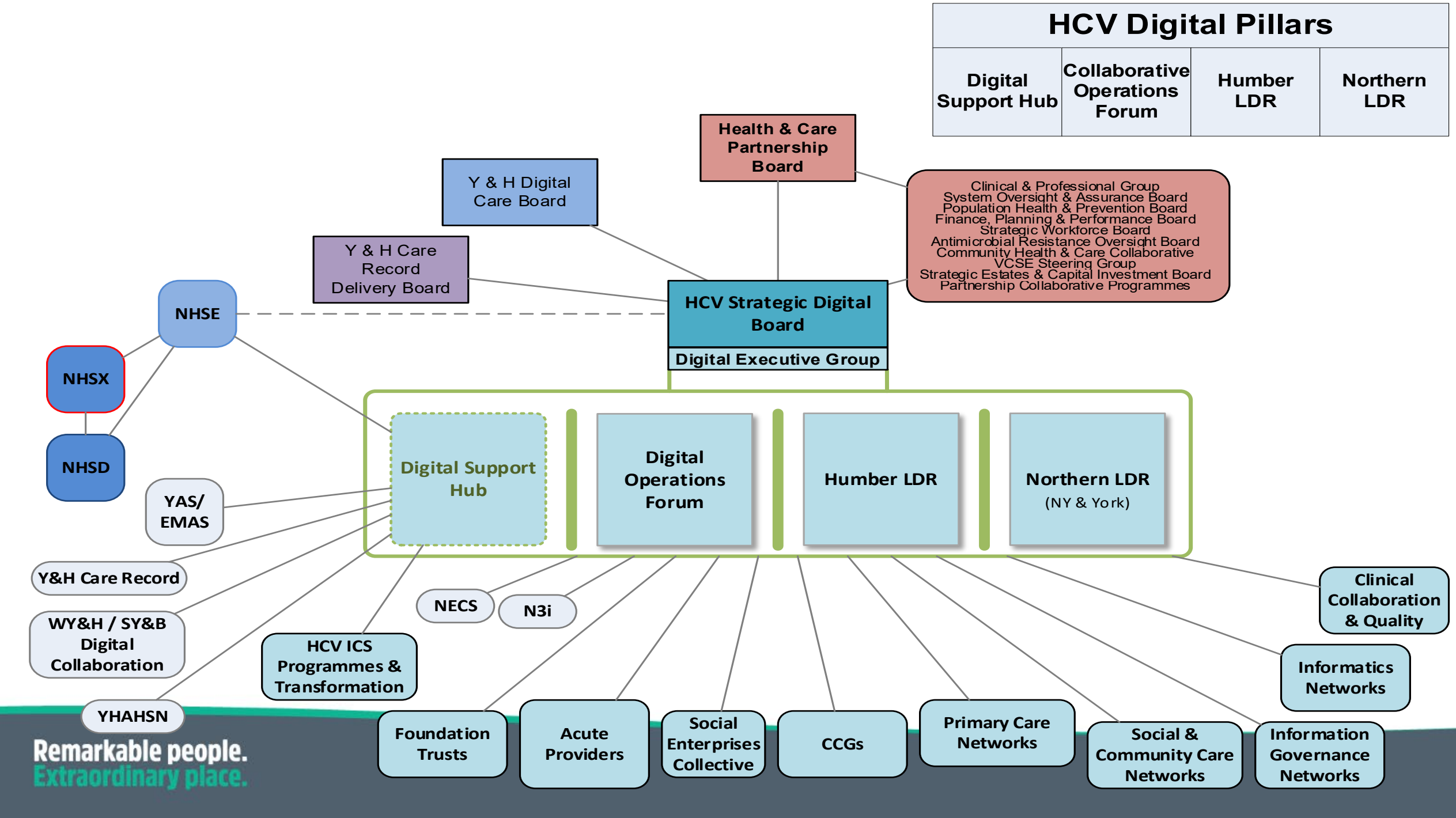

Reduce mortality
Improve recognition and management of the deteriorating patient and sepsis to improve safety of services
Improve performance against constitutional standards to improve the clinical effectiveness and safety of Trust services
Reduce waiting times and outpatient backlogs to improve the effectiveness and experience
Aspiration for NLaG to become a learning organisation, which will lead to improved safety standards and a better patient experience
Improve patient experience and effectiveness of cancer pathways
Improve patient flow through NLaG's hospitals will result in safer, more effective care delivery


Horizon one
Establishing the foundations
(2021 - 2022)
People – building digital literacy
Processes – redesigned for digital first operations
Technology – modern processing and devices
Information – information that is accurate and is delivered in real time to enable algorithms to be run to present predictions for future decision making
EHR / EPR - connect to community ICS, upgraded PAS, workflows reducing duplication, a detailed plan for "one record of truth" - one patient one record'
Horizon two
Evolution
(2022 - 2023)
Out of hospital care – Transform patient care (virtual visits, online access to patients, and digital communication helping to make work life better for those delivering care and supporting care providers)
Patient experience – improvement of digital literacy for end users
Horizon three
The Digital Hospital
(2023 - 2024)
Re-imagine the future - (new hospital, command centre, paperless)
Expand integrated systems - such as Building Information Management Systems and AI

Hull University Teaching Hospitals NHS Trust

Annex 2b
Digital Strategy (Future)

HCV ICS Digital Governance Structures and Strategic approach


HCV Digital Pillars
Digital Support Hub
Collaborative Operations Forum
Humber LDR
Northern LDR
Health & Care Partnership Board
Y & H Digital Care Board
Y & H Care Record Delivery Board
Clinical & Professional Group
System Oversight & Assurance Board
Population Health & Prevention Board
Finance, Planning & Performance Board
Strategic Workforce Board
Antimicrobial Resistance Oversight Board
Community Health & Care Collaborative
VCSE Steering Group
Strategic Estates & Capital Investment Board
Partnership Collaborative Programmes
NHSE
HCV Strategic Digital Board
Digital Executive Group
NHSX
NHSD
Digital Support Hub
Digital Operations Forum
Humber LDR
Northern LDR
(NY & York)
YAS/ EMAS
Y&H Care Record
WY&H / SY&B Digital Collaboration
YHAHSN
HCV ICS Programmes & Transformation
NECS
N3i
Clinical Collaboration & Quality
Informatics Networks
Information Governance Networks
Social & Community Care Networks
Primary Care Networks
CCGs
Social Enterprises Collective
Acute Providers
Foundation Trusts
Remarkable people.
Extraordinary place.

Our Healthcare Strategic Priorities

NHS Long Term Plan	HCV Digital Strategy Priorities	HCV Digital Fast Forward Plan	HCV 2021-22 Transition Priorities	NHS 2021-22 Planning Guidance	HCV 2021-22 Strategic Objectives	Eleven Cross Cutting Outcomes
Reduce Inequalities	Citizen Involvement	Leadership & Governance	Citizen Centred	Staff Wellbeing & Recruitment	Pandemic Response	Citizen Centred (& Personalised Care) A
Pop Health Management	Acute System Levelling	Invest in People	C-19 Response	Vaccine Programme	Deliver Operating Plan Staff Wellbeing PCN Capacity Increase Prevent Admissions Improve Waiting Time Cancer Services Plan Third Sector Support Inequalities Priorities Finance Plan & Control Public Health	Reduce Inequalities (& Citizen Digital Enabling) (& Digital Inclusion) B
Bring Primary & Community Care Closer	Device Updating	Information Management, Security and Privacy	Restore Services	Build on Transformational Learning (& Elective/Out Patients) (& Cancer) (& Mental Health)		Prevent Admissions (& Pop Health) (& Community & PCNs) (& Personalised Care) (& Third Sector Support) C
More Personalised Care (Prevent Admission)	Cyber Essentials	Infrastructure Investment	Transform Care Services			
Cancer Rapid Diagnosis	Appoint CDIO	Digital Skills	Inequalities & Inclusion Develop Pop Health	Expand Primary Care (Inequalities) (Improve Access)	Leadership Development People Plan Equalities Population Health Acute Services Progs	Transform Cancer Services D
Speedier Access to Mental Health Services	Governance Definition		Connect Health & Care	Community & Emergency Department Provision (Prevent Admission)		Transform Mental Health Services E
Single Clinical Assessment Service	Adopt HIMSS Maturity		Strong Foundations	Work Collaboratively	Transition to New ICS	Digital First and Total Digital Provision (& Connected Care Record) (& Maturity) (& Levelling) (& Infrastructure – Devices, Security, Etc) F
Digital First Primary Care	5 Year Investment Plan					
Fully Digital Trusts						
Expand Primary Care						Governance & Strategic Focus G
Invest in Workforce						Workforce Investment (& Leadership) (& Digital Specialisms) (& Digital Literacy) H
Integration & Collaboration						Integrate & Collaborate I
Investment Planning						Investment Planning J
						C-19 Recovery (& Elective/Out Patients) K

NHS
Hull University Teaching Hospitals
NHS Trust

Current ICS Digital Priorities

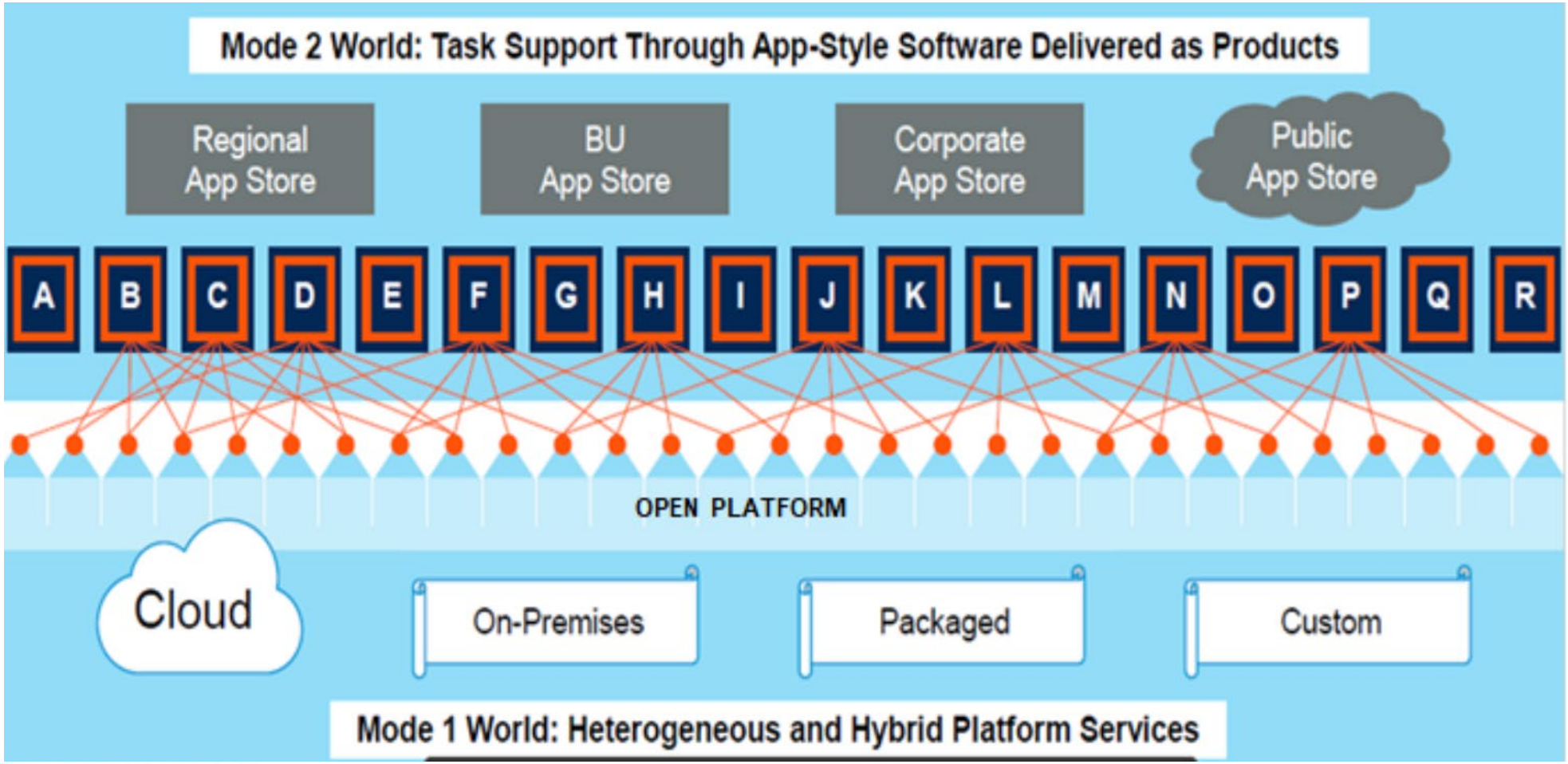
Hull University Teaching Hospitals NHS Trust

HCV - Digital Commitments Matrix

31 Active Workstreams

Ref	Priority	Work Stream	Owner	Lead
1	1	Inclusion Schemes	CT	DM
4	1	eHealth Record Strategy (EPR)	DR	
17	1	Divert demand from ED (X Ref Referral Management)	JM	[DB]
21	1	Regional Data Set Building (YHCR in HCV)	JM	
25	1	Maternity System	AW	[BC]
26	1	Digital First Primary Care	JM	
27	1	Diagnostics - Digital Development	TS	[DB]
28	1	Digital Mental Health Provision	LR	[MC]
29	1	Digital Eye Care . (Moving in-hospital services into community)	JM	
30	1	Humber Acute Services Review Support	TS	
38	1	Video Consultation - 2022 and Beyond	AW	[DB]
41	1	Waiting Well - Risk Stratification	TS	

ICS EPR Strategy



Tier 2 ICS Digital Priorities

6	2	Frailty Service Design	DR	
8	2	Standardised Referral Management Solution (Inc UEC)	AW	
16	2	Data Mart/Warehouse Roadmap	SM	
18	2	Combined Intelligence & Insight (BI)	SM	
32	2	Community Diagnostics - Digital Development	JM	
34	2	Care Home Digitisation/Upskilling	AW	[EN]
35	2	Clinical Messaging (NE Lincs CCG for ICS)	JM	
42	2	Community/Social Care Digitisation	AW	[FA]
43	2	Digital Red Book (Child Health Record)	AW	[BC]
44	2	PHM - Digital Collaboration	SM	
45	2	Virtual Wards	AW	[JMa]
46	2	Common Data Standard - Coding	LR	

Hull University Teaching Hospitals NHS Trust

Annex 3 – Unified Tech Fund Bids

Latest stage of HCV ICS bids to NHSx National digital funding offer

Funding Type	Intended Organisation	Deadline	Lifespan	Match Funding
UTF - ERTF (TIF - Elective Recovery) (Classified as: - Smart Triage & Patient Management - Productise Improvement - Growing Capacity)	Elective and Outpatient Providers	Thu - 14/10/21 (NHSE) Fri - 29/10/21 (NHSX)	Multi Year	No
UTF - Frontline Digitisation (Classified as: - Seed Funding - Aspirant - Infrastructure)	Secondary Care Mental Health Community Trusts Ambulance Trusts ICS CIC	Fri - 15/10/21	Multi Year	Yes
UTF - Digital Maternity	ICSs (LMS's)	Thu – 15/11/21	21-24	No
UTF - Digital Productivity	NHS VCS CICs CCGs ICSs Arm's Length Partners	Tue - 30/11/21	21-22	Yes
UTF - Cyber Security Infrastructure	NHS Trusts CCGs	Thu - 23/12/21	21-22	No
UTF - Diagnostics	Imaging or Pathology Networks	Thu - 23/12/21	21-22 (21-24)	No
UTF - Shared Care Records	ICS	Tue - 22/03/22	21-22	Optional
UTF - Digital Child Health	TBA	TBA	TBA	TBA
ETTF – Estates & Digital	NHS	N/K	N/K	No

NHS
Hull University Teaching Hospitals
NHS Trust

Bid or Funding Source		Bid Value-£k	Cap-£k	Rev-£k
Community Diagnostic Hubs	HCV	£400		
Digital Social Care Records (DSCR)	HCV	£50		£50
Inflammatory Bowl Disease App	HUTH/NLaG	£190	£190	
Health Hub Development	H&DFT	£24	£2	£22
Perioperative Transformation - PKB Integration	Y&SFT	£500	£0	£500
User Centric Design SMI	TEWV (HCV)	£100		£100
Diagnostics:	*HCV*	*£2,899*	*£2,899*	
Image Sharing Infrastructure		£1,000	£1,000	
LIMS Interop - Winpath - ICE Integration		£115	£115	
LIMS Interop - Winpath MSC Conversion		£600	£600	
LIMS Interop - Legacy data Access		£120	£120	
Home Reporting Stations		£445	£445	
Home Reporting Stations (Breast)		£36	£36	
Image Sharing - HH devices		£60	£60	
Image Sharing - RIS Connect		(2022)		
Image Sharing - PCN Referral		£173	£173	
Image Sharing - Current Kit Upgrade		£350	£350	

NHS
Hull University Teaching Hospitals
NHS Trust

TIF (ERFT) H2 Elective Recovery Digital Funding	*£6,093k*
Digital Elements of Castle Hill Build	£300
Digital Elements of York Build	£377
Digital Elements of Harrogate Build	£300
Community Eye Care (Optom)	£100
HCV Connected for Health	£1,200
Improved Device Maturity	£1,104
Improved Patient Support - Digital Apps (ORCHA)	£850
Y&SFT (York) Theatre Booking System	£100
HCV wide PKB Licenses and Supporting Resource	£1,032
Somerset Cancer Solution in Y&SFT (York)	£80
System Level Video Consultations	£650

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Workforce, Education & Culture Committee (WECC)	
Meeting date:	11th October 2021
Title:	Responsible Officer Report 2020/21
Presented by:	Mr Peter Sedman, Deputy Chief Medical Officer on behalf of Dr Makani Purva – Chief Medical Officer/Responsible Officer
Author:	Oliver Miskin, Senior e-Medical Workforce Officer on behalf of Dr Makani Purva – Chief Medical Officer/Responsible Officer
Purpose:	The Responsible Officer has a duty, defined in the 'Framework for Quality Assurance of Responsible Officers and revalidation' (NHS England and NHS Improvement, first published in April 2014), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission and NHS England and NHS Improvement.
Recommendation(s):	The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is in compliance with the regulations.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

RESPONSIBLE OFFICER REPORT 2020/21

1. Purpose of the Paper

The Responsible Officer has a duty, defined in the 'Framework for Quality Assurance of Responsible Officers and revalidation' (NHS England and NHS Improvement, first published in April 2014 and updated in February 2019), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission and NHS England and NHS Improvement. The Framework for Quality Assurance, in defining the purpose of the annual report, states that: "The Trust Board should understand its responsibilities under the Responsible Officer Regulations. It should also understand the appraisal and revalidation process within the organisation, and be aware of progress in establishing and maintaining a successful revalidation programme for medical staff. NHS England and NHS Improvement requires that the Trust Board demonstrates fulfilment of these requirements by formally acknowledging receipt of this paper, and returning a statement of compliance signed by the Chairman."

2. Background

Following public and professional concern about the regulation of the medical profession a new system of assurance was introduced from the end of 2012. A Statutory Instrument passed in 2010 mandates the appointment of a 'Responsible Officer' for each organisation employing Doctors. The Responsible Officer has a duty to confirm that the Doctors for whom they are responsible are fit to practise, and comply with General Medical Council guidance on Good Medical Practice. This Statutory Instrument is the legislation underpinning the General Medical Council process of revalidation, which applies to all Doctors in the United Kingdom who require a licence to practise. A licence is required by all Doctors working at Hull University Teaching Hospitals NHS Trust. Revalidation is the process by which Doctors have to demonstrate to the General Medical Council that they are fit to practise. The purpose of revalidation is to assure patients and the public, employers, and other healthcare professionals that licensed Doctors are up to date and working appropriately. Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations, and it is expected that the Trust Board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking that there are effective systems in place for monitoring the conduct and performance of their Doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their Doctors; and
- ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Previous reports outlining GMC revalidation and appraisal at Hull University Teaching Hospitals NHS Trust have been submitted to the Trust Board since 2013/14 and to the Quality Committee.

The Trust has chosen to separate performance management from appraisal, thus allowing a formative and developmental appraisal process to operate alongside the assurance framework. The appraisal system is described in more detail in section 5. Performance management and assurance remains the responsibility of clinical managers, and is described in section 6.

3. Governance Arrangements

Recommendation to the General Medical Council for revalidation of individual Doctors is the responsibility of the Responsible Officer. The Responsible Officer is supported in discharging this duty by a Revalidation Panel consisting of representation from senior clinical management, the Senior Appraiser Team, a representative from the Local Negotiating Committee, the HUTH Revalidation Team and the Head of HR Services. The Panel meets on a monthly basis. Appraisal and revalidation processes are overseen by the Revalidation and Appraisal Committee, chaired by the Responsible Officer. This committee reviews progress against appraisal and revalidation targets, and determines actions to address failures to meet these targets. The Revalidation and Appraisal Committee meets monthly and reports by exception to the Quality Committee.

The Trust is required to maintain an accurate record of Doctors with a prescribed connection to the organisation (as a Designated Body). This is done using the online GMC Connect system, and is kept up-to-date by the HUTH Revalidation Team. Doctors transferring between Designated Bodies are required to provide their new RO with details of their previous Designated Body, so that information can be exchanged between the two ROs. The Trust has developed a standard form to respond to requests for information from other Designated Bodies.

Dr Makani Purva is the Trust's appropriately trained and appointed Responsible Officer for the Hull University Teaching Hospitals NHS Trust Designated Body and for Dove House Hospice Designated Body via a Service Level Agreement (SLA).

The Trust is required to complete an annual report (with quarterly updates) to NHS England and NHS Improvement describing the extent of compliance with its obligations as a Designated Body. This report is called the Annual Organisational Audit (AOA). Due to the Covid-19 global pandemic, the National Responsible Officer for NHS England and NHS Improvement, Professor Stephen Powis wrote to all Responsible Officers in England in March 2020 to advise that NHS England and NHS Improvement had made the decision to cancel the 2019/20 Annual Organisation Audit with Trusts not expected to submit a return. In April 2021, a further update to Responsible Officers and Medical Directors in England was provided to inform them that although the 2020/21 AOA exercise had been stood down, organisations would still be able to report on their appraisal data in their annual Board report and Statement of Compliance.

Policy and Guidance

Revalidation and appraisal is conducted in accordance with the Revalidation and Appraisal for Medical Staff policy, which underwent a full review and update in February 2020. A Medical Appraisal Escalation Policy, which sets out the process to be followed when a Medical member of staff (with a prescribed connection to Hull University Teaching Hospitals NHS Trust) does not undertake an appraisal within the 12 month period required is also in place and underwent a full review with an updated version published in October 2019.

In order to comply with Maintaining High Professional Standards in the NHS (HSC 2003/12), the Trust has in place the Maintaining High Professional Standards Policy for Medical and Dental Staff and supporting procedures. The policy and supporting procedures are also based on the NHS Resolution (formerly National Clinical Assessment Service, NCAS) document 'Back on Track' and is in line with the Department of Health document 'Tackling Concerns Locally'.

4. Restrictions, Remediation, and Investigations

Hull University Teaching Hospitals NHS Trust was the Designated Body for 640 Doctors in 2020/21; this included 484 Consultants, 47 Specialty and Associate Specialist (SAS) Doctors and 109 other non-training Doctors (mainly short term Trust Grade Doctors).

In 2020/21, there were no Doctors for whom the Trust is the Designated Body who were either under active investigation by the General Medical Council, or who had current notices on their licence to practise as a result of previous GMC investigations.

It is important to note that Doctors in training working at the Trust who may either be under investigation by the GMC or who have warnings on their licence fall under the responsibility of Health Education England (Yorkshire and the Humber), with the aforementioned acting as their Designated Body. Doctors in training are therefore not included in these statistics.

During 2020/21, 5 Doctors with a prescribed connection to Hull University Teaching Hospitals NHS Trust were under internal investigation; 4 out of 5 of these cases are now closed.

The outcomes of the 4 investigations that are now closed are summarised below:

Grade	Type of Investigation	Investigation Outcome
Consultant	Disciplinary	Closed - No Further Action
Consultant	Grievance	Withdrawn
Consultant	Disciplinary	Closed - No Further Action
Non-Consultant	Disciplinary	Closed - No Further Action

5. Medical Appraisal

Appraisal rates

In response to the Covid-19 global pandemic, the national Responsible Officer (RO) for NHS England and NHS Improvement, Professor Stephen Powis wrote to all Designated Bodies and ROs in the UK to advise that with immediate effect (in March 2020), it was strongly recommended that medical appraisals were suspended until further notice, unless there were exceptional circumstances agreed by both the Doctor and their Appraiser. This was to help to immediately increase capacity in the Medical workforce by allowing Doctors to focus on clinical practice and deal with the expected clinical pressures that Trusts/Organisations would face.

As a result of the NHS England and NHS Improvement advice received, the RO for Hull University Teaching Hospitals NHS Trust made the decision to cancel medical appraisals across the Trust with effect from March 2020. The appraisal process remained cancelled until March 2021, with no requirement for Doctors to catch up on an appraisal that was missed/cancelled in 2020/21 due to the pandemic.

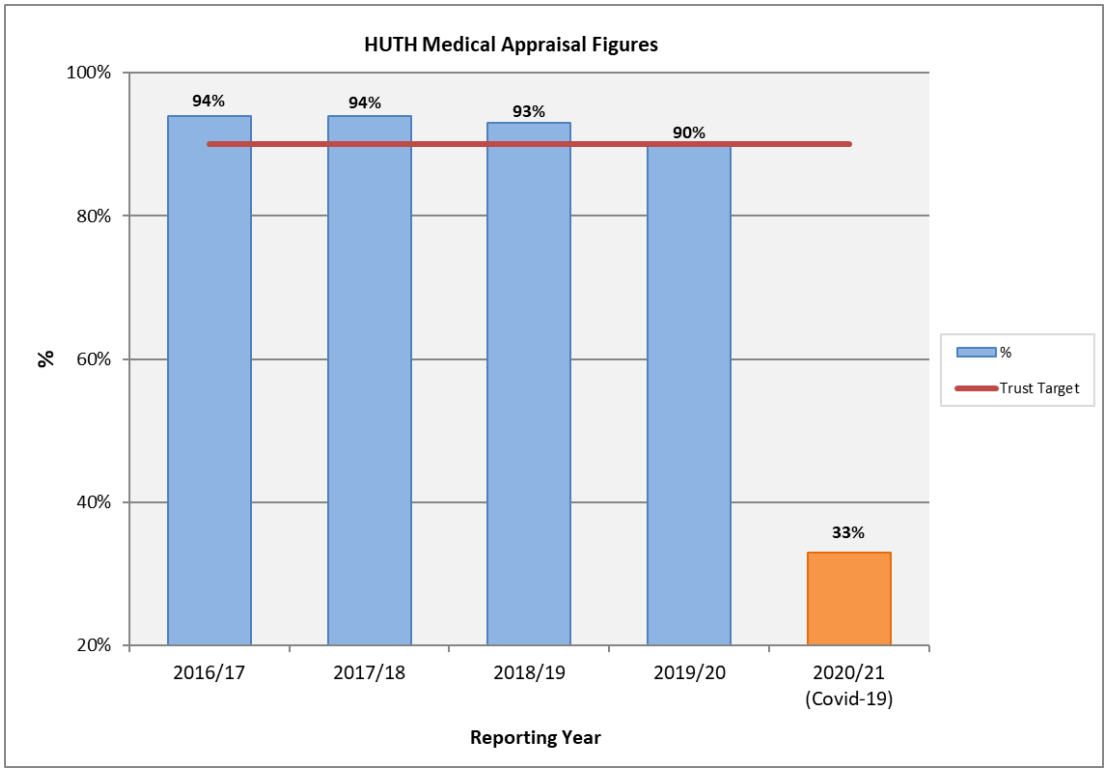
The GMC re-commenced putting Doctors under notice of their revalidation submission dates from April 2021 and advised that appraisal should continue to be managed and delivered locally. It was agreed at the Revalidation & Appraisal Committee in April 2021 that all Doctors are expected to participate in the appraisal process in the appraisal year 2021/22.

The Trust's medical appraisal figures are discussed monthly at every Health Group performance meeting, as well as at the monthly Revalidation and Appraisal Committee chaired by the Responsible Officer. It is to be noted that the Medical Appraisal Escalation policy (referred to in section 3) was suspended during 2020/21 as a result of the Covid-19 pandemic and subsequently the cancellation of medical appraisals. This will be re-introduced in 2021/22.

The table below provides further information on medical appraisals in 2020/21 and shows that 211 (33%) of appraisals were undertaken in 2020/21, with 429 (67%) not undertaken but were an agreed exception (due to Covid-19):

Name of organisation:	Hull University Teaching Hospitals NHS Trust
Total number of Doctors with a prescribed connection as at 31 March 2021	640
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	211
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	429
Total number of agreed exceptions	429

Prior to the cancellation of medical appraisals in 2020/21, Hull University Teaching Hospitals NHS Trust had a medical appraisal completion rate that was consistently above, or in-line with the Trust target of 90%, with the exception of 2020/21. This is shown in the 5 year graph below:



As a process of facilitated self-review, medical appraisal offers an opportunity to help Doctors reflect on their health and wellbeing to the extent that this is relevant to their ability to provide high-quality, safe care. While there is evidence that this has already been a valuable component of many appraisals, it is of particular importance in the current pandemic response.

Appraisers

The Trust currently has 60 'active' trained Appraisers, including 2 'Senior Appraisers'. The Senior Appraisers are responsible for ensuring that the training of the Appraiser team is up-to-date, delivering training to new Appraisers and the Quality Assurance of appraisals. Each Appraiser is responsible for carrying out up to 10 appraisals per year. There is an annual Appraiser Network meeting which provides the opportunity for the Trust's medical Appraisers to share best practice and receive updates on local and national processes surrounding

revalidation and appraisal. Due to the Covid-19 pandemic and cancellation of all non-essential meetings across the Trust, the 2019/20 Appraiser Network Meeting was cancelled. In 2020/21 and following preparation for the restart of appraisals, there were 2 virtual Appraiser information sessions that took place in February 2021, which provided Appraisers with updates on the appraisal process and requirements in the context of the pandemic.

Quality Assurance
Every Doctor being appraised completes an anonymous feedback form on the appraisal process and their Appraiser. To complete the appraisal process, every Doctor must complete this feedback questionnaire otherwise their appraisal will remain incomplete. This feedback is then collated and an anonymous report is provided to Appraisers for inclusion in their own appraisal as supporting information for appropriate discussion and reflection.

There is a bi-annual revalidation bulletin which is circulated to all Doctors with a prescribed connection to Hull University Teaching Hospitals NHS Trust. This bulletin provides updates from the Responsible Officer, Senior Appraiser Team and HUTH Revalidation Team and provides Doctors with the opportunity to raise any queries they may have in relation to the revalidation and appraisal process. Throughout the pandemic, updates have been provided to Doctors on behalf of the Responsible Officer and HUTH Revalidation Team to keep them informed on the revalidation and appraisal process, requirements and any such changes.

The Responsible Officer, Senior Appraiser Team and HUTH Revalidation Team attend quarterly NHS England and NHS Improvement regional RO Network and Medical Appraisal Lead (MAL) Networks, which provide updates from NHS England and NHS Improvement and the GMC on matters surrounding revalidation and appraisal. These have continued throughout the pandemic in the form of virtual meetings.

All appraisal inputs and outputs of those Doctors due for revalidation are reviewed by the Senior Appraiser Team and HUTH Revalidation Team prior to the monthly Revalidation Panel in the form of a revalidation checklist. Any concerns are raised by the Senior Appraiser Team/HUTH Revalidation Team at the monthly Revalidation Panel chaired by the Responsible Officer for appropriate discussion and action. Reflections on good or bad practice in completing these outputs are then used in the ongoing Appraiser training programme.

Clinical Governance
The Trust continues to provide suitable governance and performance information for individual Doctors to support appraisal. Trust information about complaints, claims, serious incidents, is managed using the DATIX system. Doctors are sent information specific to them in relation to claims, complaints and Serious Incidents (SI's) by the HUTH Revalidation Team in the months leading up-to their annual appraisal. Doctors are also able to request a report (at any time) to support appraisal.

Doctors who provide work outside of the NHS e.g. via the private and/or independent sector are required to provide evidence of no complaints/serious incidents in their annual appraisal, as well as declaring these roles in their scope of work. Similarly, if there are any complaints/serious incidents, these must be declared and discussed as appropriate.

6. Monitoring Performance

All Doctors being considered for revalidation must demonstrate participation in regular appraisal. However appraisal in itself is neither an objective assessment of a Doctor's performance, nor of their compliance with Trust policies and procedures. The Revalidation Panel therefore also requires confirmation from each Doctor's clinical manager that there are no concerns about performance or conduct. At present, this takes the form of a signed statement

from the relevant Health Group Medical Director, based on personal knowledge and information from line managers. In any case the revalidation process (occurring as it does once every 5 years) should not be the point at which concerns first come to light.

7. Revalidation Recommendations

Following discussions with ROs and Doctors across the UK, The GMC issued communication in March 2020 to state that as a result of the Covid-19 pandemic, Doctors who were due to revalidate between March 2020 and March 2021 would have their revalidation submission dates moved back by one year. The GMC made this decision to give ROs and Doctors more time to reschedule and complete appraisals in the hope that this would support the health service to prioritise clinical care for patients during the coronavirus pandemic. To accommodate flexibility in making recommendations, all Doctors whose dates were moved as part of the GMCs pandemic response were also put under notice. This meant that ROs could submit recommendations to revalidate those Doctors at any time up to their new submission date. Further communication was provided by the GMC in October 2020 to advise ROs and Doctors that they had taken the decision to extend the flexible approach to revalidation they offered doctors earlier in 2020, to those who were due to revalidate between March and July 2021 and who had not had their dates previously rescheduled. The GMC moved back the revalidation dates by four months and alongside this offered Doctors the opportunity to revalidate at any time from autumn 2020 through to their new date to alleviate pressure to meet revalidation requirements during the winter months.

The Trust made 51 revalidation recommendations to the GMC between 1st April 2020 and 31st March 2021. The Responsible Officer has three options in making a recommendation: recommendation for revalidation (positive recommendation), deferral, or failure to engage. It is not possible to recommend 'non-revalidation'. The Trust has not made any notifications of failure to engage/non-engagement. The breakdown of recommendations is shown below:

Recommendation	Number of Recommendations submitted
Recommendation to revalidate	51
Defer	0
Non-engagement	0
Total Recommendations	**51**

In summary, 100% of recommendations submitted by the RO in 2020/21 were for a positive recommendation.

8. Recruitment and engagement background checks

The Trust's Human Resources department has in place a system for checking identity, current and previous GMC conditions or undertakings, appropriate recent references, details of last (or current) Responsible Officer, qualification check, and police clearance. The Responsible Officer continues to use an 'RO Transfer Form', to be completed by the RO from the prospective employee's previous organisation: this includes revalidation date, date of last appraisal and any concerns arising from appraisal, details of ongoing or previous GMC/NHS Resolution investigations (formerly NCAS), local conditions or undertakings, and any unresolved performance concerns.

9. Responding to Concerns and Remediation

Revalidation should not be the expected route for identifying concerns about an individual Doctor's conduct or capability, occurring as revalidation is only every 5 years. Appraisal may

sometimes identify areas for improvement, but again it is unlikely that serious concerns will come to light purely through appraisal, which is principally a formative and developmental process. More commonly problems will be identified either through investigation of a specific incident, or following expression of concern by staff or patients. Please refer to section 4 of this report for information relating to this restrictions, remediation and investigations.

Where there is concern about a Doctor's conduct or capability this is managed under the Trust's Maintaining High Professional Standards Policy. In all cases involving capability, and where appropriate in cases of possible misconduct, the investigation process would be conducted in consultation with NHS Resolution (formerly the National Clinical Assessment Service, NCAS). If misconduct is substantiated a range of disciplinary sanctions, ranging from reflective learning to dismissal are available. If concerns regarding capability are substantiated, an appropriate course of action developed in conjunction with NHS Resolution may be put in place. In the majority of capability cases the first option is to consider remediation and support.

In addition to local Trust investigations Doctors may also be subject to investigation by the GMC. Where appropriate. this is as a result of the Trust reporting the result of a local investigation to the GMC, but more commonly the Doctor has been referred to the GMC by someone else (patient, relative, previous employer, etc.). The Trust cooperates fully with any GMC investigation into employees.

10. Conclusions

- The Trust has an appointed Responsible Officer, who is trained and supported to perform the role

- The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on revalidation

- The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice

- There is a robust appraisal system in place, which is developmental and formative in nature

- Due to the ongoing Covid-19 pandemic, medical appraisals in the Trust were cancelled in 2020/21 with with no requirement for Doctors to catch up on an appraisal that was missed/cancelled during this period. All Doctors are expected to participate in the appraisal process in the appraisal year 2021/22

- The Trust has a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required 12 month period are given the appropriate steps to follow. This policy has been ratified by the Local Negotiating Committee (LNC) - It is to be noted that this policy was suspended during 2020/21 as a result of the Covid-19 pandemic and subsequently the cancellation of medical appraisals. This will be re-introduced in 2021/22

- Maintaining a high level of appraisal rate is reliant on the continued implementation of an electronic platform, continuing essential administrative support and the Trust having sufficient numbers of trained medical Appraisers

11. Recommendations

The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is in compliance with the regulations. This must be signed and returned to NHS England and NHS Improvement.

Appendix 1

Designated Body Statement of Compliance

The Board of Hull University Teaching Hospitals NHS Trust has reviewed the content of this report and can confirm the Organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013):

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Yes - Dr Makani Purva is the Trust's appropriately trained and appointed Responsible Officer for Hull University Teaching Hospitals NHS Trust and Dove House Hospice for 2020/21

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Yes

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   Yes

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

   A peer review did not take place in 2020/21 due to the Covid-19 pandemic and the cancellation of appraisals and deferment of a large proportion of revalidation dates by the GMC. It is anticipated that a peer review will take place in 2021/22.

6. A process is in place to ensure locum or short-term placement Doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

   Yes

7. All Doctors in this organisation have an annual appraisal that covers a Doctor's whole practice, which takes account of all relevant information relating to the Doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any

other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the Doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change.

Yes – however, due to the ongoing Covid-19 pandemic, medical appraisals in the Trust were cancelled in 2020/21 with no requirement for Doctors to catch up on an appraisal that was missed/cancelled during this period. All Doctors are expected to participate in the appraisal process in the appraisal year 2021/22

8. Where in Question 7 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Yes

9. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

10. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Yes

12. The appraisal system in place for the Doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

13. Timely recommendations are made to the GMC about the fitness to practise of all Doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

14. Revalidation recommendations made to the GMC are confirmed promptly to the Doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the Doctor before the recommendation is submitted.

Yes

15. This organisation creates an environment which delivers effective clinical governance for Doctors.

Yes

16. Effective systems are in place for monitoring the conduct and performance of all Doctors working in our organisation and all relevant information is provided for Doctors to include at their appraisal.

Yes

17. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

18. The system for responding to concerns about a Doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the Doctors.[2]

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about Doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Yes

19. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) Doctors connected to your organisation and who also work in other places, and b) Doctors connected elsewhere but who also work in our organisation.[3]

Yes

20. Safeguards are in place to ensure clinical governance arrangements for Doctors including processes for responding to concerns about a Doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes

21. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all Doctors, including locum and short-term Doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Hull University Teaching Hospitals NHS Trust**

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item	8.4	**Meeting**	Trust Board	**Meeting Date**	09 November 2021
Title	Royal College of Physicians Cardiology Review				
Lead Director	Dr Purva – Chief Medical Officer				
Author	Leah Coneyworth – Head of Effectiveness and Improvement				
Report previously considered by (date)	Presented to the Quality Committee in October 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 recommended to:

- Receive the final report from the Royal College of Physicians Cardiology Peer Review and the supporting improvement plan.
- Decide if sufficient assurance has been received in relation to the improvement actions undertaken and planned.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
ROYAL COLLEGE OF PHYSICIANS CARDIOLOGY REVIEW

1. PURPOSE

The purpose of this report is to provide the Trust Board with the final report from the Royal College of Physicians Cardiology Peer Review and the improvement plan.

2. CARDIOLOGY PEER REVIEW

In August 2020, the Trust approached the Royal College of Physicians (RCP) Invited Reviews (IR) team following concerns identified via the Freedom to Speak up Guardian due to the poor working relationships between the interventional and non-interventional consultant cardiologists, a potential weakness of insight into patient safety concerns and the overall performance within the cardiology department.

The Trust and Invited Review team agreed a process to review a selection of clinical cases to understand the management of protocols and pathways; review the service design and level of provision for cardiology; a cultural review including the quality of team working, leadership and behaviours within the department; and the quality of clinical governance arrangements in place to support and maintain oversight of the service. These areas formed the basis of the Terms of Reference.

The review took place in December 2020. In January 2021, the Trust received a letter providing immediate feedback and actions, which the Trust began work on immediately as detailed in section 3 of this report. The draft report was received in July 2021, the Trust provided a factual accuracy response and the final report was received 11 August 2021.

A task and finish group (includes members of the Cardiology Service) was established, with the first meeting taking place in June 2021 to address all recommendations from the report and manage the delivery of the communications plan. The full report and communication plan was presented to the Executive Management Committee and Quality Committee in September and October 2021. The Trust Board was also informed of the final report in the September 2021 Integrated Performance Report.

The full report is attached at Appendix A. It must be noted that some elements of this report have been redacted to ensure patient confidentiality is maintained.

3. IMPROVEMENTS TO THE CARDIOLOGY SERVICE

The report commended the staff for their help and support in the co-ordination of this review and thanked staff for their frank and open way they engaged with the interviews to help inform the report findings and recommendations. The Cardiology Service is committed to providing safe and effective care to all patients and a positive culture for staff, this was reflected in their engagement with the review and with the improvements made since January 2021.

A significant amount of work has been and continues to be undertaken by the task and finish group with updates and changes made week by week. This section of this report will provide an update against the key conclusions made at the time of the review and the progress made at the time of writing this report to the Trust Board.

In summary, the key changes that have been made since the review to ensure patient safety a greater service resilience, include:

- The implementation of a standalone Cardiology Leadership with the appointment of the Associate Medical Director, two Clinical Leads, the Clinical Governance Lead supported by two new HC&V network clinical leads.

- Strengthened governance arrangements with improved clinical engagement, re-establishment of the Cardiology Mortality and Morbidity Meetings, case reviews, audit cycles and complaint analysis
- Improvements regarding the management of incidents and Serious Incidents both locally with a streamlined potential SI process that is quicker, more transparent, and in line with agreed departmental policy and Trust policy and at a Trust level with the introduction of the Weekly Patient Safety Summit.
- Service strategy is being developed at pace, with a weekly working group including clinical, operational, and nursing leadership – in turn informing a wide scale review of consultant job planning
- Engagement with the Consultants leading to Organisational Development support and a cultural improvement programme and team building sessions
- Improvement in the trainee survey results
- The detailed recommendations from the report are being built into each element of service development. Agreed plans to develop a dedicated cardiac ward at HRI with a dedicated ECHO room and a new ECHO machine to improve the quality of the echocardiograms. This will also allow enhanced cardiology input into HRI, trainee supervision, and fostering a much greater involvement of cardiology in the acute patient flow from front door to discharge, and greatly improved echocardiography services at HRI
- Mr Stuart Hall, Chair of the Trust Quality Committee is fully briefed on the improvement plan, progress made and members of the cardiology team attended the October 2021 Quality Committee to answer questions from the Chair and the committee
- These programmes are driven by a weekly working group in cardiology with regular oversight from the CMO / Deputy CMO, Medicine Health Group Board, and the Trust Chairman.
- The Department acknowledge the scope and degree of work still to be undertaken, particularly around ensuring longer term cultural change within the service. The degree of engagement with strategic development of the service, which was less prevalent before indicates a service and team that is looking to the future rather than undertaking cycles of inter-personal conflict characterised in the report.

The table below, provides more detail on the actions and improvements made. The full Cardiology Improvement Plan is also attached at Appendix B.

December 2020	**November 2021**
The key themes from the clinical record review included the need for formalised MDT discussions to support and challenge clinical decision making, and to expedite patients where urgent treatment is required. There is a need to better support the timely review of patients, and to ensure that their information on the administration databases is accurate so that treatment and follow up are logged and appointed appropriately. **(Recommendations 6 and 9)**	There currently are four MDTs meetings in place with established and agreed Terms of reference. The meetings are well embedded in the jobs plans, have evidence of high levels of attendance, formal minutes, and supported by appropriate software. The department is exploring daily MDT to improve speed of decision making further - using the Leeds model as a benchmark and will be feasibility assessed during the ongoing job plan round. The waiting times are continually under review and monitoring of performance is in place within the Cardiology service and at Trust-level including the Executive Performance Reviews, Performance and Finance Committee and the Trust Board. The appointment of a cardiology clinical lead for the cath labs, along with a 'catheter lab user group (CLUG) allows week on week cath lab

	utilisation to be planned between clinical and operational teams to maximise cath lab utilisation. The CLUG has a ToR to improve cath lab flow, efficiency and quality and reports to the AMD and DGM directly. Cardiology out-patient performance continues to improve despite existing pressures across the system. The Department obtained a £28k grant from NHSI to deliver a pilot community clinic in a single PCN (River and Wolds) which has started in November 2021 to deliver additional community based activity directly in the GP surgery.
In most modern services a cardiology patient would expect to be seen by a consultant cardiologist within the first 24 hours of being admitted and for a daily consultant led ward round to take place thereafter. Further to this, the responsibility of the most junior trainees managing the cardiology patients at the HRI site, with limited consultant support is deemed unacceptable both from a patient care point of view and doctors' training. **(Recommendation 7)**	Consultant cover is provided 7 days a week. Cover is also provided at HRI weekdays in the morning. However, the Associate Medical Director is undertaking a full review of the consultant job plan with oversight by the Chief Medical Officers Office. Consultant job planning sessions have been undertaken in October 2021. A follow up session has been arranged for 19 November 2021 to agree any outstanding job plans by then. The changes to consultant job plans are significant, including formation of a second general cardiology consultant on-call rota. This on-call rota will deliver senior cardiology input into HRI at weekends. Transition of the complex device on-call rota into a simple and complex device on call rota – allowing implantation of simple or complex pacemakers over weekends. Likely the most significant enhancement of cardiology input will be the development of the cardiology in-patient base at HRI – offering 7-day in-patient and in-reaching services across the HRI site, along with much higher quality provision of trainee supervision, echocardiography services, and cardiology support at the front door of the acute flow through the organisation.
The review team were also informed of the poor echocardiography facilities at the HRI site, where there is no appropriate room for the equipment causing inefficiency and unnecessary delays to patient care **(Recommendation 3)**	The service have been working with the Director of Estates and Facilities to identify an appropriate location for an echocardiography near to the inpatients at the HRI site. At the beginning of November 2021, it was agreed that there will be a dedicated Cardiac Ward at HRI with an appropriate echocardiography room, this will provide easier and quicker access for patients at HRI. A new echocardiography machine was also installed in October 2021. Although, this is in the current facilities which are not fit for purpose it will still improve quality of the echocardiograms.

	This machine will be transferred to the dedicated room as required.
There was concern from a number of staff that some patients have temporary pacing wires that are left in for too long and it would be advisable for the Trust to review a subset of cases and develop a standard operating procedure for temporary pacing wires. **(Recommendation 4)**	The standard operating procedure for acute pacing has been developed and is currently being trailed with clinicians. Cover is provided Monday to Friday and during a weekend by two operators. To eventually place this service on both a more resilient footing, and to respond to the requirements of 7 day services in the DGH's this will move to a network wide service as outlined above using the 7 cardiologists (5 from HUTH) who presently deliver a 'complex device service' and changing this to a simple and complex device service, allowing availability of consultants to implant simple devices over the weekend as outlined by the RCP. Further work is ongoing to improve the weekday and weekend pacing service as detailed on the improvement plan.
In some cases (from interviews or reviewed as part of the CRR) not all consultant staff properly participate in WHO checklists at the start and end of each procedure. **(Recommendation 5)**	An electronic audit tool is in place to record the completed WHO checklists/Local Safety Standards for Invasive Procedures (LOCSSIPs). The Chief Nurse Information Officer provides all Health Groups with a monthly performance report, which is monitored at Cardiology Governance, this is also monitored at the Trust Patient Safety and Clinical Effectiveness Committee and the Executive Performance Reviews. The service has noted an improvement in the completion of the WHO Checklists and positive feedback has been received from staff that it is working well. Performance has increased from 88.6% in May 2021 to 94.3% in July 2021 and 100% achieved in June, August and September 2021 and 99.1% in October 2021 demonstrating an overall performance of 98.4% which is very good.
There is a need to develop a clear process to investigate serious incidents that may be never events, and to consider those potential events that were raised in the interviews. Corporate oversight and with independent investigation from trained reviewers from other parts of the Trust is likely to be required. The review team heard accounts of two potential Never Events. One event related to a possible retained swab and the other where the wrong device was implanted in a patient. The Trust should consider urgently reviewing their serious incident and never event protocols to ensure that these two cases have been investigated appropriately. These matters were raised in the preliminary feedback letter and acted on by the executive.	The Trust has the Incident Reporting and Investigation Policy (CP379) which provides a clear process for staff to follow when report all incidents including potential Serious Incidents (SIs) and Never Events (NE). The Trust has also implemented a Weekly Patient Safety Summit (WPSS) which reviews all incidents reported with a rating of moderate and above, this includes potential Serious Incidents and Never Events. This provides strengthened governance arrangements and corporate oversight, with SIs and NEs agreed in conjunction with Executive Leads and members of the Health Group Triumvirates, supported by the Patient Safety Team. As part of this process an SI/NE Executive Chair is appointed and allocated support and resource

	from the Patient Safety Team who are trained in RCA and investigations. The Chief Medical Officer undertook a further review of the two potential Never Events the Royal College report refers to and it was confirmed that these incidents did not fit the criteria for a Never Event and agreed that the right course of action had been taken. The 5 remaining cases that were identified by the RCP are being reviewed in a staged process, initially a cardiology clinical review is being undertaken by the AMD and Clinical Governance lead of the 5 cases with a summary narrative to escalate to the Deputy CMO for further consideration and adjudication of the status of each case. A final report will be produced summarising the outcomes and narrative for each case.
There were several allegations of belittling, intimidation, and undermining. The review team believe this behaviour is impacting on patient care and therefore, all medical staff should be reminded of Good Medical Practice as the GMC code of conduct of how doctors must work collaboratively with colleagues. **(Recommendations 10 and 11)**	An organisational development programme is now in place within Cardiology, led by the Head of Learning and Development. This programme will focus on behaviour, team building, values and sustainability. Time-outs organised to progress 4 identified priorities each with a clinical lead and multi-disciplinary work stream members. Consultant timeout sessions agreed with Trans2Performance; dates 5th and 12th November 2021. Formal communication was also sent to the Cardiology Team on how to raise concerns from the Deputy Chief Medical Officer. No referrals have required to be made to the Maintaining High Professional Standards (MHPS). Team building has also been undertaken between the operational leads and the clinical teams with strengthened working relationships and a strong division with MDT working arrangements also with the Nursing and Physiotherapy teams. There are regular team meetings in place; however, these are to undergo a 'fresh eyes' review as detailed in recommendation 6 on the improvement plan. All available feedback for the department has been actively reviewed. The British Junior Cardiology Association (BJCA) is a key national feedback mechanism allowing SpR's to rate their training experience of their deanery. From 2019 to 2021 this has improved significantly for East Yorkshire with a very large increase in the proportion of trainees who would 'recommend this training to a younger peer'. The department has engaged in the recent HEE visit, specifically to address the concerns regarding supervision

	of cardiology middle grades at HRI. The delivery of an in-patient service there and the associated job plans of the consultant team based there will include allocated ring fenced time for supervision of middle grades and ACP's.
Job planning in the department requires urgent review of all the consultant job plans including the equitable allocation of resource across the CHH and HRI sites. There are too few specialist nurses to support the cardiology department compared to other modern cardiology services, and so it is vital that the Trust review the cardiology workforce. Additional consultants maybe needed in specific areas e.g. the management of heart failure. Despite these limitations, the review team believe new working patterns and team job planning could deliver better care for patients at HRI in the short term and we will include an example rota as an appendix in the full report. **(Recommendations 7 and 8)**	Consultant cover is provided 7 days a week. Cover is also provided at HRI weekdays in the morning. However, the Associate Medical Director is undertaking a full review of the consultant job plan. Consultant job planning sessions have been undertaken in October 2021. A follow up session has been arranged for 19 November 2021 to agree any outstanding job plans by then. In anticipation of any delay or significant issues in making changes to consultant job plans in line with these recommendations the cardiology AMD and Deputy CMO are working through the Trust policy CP097 Organisational change, and if required undertake the required steps in consultation of the clinical teams to allow the changes to take place. The required steps for this are a business case, which is before the MHG Board, and a series of 'cardiology vision drop in sessions' for the consultant teams to discuss the proposed changes. These are scheduled from November 12th over a 3 week period.
The review team welcomed the appointment of Mr Sedman as the interim associate medical director, he has perceived impartiality and received very positive feedback from managers and clinicians. The review team were of the view that there should be a move to a separate cardiology directorate, recognising weaknesses in the previous management from a large division predominantly at HRI. More focused management support and clinical leadership roles with appropriate time allocation and training should further help to drive change in the department. **(Recommendation 12)**	Since the immediate letter was received in January 2021 changes have been made to the Cardiology Leadership Team which were implemented before the final report was received. There is now a standalone Leadership Team for Cardiology. Mr Simon Thackray is the Associate Medical Director. There are also three Clinical Leads and Clinical Governance Lead in place. Appropriate mentorship is in place and is provided by Associate Medical Director, Cardiology. The management team has recently been augmented by the appointment of two cardiology network lead roles funded by NHSE, Dr Davison from HUTH and Dr Ghosh from YTH. These will allow greater system working for the department and improved responsiveness as a tertiary service. Carole Joyce has taken the lead on the training element and has agreed that the Physiologists team will support this.
More should be done to ensure transparency across the department and a move away from incident reporting being viewed as a tool for reprisal. Meetings should include all multi-professional staff and should demonstrate the	The Trust has implemented a weekly Patient Safety Summit (WPSS) where all moderate and above incidents reported are reviewed and agreed if should be an SI or not. It also reviews overdue incidents, duty of candour and SIs from

importance and seriousness of an open and transparent patient safety culture. (**Recommendation 17)**	the Rapid Review Reports. Cardiology have escalated to the WPSS as required. The Clinical Governance Lead is to develop a formal SOP to ensure all Rapid Review Reports are completed within 48 hours. However, there is an improved, stronger culture for Governance. The overall cardiology clinical governance strategy has been documented by Dr Davison following a broad multi-professional consultation, the document will be finalised in November 2021, for approval through the departmental then MHG route.
There should be regular mortality and morbidity meetings to encourage a culture of learning. There should be time ring fenced in job plans for formal MDTs, M&M meetings and governance meetings. (**Recommendation 19)**	The Cardiology Clinical Governance Lead is working with the Effectiveness and Improvement Manager to further strengthen the Cardiology Mortality and Morbidity Specialty Meeting and how the service reviews and learns from deaths.

4. RECOMMENDATIONS

The Trust Board is recommended to:

- Receive the final report from the Royal College of Physicians Cardiology Peer Review and the supporting improvement plan.
- Decide if sufficient assurance has been received in relation to the improvement actions undertaken and planned.

Leah Coneyworth
Head of Effectiveness and Improvement
November 2021

APPENDIX B

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
CARDIOLOGY PEER REVIEW IMPROVEMENT PLAN

Red	Off track and overdue
Amber	Off track but recoverable
Green	In progress/on track
Blue	Completed

Recommendation	Timeframe	Actions / Progress Update	Lead	Due Date	Status
Trust Board					
1. The healthcare organisation should share this report with the Care Quality Commission as part of a demonstration of the drive to improve services	Short term 0 – 6 months	The CQC have been informed of the report. The final version will be shared with the CQC following presentation to the November 2021 Trust Board meeting.	LC	November 2021	On-track
2. This report should be considered by the Trust Board and oversight of an action plan should be given to a Non-Executive Board member to ensure these recommendations are completed.	Immediate 0 – 3 months	The Quality Committee (Chaired by a Non-Executive) and the Trust Board have been informed of the report and have received the communication plan. The final report and actions have been shared with the Quality Committee in October 2021 and it will be presented to the Trust Board in November 2021.	LC	November 2021	Completed
Service design and level of provision for the cardiology service					
3. The Trust needs to dedicate a room to echocardiography near to the inpatients at the HRI site. This will ensure that patients are in receipt of a timely and effective echocardiograms (ECHO)	Short term 0 – 6 months	The service have been working with the Director of Estates and Facilities to identify an appropriate location for an echocardiography near to the inpatients at the HRI site. At the beginning of November 2021, it was agreed that there will be a dedicated Cardiac Ward at HRI with an appropriate echocardiography room, this will provide easier and quicker access for patients at HRI. A new echocardiography machine was also installed in October 2021. Although, this is in the	PL / CJ / ST	January 2022	On-track

		current facilities which are not fit for purpose it will still improve quality of the echocardiograms. This machine will be transferred to the dedicated room as required.			
4. There must be a review of patients requiring temporary pacing wires (TPW) and the Trust should develop a standard operating procedure for acute pacing (specifically temporary pacing wires) with a view to offering timely permanent pacing systems. The department should consider the British Heart Rhythm Society guidance which states that for patients with TPW facilities and staff should be able to offer a permanent pacemaker within 24 hours.	Immediate 0 – 3 months	The standard operating procedure for acute pacing has been developed and is currently being trailed with clinicians. Cover is provided Monday to Friday and during a weekend by two operators. <u>Weekday pacing service;</u> lab lead to ensure 5-day cover; • Development of a Cardiology Coordinator role for acute pacing • Daily huddle to be embedded <u>Weekend pacing service</u>; • Scoping of 7-day model • Business Case development • Recruitment and training • Review of current resource to identify opportunities to expand 5-day service • Review of staffing levels against service need • Exploring a hub and spoke model with the network	RC / ST	March 2022	On-track
5. There is an urgent need to ensure a better safety culture in the Cath lab. World Health Organization (WHO) checklists/Local Safety Standards for Invasive Procedures (LOCSSIPs) are used by some consultants but not all. All staff (including consultants) must use these checklists at the start of each procedure and its conclusion to decrease the likelihood of adverse events and to	Immediate 0 – 3 months	An electronic audit tool is in place to record the completed WHO checklists/Local Safety Standards for Invasive Procedures (LOCSSIPs). The Chief Nurse Information Officer provides all Health Groups with a monthly performance report, which is monitored at Cardiology Governance, this is also monitored at the Trust Patient Safety and Clinical Effectiveness Committee and the Executive Performance Reviews.	BD / MP	October 2021	Completed

improve team working and communication.		The service has noted an improvement in the completion of the WHO Checklists and positive feedback has been received from staff that it is working well. Performance has increased from 88.6% in May 2021 to 94.3% in July 2021 and 100% achieved in June, August and September 2021.			
6. The cardiology team needs to revise the current multidisciplinary department team meeting processes to make these more robust and fit for purpose. This requires: • A robust discussion around patient selection, there should be agreement about which cases need to be brought to the MDT. • The MDT should be the cornerstone of the clinical week with appropriate representation from all relevant sub specialities including surgery. • A change in the current date and time of the meetings to secure input of the wider teams. The meeting should be job planned in each of the core members' schedules. A review of attendance at the meetings should feature in the clinicians' appraisals. • Significant improvements to record keeping; this should include details of the discussions had, an agreed course of action and a list of attendees. Each patient should have a copy of the MDT discussion in their notes with a copy to the GP and patient. This is likely to	Short term 0 – 6 months	There currently are four MDTs meetings in place with established and agreed Terms of reference. The meetings are well embedded in the jobs plans, have evidence of high levels of attendance, formal minutes, and supported by appropriate software. The department is exploring daily MDT to improve speed of decision making further - using the Leeds model as a benchmark and will be feasibility assessed during the ongoing job plan round. The waiting times are continually under review and monitoring of performance is in place within the Cardiology service and at Trust-level including the Executive Performance Reviews, Performance and Finance Committee and the Trust Board.	PS / RC / ST	February 2022	On-track

require additional administrative support to be put into place.					
7. The provision of Consultant driven care to acute cardiac patients requires improvement. There needs to be an urgent reassessment of job plans to ensure that all patients across both sites receive a consultant cardiologist review within 24 hours. There should be a fair distribution across the cardiology specialties, and the Trust should consider recruitment to new posts.	Medium term 6 – 12 months	Consultant cover is provided 7 days a week. Cover is also provided at HRI weekdays in the morning. However, the Associate Medical Director is undertaking a full review of the consultant job plan with oversight by the Chief Medical Officers Office. Consultant job planning sessions have been undertaken in October 2021. A follow up session has been arranged for 19 November 2021 to agree any outstanding job plans by then.	PL / CJ / ST	January 2021	On-track
8. The on-call consultant cardiology rota requires an urgent review, the interviews raised concerns where patient safety may have been compromised due to the lack of available consultant cover to support the service. The Trust should develop a formal out of hours on-call rota that meets the need of cardiology patients at the CHH and HRI 7 days a week	Short term 0 – 6 months	The changes to consultant job plans are significant, including formation of a second general cardiology consultant on-call rota. This on-call rota will deliver senior cardiology input into HRI at weekends. Transition of the complex device on-call rota into a simple and complex device on call rota – allowing implantation of simple or complex pacemakers over weekends.	ST / MB / RC	November 2021	On-track
9. The Trust will need to review its waiting list co-ordination and IT systems to ensure that all patients are in receipt of a timely consultant review, treatment and followed up within the appropriate timeframes according to the UK national guidance.	Short term 0 – 6 months	The waiting times are continually under review and monitoring of performance is in place within the Cardiology service and at Trust-level including the Executive Performance Reviews, Performance and Finance Committee and the Trust Board. The action has been addressed; however, the outcomes are yet to be achieved.	TF / RC	February 2022	On-track
Team working and leadership within the department					
10. There is a lack of respect among some consultant cardiologists and some behaviours are reported as being either unacceptable or borderline. The consultant body should be reminded of	Immediate 0 – 3 months	An organisational development programme is now in place within Cardiology, led by the Head of Learning and Development. This programme will focus on behaviour, team building, values and sustainability. Time-outs organised to progress 4	CJ / ST	November 2021	On-track

Good Medical Practice and the need for doctors to work collaboratively with colleagues. Documented poor behaviours should be dealt with under Maintaining High Professional Standards (MHPS) or appropriate organisational conduct policies		identified priorities each with a clinical lead and multi-disciplinary work stream members. Consultant timeout sessions agreed with Trans2Performance; dates 5th and 12th November 2021. Formal communication was also sent to the Cardiology Team on how to raise concerns from the Deputy Chief Medical Officer. No referrals have required to be made to the Maintaining High Professional Standards (MHPS). Team building has also been undertaken between the operational leads and the clinical teams with strengthened working relationships and a strong division with MDT working arrangements also with the Nursing and Physiotherapy teams.			
11. There is a need for the management to support and facilitate team building exercises to air discord and to help support the development of a shared vision and strategy specific to cardiology (as outlined in recommendation 13). Regular consultant meetings should be scheduled to help facilitate additional forums for interaction and the meetings should be appropriately job planned. Any team building and improvement exercises to aid mutual working should also focus on respect, job planning, and an evaluation of the purpose and use of datix.	Medium term 6 – 12 months		CJ / ST / MB	November 2021	On-track
12. There is an urgent need to address the cardiology clinical leadership posts (i.e. the clinical director and clinical lead posts). The Trust should consider designating responsibility in key areas for example a clinical lead for governance and for job planning. Once appointed the roles should be given the appropriate mentorship support and enough time to enable them to carry out the additional responsibilities.	Short term 0 – 6 months	Since the immediate letter was received in January 2021 changes have been made to the Cardiology Leadership Team which were implemented before the final report was received. There is now a standalone Leadership Team for Cardiology. Mr Simon Thackray is the Associate Medical Director. There are also three Clinical Leads and Clinical Governance Lead in place. Appropriate mentorship is in place and is provided by Associate Medical Director, Cardiology.	CL / ST	September 2021	Completed

		The management team has recently been augmented by the appointment of two cardiology network lead roles funded by NHSE, Dr Davison from HUTH and Dr Ghosh from YTH. These will allow greater system working for the department and improved responsiveness as a tertiary service.			
13. The executive team, clinical director and managers need to work with the department and wider network to create a cardiology strategy, which uses this report, alongside key cardiology audits as a framework to benchmark against clinical indicators. The strategy should be developed collectively with the department with an aim to facilitate a new shared vision and goals with patient care provision and equity of care at the centre of any changes.	Short term 0 – 6 months	The service is to develop a Cardiology Strategy which will be presented to the Executive Session regarding Cardiology in November 2021. A Cardiology Getting it Right First Time 'GIRFT' deep dive review is also scheduled for 26 November 2021 and involves the Medical Health Group Triumvirate, Cardiology Clinical Leadership Team and the Executive Team. This will also help inform the strategy. Improve provision for patients with Heart Failure through: • Working to the standards set out in NICE Guidance for inpatient care, including • Patient review within 24hrs of referral (see 5 and 6) • Echo carried out within 48 hours • Development of a workforce plan to support staff development (see 6) • Development of the Heart Failure nurse network, to improve inpatient support Improve provision for patients with chest pain through: • stablishing a 'one-stop' RACP clinic • development of an AHP/ANP-led RACP service • development and implementation of an Angina pathway	MB/RA/AG/CW	February 2022	On-track
14. The Trust urgently need to review job plans and ensure that there is	Immediate	This is linked to actions 7 and 8.	NA – actions are picked up in recommendations 7 and 8		On-track

consistency across the cardiology department to cover rotas in and out of hours for the benefit of improved patient care. Within this staff should have an appropriate amount of time to attend MDT and governance meetings and for undertaking tasks associated with lead roles.	0 – 3 months				
15. The Trust need to review its GMC trainee feedback and work with the leadership team to identify ways to improve the experience in clinical supervision out of hours, teamwork, experience, and curriculum coverage, along with developing a more supportive environment. Some of these may be improved because of the implementation of other recommendations, however a clear action plan and lead clinician is required so that this can be monitored.	Medium term 6 – 12 months	The Cardiology Clinical Leadership Team are to undertake a full review of the feedback results and identify what has improved and what could be done better. This will then form part of the improvement plan.	ST / CJ	November 2021	On-track
16. The echocardiography teaching programme for trainees should be reviewed and updated, the Trust may consider running a focus group to identify key areas for improvement and then work with the education lead to implement the necessary changes. There should also be better support and guidance for clinical fellows (who joined from outside of the UK).	Medium term 6 – 12 months	The service is delivered by three registrars, which is unusual; however, the Health Group have developed a business case which was approved.	CJ	May 2022	On-track
Clinical governance					
17. The executive and divisional leadership team need to review and formalise the process for raising and responding to serious incidents within cardiology	Short term 0 – 6 months	The Trust has implemented a weekly Patient Safety Summit (WPSS) where all moderate and above incidents reported are reviewed and agreed if should be an SI or not. It also reviews overdue	BD	December 2021	On-track

services. Further to this, once incidents have been raised and reports have been produced recommendations should be clearly acted on to embed learning within the workforce.		incidents, duty of candour and SIs from the Rapid Review Reports. Cardiology have escalated to the WPSS as required. The Clinical Governance Lead is to develop a formal SOP to ensure all Rapid Review Reports are completed within 48 hours. However, there is an improved, stronger culture for Governance.			
18. The executive team should take steps to review cases identified in this report, in particular, the five CRR cases viewed as unsatisfactory. These five unsatisfactory cases should be investigated as SI's if they have not already done so and any learning points highlighted by this report considered as part of this. The department should take the opportunity to discuss the cases reviewed by the RCP panel, and reflect on the comments made.	Medium term 6 – 12 months	The 5 remaining cases that were identified by the RCP are being reviewed in a staged process, initially a cardiology clinical review is being undertaken by the AMD and Clinical Governance lead of the 5 cases with a summary narrative to escalate to the Deputy CMO for further consideration and adjudication of the status of each case. A final report will be produced summarising the outcomes and narrative for each case.	CW / BD / ST	March 2022	On-track
19. The Trust need to review its mortality and morbidity process to ensure that appropriate steps are undertaken by staff so that all relevant cases are discussed and learning is embedded within the workforce. It should implement the following: • Monthly morbidity and mortality meetings. These should involve members of the wider medical team and the meetings should be job planned in the clinicians' schedule. • Open and honest documented conversations regarding all	Short term 0 – 6 months	Bi-monthly M&M meetings and Bi-monthly Governance meetings ae now in place. The Effectiveness and Improvement Team are undertaking mortality improvement work across the organisation and within Cardiology with the Clinical Governance Lead, which includes: • Standardisation of the Mortality and Morbidity structure across the organisation to ensure the meetings take place on a regular basis, discussion of deaths and learning and recording of the meetings and discussions • Increasing the completion of Structured Judgement Reviews, discussion of the reviews at M&M meetings, Health Group Governance	BD	January 2022	On-track

complications or adverse outcomes and which considers all possible contributing factors (these should also be completed in a timely way). • Processes in place for reviewing trends, sharing learning and measuring+ the success of actions arising. Consideration should be given to visiting or liaising with departments that have mature governance processes and the RCP/BCS can put them in touch with relevant individuals or departments if required. • Embedding of a clear Trust policy on the process for reviewing mortalities and for undertaking of any consequent root cause analysis. Consideration should be given to external representation and external views outside of those members within the cardiology department		Committee meetings and Mortality Committee and the Learning from Deaths report • Improved reporting in the quarterly Learning from Deaths report to Mortality Committee, Quality Committee and Trust Board • Further implementation and embedding of the Trust Learning from Deaths Policy			

Royal College of Physicians

Setting higher standards

Report

of the invited service review to

Hull University Teaching Hospitals NHS Trust on 17 and 18 December 2020

This report is the property of the healthcare organisation responsible for the commission of this invited service review

Contents

1.0 Executive summary

The Hull University Teaching Hospitals Trust ("the Trust") serves a population of approximately 603,000 people and operates across two main hospital sites - the Hull Royal Infirmary (HRI) and the Castle Hill Hospital (CHH). The cardiology department is located at the CHH and the emergency department is located at the HRI.

The Trust approached the Royal College of Physicians (RCP) Invited Reviews (IR) team due to the poor working relationships between the interventional and non-interventional consultant cardiologists, a potential weakness of insight into patient safety concerns and the overall performance within the cardiology department.

The Trust and Invited Review team agreed a process to review a selection of clinical cases to understand the management of protocols and pathways; review the service design and level of provision for cardiology; the quality of team working, leadership and behaviours within the department; and the quality of clinical governance arrangements in place to support and maintain oversight of the service. These areas formed the basis of the Terms of Reference.

The evidence gathered to inform the findings and recommendations for this report was based on a clinical record review (CRR) of 14 cases where there had been delays to treatment (these were randomly selected), cardiology specific documentation, and interviews with staff and key personnel.

The review team wish to commend the staff for their help and support in the co-ordination of this review. We'd also like to thank staff for their frank and open way they engaged with the interviews to help inform the report findings and recommendations.

Of the 14 cases reviewed; five were rated 'good practice,' three were graded 'room for both clinical and organisational improvement' and five were graded 'unsatisfactory', two could not be graded due to 'insufficient information.' In the 'unsatisfactory' cases the key themes included limited evidence of formalised multidisciplinary team (MDT) discussions to inform clinical decision making, and, to ensure that the patients' urgent treatment was undertaken in a timely fashion. The review team highlighted that some delays to treatment had also been a result of administration errors or limited evidence for interaction with other specialties. Some cases had also highlighted the need for timelier consultant review of patients, and better oversight from consultants for their patient's management plans. In the cases deemed 'unsatisfactory,' the delays to patient treatment were above the national expected average for the UK and subsequently the review team reported that three cases were not managed in line with current or best practice guidance.

The review of documentation, and interviews with staff identified a number of long-standing issues with the clinical governance of the department, namely the process for responding to and learning from serious incidents and never events. The review team heard accounts of a culture where datix has been used as a tool for possible personal reprisal along with ignoring/downplaying incidents that have been raised. More needs to be done by the managerial and clinical leadership teams to promote a culture of learning from incidents. The review team recommend that the process for serious incidents is reviewed so that key learning and recommendations are embedded within the workforce to improve patient care.

The service review also identified that there was poor consultant presence for acute cardiology patients admitted to HRI. Therefore, there is a need for an improved on-call rota for evening and weekends across the CHH and HRI sites, the general cardiology rota should also be reviewed to ensure that registrars are supported appropriately at the HRI site and patients are in receipt of timely consultant review.

The department has recently (in September 2020) moved forward with the opportunity for establishing a new clinical leadership team. However, the review team recommend that the newly appointed clinical leadership roles have appropriate time ringfenced in their job plans to lead the department on priority areas such as clinical governance and clinical job planning.

The interviews raised allegations of bullying and poor behaviours by consultants to other members of staff which has contributed to poor working relations across the department. The review team recommend that the executive team address these allegations and work is to be done to remind clinicians of the GMC code of good medical practice (GMC, 2014).

A clear strategy and goals for the cardiology department is needed to unite the teams and work towards a shared aim to provide the best care to the patients of Hull and East Riding.

The Trust were provided with a letter providing immediate feedback after the visit and in particular were asked to clarify that two serious incidents reported to the review team were or were not “never events.”

2.0 Introduction

Dr Makani Purva, chief medical officer of Hull University Teaching Hospitals NHS Trust contacted the Royal College of Physicians (RCP) regarding the cardiology service in August 2020. Following discussion, it was agreed that a combined clinical record review (CRR) and service review would be undertaken virtually on MS Teams. The CRR took place on 9 December 2020 and the service review on 17 and 18 December 2020.

2.1 Description of the service

The Hull University Teaching Hospitals Trust "the Trust" serves a population of approximately 603,000 people across Hull and the East Riding of Yorkshire, North Yorkshire and the North and North East Lincolnshire (CQC, 2020).

The Trust operates from two main hospital sites:

- Hull Royal Infirmary (HRI) where the following services are located; paediatrics, geriatrics, maternity, gastroenterology, stroke/neurology, chest medicine, rheumatology, trauma and orthopaedics, ear nose and throat services, vascular, renal, end of life care, surgery, urgent and emergency care, and outpatients.

- Castle Hill Hospital (CHH) where services include cardiology, intensive care, disability medicine and rehabilitation, haematology, immunology and allergy, oncology, palliative care, urology, infectious diseases, and complex rehab.

The cardiology department is located at CHH and includes the following services: a primary percutaneous coronary intervention service (PPCI), electrophysiology, pacing, complex devices and cardiac imaging, the transcatheter aortic valve insertion (TAVI[1]) procedures are performed within the four cardiac catheter labs.

There are two cardiology wards (C26 and C28) which have 26 and 17 beds respectively, there is a further cardiology monitoring unit (CMU) which has 10 beds and a cardiac 5 day/overnight ward (CCD5) which has 11 beds.

There are 17 consultant cardiologists (9 interventional and 8 non-interventional). The sub-specialties are listed below:

- 9 consultant interventional cardiologists
- 3 consultant electrophysiologists (EP)
- 2 cardiac imaging consultants
- 2 cardiology heart failure (HF)/devices consultants
- 1 cardiology congenital heart disease consultant

The department has five clinical fellows, 10 registrars and seven junior doctors.

The nursing staff includes:

- Specialist nurses (band 7): 2.0 whole time equivalent (WTE)

[1] TAVI - https://www.nhs.uk/conditions/aortic-valve-replacement/alternatives/

- Specialist nurses (band 6): 2.27 WTE
- Charge nurse (band 7): 1.0 WTE for ward C26; 1.0 WTE for ward C28/CMU; 1.0 WTE for the cardiac day ward and cath labs
- Registered nurse (band 6): 0.88 WTE for ward C26; 7.0 WTE for ward C28/ CMU; 0.8 WTE for the cardiac day ward; 1.0 WTE for the cath labs
- Registered nurses (band 5): 19.13 WTE for ward 26; 19.96 WTE for ward 28/CMU; approximately 12.0 for the cardiac day unit and approximately 6.0 WTE for the cath labs)

The cardiac physiology staffing includes:

- Band 8a (1 WTE); Band 7 (8.44 WTE); Band 6 (6.08 WTE); Band 5 (5.64 WTE); Band 3 (2.07 WTE); Band 2 (6.56 WTE).

2.2 Terms of reference

1. To undertake a clinical record review (CRR) of 14 randomly selected cases of patients from January 2019 – June 2020[2]:

   - 2 deaths following elective PCI and their discussion at a clinical governance meeting
   - 2 deaths of patients from heart failure as this is a mortality outlier concern
   - 2 cases waiting longer than 9 months for a pulmonary vein ablation procedure
   - 2 cases of patients waiting greater than 6 months for a defibrillator
   - 2 cases of patients waiting greater than 6 months for a biventricular pacemaker
   - 2 cases in the last 6 months of endocarditis
   - 2 cases of TAVI cases in the last 12 months that have had a complication e.g. stroke, major vascular complication or death (to have also been discussed at a clinical governance meeting).

   The clinical record review (CRR) enables the ISR team to assess the management of care, including identifying any avoidable risks. The purpose of this would be to gain a greater understanding of the pathways and protocols in action. This will include considering whether the care is in line with national good practice and guidelines, and/or what would be considered by the view of a body of clinical professionals in a similar situation.

2. To assess the service design and level of provision of the cardiology services. This will include a review of current activity levels and outcomes, protocols and pathways, services offered and MDT working. Consideration will be given to the management of consultant rotas, waiting lists and workload. Consideration will also be given to whether the current practices are contemporaneous and comply with national and RCP guidance.

3. To review the quality of team working and leadership within the department and to give a view on whether this supports the delivery of high quality and safe care. Consideration will be given to clinical and managerial leadership, culture, individual behaviours, interactions with members of the wider medical team, multidisciplinary team working and job planning.

4. To evaluate the quality of clinical governance arrangements currently in place to support and maintain oversight of the service. Consideration will be given to raising and responding to concerns, audits, clinical incident reporting (such as datix and serious incident reporting), reviews of morbidity and mortality and patient complaints/feedback.

5. Highlight any new area of concern that arises during the ISR.

[2] In six cases the patient clinical notes were provided and reviewed for the period following June 2020. This was to ensure an adequate sample size.

2.3 Approach to this review

The RCP consulted with the British Cardiology Society who nominated specialist reviewers for the review team, as set out in table 1 (below).

In advance of the visit, the review team undertook a clinical record review of 14 patient case notes (details outlined in section 4.0. ToR 1). Each reviewer used a structured form adapted from the RCP National Mortality Case Record Review (NMCRR) programme[3] to independently examine all phases of care that the patient received. These were graded by the review team as **1 = very poor care; 2 = poor care; 3 = adequate care; 4 = good care, or 5 = excellent care**. The review team also used a grading system originally developed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)[4] to give an overall perspective on the quality of care provided. This considers both clinical and organisational care. The overall gradings were as follows: **good practice, room for improvement – clinical, room for improvement – organisational, room for improvement – clinical and organisational, unsatisfactory, insufficient information**. (See figure 1. Methodology flowchart).

The documentation provided by the healthcare organisation was also examined for the insights it offered in respect of the terms of reference. The review team held face to face interviews with staff virtually, on MS Teams on 17 and 18 December 2020. Details of these have been included in section 10. Appendices.

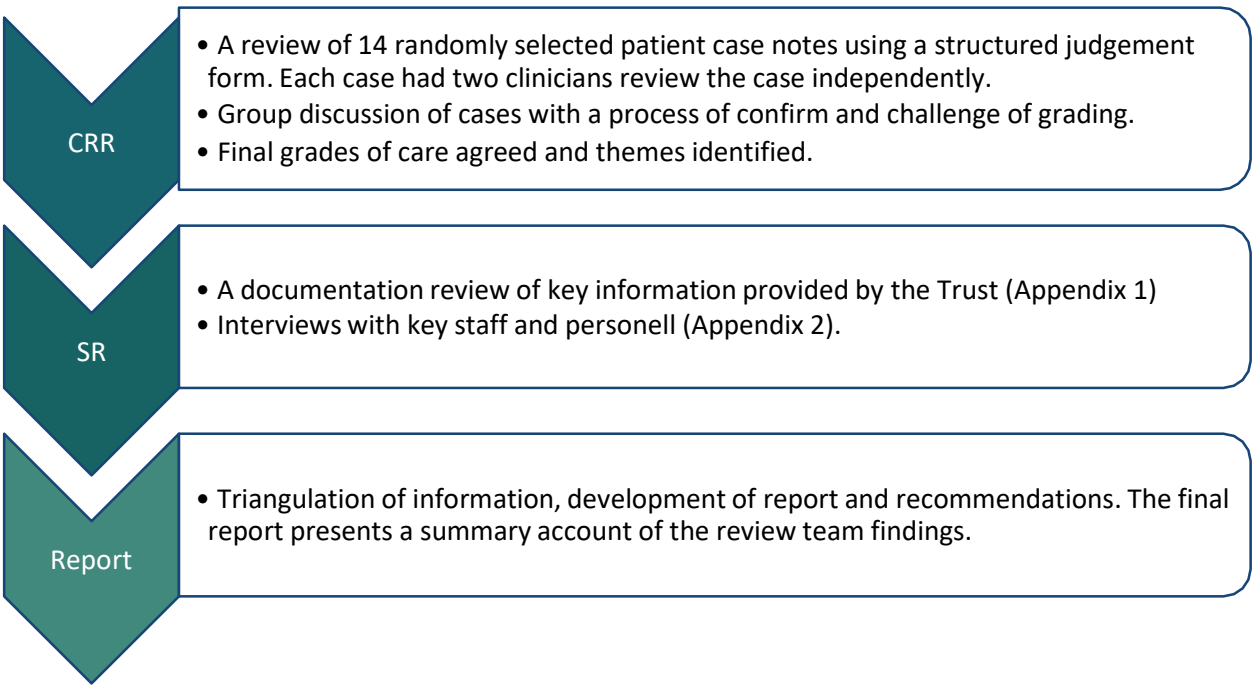
The findings contained in this report are outlined in sections 4.0 – 7.0 and represent a summary of the information gathered by the review team during the CRR, interviews and from the documentation submitted. The findings are organised under the headings of the agreed terms of reference. The information presented sometimes reflects the viewpoints of those individuals being interviewed and where this is the case it will be made clear; it will not necessarily reflect the views of the healthcare organisation, the RCP or its reviewers. The views of the review team are given in the conclusions which have informed the recommendations.

Table 1. Invited Review team

Name	Role
Dr Peter Belfield	Medical director of Invited Reviews and chair, RCP
Dr Adam de Belder	Deputy medical director of Invited Reviews/consultant cardiologist, Brighton and Sussex University Hospitals NHS Trust
Dr Helen Routledge	Consultant cardiologist, Worcestershire Royal Hospital
Dr Saib Khogali	Consultant cardiologist, The Royal Wolverhampton NHS Trust
Dr Ceri Davies	Consultant cardiologist, Barts Health NHS Trust
Professor Louise Higgins	Lay reviewer
Mrs Karina Pall	Review manager

[3] NMCRR: https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme
[4] NCEPOD grading: http://www.ncepod.org.uk/grading.html

Figure 1. Methodology flowchart



3.0 Recommendations

In this report we have given an expected timeframe for completion of implementation of that recommendation. These are:

Immediate (0-3 months) – action should be complete within 3 months of receipt of the initial ISR visit feedback letter sent on 11 January 2021.

Short term (0-6 months) - action should be complete within 6 months of receipt of the ISR report.

Medium term (6-12 months) – action should be complete within at least 12 months receipt of the ISR report. Planning for actions resulting from these recommendations should start immediately.

Long term (12-24 months) - action should be complete within at least 24 months receipt of the ISR report. Planning for actions resulting from these recommendations should start immediately.

Timeframe for implementation

Trust Board

1. The healthcare organisation should share this report with the Care Quality Commission as part of a demonstration of the drive to improve services. **Short term (0-6 months)**

2. This report should be considered by the Trust Board and oversight of an action plan should be given to a Non-Executive Board member to ensure these recommendations are completed. **Immediate (0-3 months)**

Service design and level of provision for the cardiology service

3. The Trust needs to dedicate a room to echocardiography near to the inpatients at the HRI site. This will ensure that patients are in receipt of a timely and effective echocardiograms (ECHO). **Short term (0-6 months)**

4. There must be a review of patients requiring temporary pacing wires (TPW) and the Trust should develop a standard operating procedure for acute pacing (specifically temporary pacing wires) with a view to offering timely permanent pacing systems. The department should consider the British Heart Rhythm Society guidance which states that for patients with TPW facilities and staff should be able to offer a permanent pacemaker within 24 hours. **Immediate (0-3 months)**

5. There is an urgent need to ensure a better safety culture in the cath lab. World Health Organization (WHO) checklists/Local Safety Standards for Invasive Procedures (LOCSSIPs) are used by some consultants but not all. All staff (including consultants) must use these checklists at the start of each procedure and its conclusion to decrease the likelihood of adverse events and to improve teamworking and communication. **Immediate (0-3 months)**

6. The cardiology team needs to revise the current multidisciplinary department team meeting processes to make these more robust and fit for purpose. This requires:

- A robust discussion around patient selection, there should be agreement about which cases need to be brought to the MDT.
- The MDT should be the cornerstone of the clinical week with appropriate representation from all relevant subspecialities including surgery.
- A change in the current date and time of the meetings to secure input of the wider teams. The meeting should be job planned in each of the core members' schedules. A review of attendance at the meetings should feature in the clinicians' appraisals.
- Significant improvements to record keeping; this should include details of the discussions had, an agreed course of action and a list of attendees. Each patient should have a copy of the MDT discussion in their notes with a copy to the GP and patient. This is likely to require additional administrative support to be put into place.

Short term (0-6 months)

7. The provision of Consultant driven care to acute cardiac patients requires improvement. There needs to be an urgent reassessment of job plans to ensure that all patients across both sites receive a consultant cardiologist review within 24 hours. There should be a fair distribution across the cardiology specialties, and the Trust should consider recruitment to new posts. **Medium term (6-12 months)**

8. The on-call consultant cardiology rota requires an urgent review, the interviews raised concerns where patient safety may have been compromised due to the lack of available consultant cover to support the service. The Trust should develop a formal out of hours on-call rota that meets the need of cardiology patients at the CHH and HRI 7 days a week. **Short term (0-6 months)**

9. The Trust will need to review its waiting list co-ordination and IT systems to ensure that all patients are in receipt of a timely consultant review, treatment and followed up within the appropriate timeframes according to the UK national guidance. **Short term (0-6 months)**

Team working and leadership within the department

10. There is a lack of respect among some consultant cardiologists and some behaviours are reported as being either unacceptable or borderline. The consultant body should be reminded of Good Medical Practice and the need for doctors to work collaboratively with colleagues. Documented poor behaviours should be dealt with under Maintaining High Professional Standards (MHPS) or appropriate organisational conduct policies. **Immediate (0-3 months)**

11. There is a need for the management to support and facilitate team building exercises to air discord and to help support the development of a shared vision and strategy specific to cardiology (as outlined in recommendation 13). Regular consultant meetings should be scheduled to help facilitate additional forums for interaction and the meetings should be appropriately job planned. Any team building and improvement exercises to aid mutual working should also focus on respect, job planning, and an evaluation of the purpose and use of datix. **Medium term (6-12 months)**

12. There is an urgent need to address the cardiology clinical leadership posts (i.e. the clinical director and clinical lead posts). The Trust should consider designating responsibility in key areas for example a clinical lead for governance and for job planning. Once appointed the roles should be given the appropriate mentorship support and enough time to enable them to carry out the additional responsibilities. **Short term (0-6 months)**

13. The executive team, clinical director and managers need to work with the department and wider network to create a cardiology strategy, which uses this report, alongside key cardiology audits as a framework to benchmark against clinical indicators. The strategy should be developed collectively with the department with an aim to facilitate a new shared vision and goals with patient care provision and equity of care at the centre of any changes. **Short term (0-6 months)**

14. The Trust urgently need to review job plans and ensure that there is consistency across the cardiology department to cover rotas in and out of hours for the benefit of improved patient care. Within this staff should have an appropriate amount of time to attend MDT and governance meetings and for undertaking tasks associated with lead roles. **Immediate (0-3 months)**

15. The Trust need to review its GMC trainee feedback and work with the leadership team to identify ways to improve the experience in clinical supervision out of hours, teamwork, experience, and curriculum coverage, along with developing a more supportive environment. Some of these may be improved because of the implementation of other recommendations, however a clear action plan and lead clinician is required so that this can be monitored. **Medium term (6-12 months)**

16. The echocardiography teaching programme for trainees should be reviewed and updated, the Trust may consider running a focus group to identify key areas for improvement and then work with the education lead to implement the necessary changes. There should also be better support and guidance for clinical fellows (who joined from outside of the UK). **Medium term (6-12 months)**

Clinical governance

17. The executive and divisional leadership team need to review and formalise the process for raising and responding to serious incidents within cardiology services. Further to this, once incidents have been raised and reports have been produced recommendations should be clearly acted on to embed learning within the workforce. **Short term (0-6 months)**

18. The executive team should take steps to review cases identified in this report, in particular, the five CRR cases viewed as unsatisfactory. These five unsatisfactory cases should be investigated as SI's if they have not already done so and any learning points highlighted by this report considered as part of this. The department should take the opportunity to discuss the cases reviewed by the RCP panel, and reflect on the comments made. **Medium term (6-12 months)**

19. The Trust need to review its mortality and morbidity process to ensure that appropriate steps are undertaken by staff so that all relevant cases are discussed and learning is embedded within the workforce. It should implement the following:

    - Monthly morbidity and mortality meetings. These should involve members of the wider medical team and the meetings should be job planned in the clinicians' schedule.
    - Open and honest documented conversations regarding all complications or adverse outcomes and which considers all possible contributing factors (these should also be completed in a timely way).
    - Processes in place for reviewing trends, sharing learning and measuring the success of actions arising. Consideration should be given to visiting or liaising with departments that

have mature governance processes and the RCP/BCS can put them in touch with relevant individuals or departments if required.

- Embedding of a clear Trust policy on the process for reviewing mortalities and for undertaking of any consequent root cause analysis. Consideration should be given to external representation and external views outside of those members within the cardiology department

Short term (0-6 months)

4.0 Terms of reference 1

ToR 1: To undertake a clinical record review (CRR) of 14 randomly selected cases of patients from January 2019 – June 2020 that met the following criteria:

- RCP 1 and RCP 2: patients waiting greater than 6 months for a biventricular pacemaker
- RCP 3[5] and RCP 4: heart failure (HF) as primary cause of death
- RCP 5 and RCP 6: patients waiting longer than 9 months for a pulmonary vein ablation procedure
- RCP 7[6] and RCP 8: patients waiting greater than 6 months for a defibrillator
- RCP 9 and RCP 10[7]: TAVI cases in the last 12 months that have had a complication e.g. stroke, major vascular complication, or death to have been discussed at a clinical governance meeting
- RCP 11 and RCP 12[8]: elective PCI and their discussion at a clinical governance meeting
- RCP 13 and RCP 14[9]: cases in the last 6 months of endocarditis

4.1 Grading summary

The table below (table 2) provides a summary of the review team's agreed grading for each phase of care. Considering this, six cases were found to have less than 'good care' across all phases (RCP 1, RCP 2, RCP 4, RCP 7, RCP 8, and RCP 10). The two phases that required most improvement[10] included 'communication between colleagues' and 'interactions with the patient and their family.'

Table 2. Phases of care – grading by case number

Phases of care grading	**Excellent care**	**Good care**	**Adequate care**	**Poor care**	**Very poor care**	**Insufficient evidence or** **Not applicable**
Investigation, treatment plans and implementation	-	RCP 3, 5, 6, 9, 11	RCP 4, 14	RCP 2,7,8	RCP 1,10	RCP 12, 13
Perioperative care	-	RCP 6,9	RCP 1,2,5,7,8,11	RCP 10	-	RCP 3,4,12,13,14

[5] [redacted]

[10] i.e. cases with a grade of poor or adequate.

Phases of care grading	Excellent care	Good care	Adequate care	Poor care	Very poor care	Insufficient evidence or Not applicable
Communication with colleagues	-	RCP 6,9,11,12	RCP 3,5	RCP 1,2,4,7,8,10,14	-	RCP 13
Interaction with patient and family	RCP 11	RCP 6,9	RCP 1,2,3,5	RCP 4,7,8,10,14	-	RCP 12,13
Clinical record keeping	RCP 11	RCP 5,6,9	RCP 1,2,3,4	RCP 7,8,10	-	RCP 12,13,14

After each phase of care was scored, an overall NCEPOD rating was given to each case (see table 3). Five cases were graded 'good practice', five were graded 'unsatisfactory', two were graded 'room for both clinical and organisational improvement' and two could not be scored due to 'insufficient evidence.'

Table 3. NCEPOD grading

NCEPOD grading	Good practice	RfI - both	Unsatisfactory	Insufficient evidence
	RCP 3,5,6,9,11	RCP 4,7	RCP 1,2,8,10,14	RCP 12,13

4.2 Phases of care

The following section outlines the key themes arising from the five phases of care 'patient's investigations, treatment plans and implementation,' 'peri-operative care', 'communication with colleagues,' 'interactions with the patient and their family' and 'clinical record keeping.'

4.2.1 Clinical decisions and investigations

The ToR 1 case criteria specifically included cases of delays to treatment. The purpose of this was to assess the management of care and gain a greater understanding of the pathways and protocols in action. The review team have highlighted several themes associated with the delays to treatment which are described in detail below.

The review team were of the view that some of the delays to treatment had been because of clinical decision making and MDT processes, for example,

- [redacted] RCP 1 was graded *very poor care*, due to the initial decision for the implantation of a non-complex device (DDR ppm[11]), instead of a complex device (CRT-P[12]). [redacted]

[redacted]

[redacted]

[redacted] RCP 10 was graded *very poor care*, due to the potentially avoidable delays in the management of this patient with severe symptomatic aortic stenosis. [redacted]

- RCP 2 was graded *poor care*, the patient's treatment plan was for CRT-D followed by a separate ablation[13]. [redacted] The review team noted that the process to effectively manage the patient within the MDT to expedite and urgently address the multiple stages in this patient's treatment plan could have been improved. These themes contributed to the NCEPOD *unsatisfactory* grading for this case.

In three cases there were examples of delays to patient treatment, associated with poor administration. For example,

[redacted] RCP 7 was graded *poor care*, [redacted]

[12] Cardiac resynchronization therapy pacemaker: a pacemaker that helps make the pumping chambers of the heart beat in time with each other. A CRT-P can also treat heart rhythms which can cause your heart to beat too slowly or miss beats.
[13] Ablation - is a procedure that aims to control or correct certain types of abnormal heart rhythms (arrhythmia). It is used to treat abnormal heart rhythm that has not responded to medication.
[14] Implantable cardioverter Defibrillator - used to treat dangerous fast heart rhythms

[redacted] These themes contributed to the NCEPOD *room for improvement – both clinical and organisational* grading for this case.

- RCP 8 was graded *poor care*; the patient was listed for a CRT-D procedure which was implanted six months later. [redacted] The review team were of the view that there was no clear evidence to support the appropriate co-ordination or administration for timely treatment. These themes contributed to the NCEPOD *unsatisfactory* grading for this case.
- RCP 14 was graded *adequate care*, [redacted] These themes contributed to the NCEPOD *unsatisfactory* grading for this case.

Good care

Where the cases were graded *good care* for investigations, treatment plans and implementation (RCP 3, RCP 5, RCP 6, RCP 9, RCP 11) the review team reported that tests, diagnoses, communication and management were timely and appropriate. All patients were managed in line with current and best practice guidance. In some cases where there were delays of 7-9 months for a biventricular pacemaker (BVI)[18] (RCP 5 and RCP 6) however, they were not out of keeping from the UK average. Further, the

[15] Angiotensin-converting enzyme inhibitors (ACEI) is used as a treatment for the effective management of patients with HF.
[16] ICD - implantable cardioverter defibrillator - an ICD constantly monitors your heart rhythm and can deliver various electrical impulses to correct potential problems.
[17] S-ICD - subcutaneous implantable cardioverter defibrillator - is used to treat fast heart rhythms
[18] Biventricular pacemaker – is needed when a patient has an abnormal heartbeat, it has his has 3 wires, which are connected to the right atrium, right ventricle and left ventricle. https://www.nhs.uk/conditions/pacemaker-implantation/why-its-done/

recognised complication from TAVI (i.e. thalamic stroke) was managed well (RCP 9). These themes contributed to the NCEPOD *good practice* grading for these five cases.

4.2.2 Perioperative care

Perioperative care was graded in nine of the 14 cases (3 – not applicable; 2 - insufficient information). The themes from this phase of care are described in detail below.

The review team identified the lack of communication with patients to explain the delays to their procedure or complications associated with the procedure. There was also limited evidence for WHO checklists and patient consent forms. For example,

- RCP 10 was graded *poor care,* due to the inappropriate access site used during a TAVI procedure [redacted] The review team reported the need for improved safety checks and better communication between the vascular and cardiology teams. These themes contributed to the NCEPOD *unsatisfactory* grading for this case.

- There were an additional six cases where there was no evidence that a WHO checklist had been performed (RCP 1, RCP 2, RCP 5, RCP 7, RCP 8, RCP 11). These cases were scored *adequate* for perioperative care, as there were consent forms provided. The review team highlighted that risks of procedures were appropriately discussed with the patients (as per consent form) but more could be done to improve safety measures before the procedure to decrease adverse events and improve teamworking and communication.

- RCP 1, RCP 2, RCP 7, RCP 8[20] were graded *adequate care* although consent forms were provided, it was unclear to the review team whether the patients had received an explanation for delays to their procedure dates.

<u>Good care</u>

Where cases scored *good care* (RCP 6 and RCP 9), there was clearly evidenced communication for consent and pre-operative checklists. A WHO checklist for ablation was completed for RCP 6. In case RCP 9, the WHO checklist was completed by the consultant anaesthetist and the recognised complication of the procedure was documented and handled appropriately.

4.2.3 Communication with colleagues

The review team identified the following themes for this phase of care; need for better consultant support to the registrars, limited interaction with other specialties, along with a lack of documented MDT discussions and representation (seen in section 4.2.1)

[19] Theme also applicable to the phase of care 'communication with colleagues'
[20] RCP 8 – consent form was provided but some parts were incomplete

- RCP 4 was graded *poor care*, [redacted] Overall, the review team highlighted the need for better consultant support to registrars regarding escalation and for better interaction with other specialities such as palliative care. These themes contributed to the NCEPOD *room for improvement both clinical and organisational* grading for this case.

- RCP 14 was graded *poor care*, due to the delays in communication between cardiology and surgery. [redacted] The review team highlighted the need for more efficient communication between surgery and cardiology. The review team were of the view that a surgeon should be present at the valve MDT meeting to ensure better and coherent team working across the specialties and avoid delays in agreeing treatment plans[23].

Good care

A total of four cases were scored good care for communication with colleagues (RCP 6, RCP 9, RCP 11 and RCP 12). In these cases, the review team reported evidence of MDT notes with a clearly documented process for decision making, good representation at the meeting, and, documented discussions across specialties. For example, in case RCP 9 there was documented discussions with the radiologists and stroke team following a recognised TAVI complication, and in RCP 11 there was clear and prompt involvement of the vascular team and urgent and emergency care, during an elective PCI complication.

4.2.4 Interaction with patients and their family

The review team identified the following themes for this phase of care, improvements in ensuring patients sign a consent form, and the need for better written and verbal communication with patients about their management plans. For example,

[21] Inotropes are commonly used to treat myocardial dysfunction.

[22] Bentall procedure is a type of cardiac surgery involving composite graft replacement of the aortic valve, aortic root, and ascending aorta, with re-implantation of the coronary arteries into the graft.

[23] Theme also identified in RCP 10 where there was a breakdown in communication between cardiology and surgery in relation to the incorrect access site during a TAVI procedure.

- RCP 4 scored *poor care*, the review team identified limited information on whether there was a discussion with the family that the patient was dying.[24] There was a ReSPECT[25] form in place, but not for EoL care.

[redacted] RCP 7 scored *poor care*, the patient had been incorrectly allocated to a valve clinic appointment, [redacted]

- RCP 8, RCP 10, and RCP 14 scored *poor care*, in all three cases there were no consent forms (in case RCP 8 it was available but incomplete) and there was limited information provided in the letters to patients regarding their management plans. In case RCP 8 there were no clinical letters to the patient within the notes regarding their CRT procedure. In RCP 10 there was no evidence that the patient had been copied into letters regarding their management plan. In RCP 14 whilst there was evidence of a discussion with the patient regarding their plan, there was no documented information from the surgeon or cardiologist about the indication for surgery or surgical risk. The review team identified the need for better written correspondence with patients regarding their treatment plans, along with evidence of written consent and risks associated with surgery.

[redacted] RCP 1 was graded *adequate care*, and not *good care* because although there was information included within the letters to the patient and between colleagues [redacted]

[redacted] RCP 2 was graded *adequate care*, and not *good care* because although there were some examples of consultant correspondence with the family [redacted]

[redacted] RCP 3 and RCP 5 were graded *adequate care*, and not *good care* because although there was evidence of discussion with the patient regarding a do not resuscitate form (DNAR) and a short note regarding the ReSPECT form, [redacted]

Good care

Where the cases scored good care (RCP 6 and RCP 9) or excellent care (RCP 11), the main themes included clear documentation of discussions with the patient including an explanation of the different management options. [redacted] There was clarity to the patients regarding their status on the waiting list and the risks of interventions were also clearly stated in the letter, along with a completed consent form. In case RCP 9, there was excellent communication throughout the hospital stay post procedure, there were clear letters to the patient and to the GP. In case 11, the complexity and risks were discussed with the patient and there was clear communication with the family members [redacted]

[redacted]

[redacted]

4.2.5 Clinical record keeping

The review team identified the following themes for this phase of care, incomplete patient records including management plans, information from across multiple hospitals, follow up arrangements and MDT documentation.

- [redacted] RCP 7 and RCP 8 were graded *poor care*, due to incomplete information regarding management plans. In RCP7, [redacted]
- [redacted] RCP 10 was graded *poor care*, due to the limited evidence to support the decision to use the incorrect access point [redacted]
- [redacted] In cases RCP 1 and RCP 4, the level of detail recorded in the letters and noted conversations were *adequate*. [redacted]
- In cases RCP 2, RCP 3, RCP 4, the review team were of the view that there could have been better communication and record keeping within the department for a patient requiring multiple steps and dependencies with other specialties.

5.0 Terms of reference 2

ToR 2: To assess the service design and level of provision of the cardiology services. This will include a review of current activity levels and outcomes, protocols and pathways (see 5.1.1), services offered and MDT working (see 5.1.2). Consideration will be given to the management of consultant rotas, waiting lists and workload (see 5.1.3 and 5.1.4). Consideration will also be given to whether the current practices are contemporaneous and comply with national and RCP guidance.

5.1 Service design and level of provision of the cardiology service

The following section outlines the key themes from the documentation review and interviews with staff along with reference to the findings from the CRR and key recommendations. Further details of the recommendations with details of the timeframes for implementation are noted in section 3.0 recommendations.

Recommendations made in relation to this section: 3, 4, 5, 6, 7, 8, 9

5.1.1 Pathways and protocols

Documentation review

The documents outlining the protocols and pathways for services associated with cardiology were requested but not made available for review.

Heart failure audit data was reviewed and figures showed that showed of 450 heart failure patients at HRI only 3% saw a consultant cardiologist compared to 98% at CHH (2018-2019). Therefore, patients at the HRI site have limited opportunities for consultant review or consultant ownership of their management plans compared to those patients at the CHH.

Comments from interviewees

HRI

The interviewees described some of the challenges associated with cardiology care at the HRI including the limited consultant cardiologist presence (as part of the in-reach service both in- and out- of hours at the HRI) and improvements to the echocardiogram (ECHO) and temporary pacing wire protocols.

The pathway of a patient with chest pain/heart failure, was described by several interviewees, as follows; the emergency department (ED) is located at the Hull Royal Infirmary (HRI) (approximately 5.5 miles from the Castle Hill Hospital (CHH) where the cardiology specialty is located, there are no emergency facilities at the CHH). When a patient arrives at the HRI by ambulance the call is taken by a trained nurse with registrar input, the patient is seen by an ED consultant and registrar (and not a consultant cardiologist). The patients are clerked in by a junior doctor, and then reviewed by the acute physician and cardiology in-reach team. The cardiology in-reach team at the HRI includes a cardiology registrar (Monday – Friday: 8.00am-5.00pm) and a cardiology consultant (in person) Monday-Friday (afternoon-only).

The review team heard that if a non-ST-elevation myocardial infarction (N-STEMI[26]) patient is admitted to the HRI on a Friday they will not have the opportunity for a consultant cardiologist review until day two or three of their admission. Further to this, some staff reported on a lack of formal post take rounds or the timely cardiology review of patients. The review team understand that the Trust provide invasive services for NSTEMI patients transferred in from other hospitals (including Scarborough and York), and there needs to be assurance of equitable access to cardiology services in Hull, independent of the point of arrival within the regional service.

The heart failure audit shows marked differences in consultant review between the two geographic sites of HRI and CHH.

The review of cardiology patients at HRI was also described as a bleep system to a single registrar throughout the day. There were reports of an informal on-call rota (covered by non-interventional consultant cardiologists) to support the registrars. However, the review team heard that junior staff do not always feel comfortable calling consultants informally during evenings and weekends. Instead several staff commented that both patients and registrars would benefit from improved consultant support in person at HRI (described in detail in section 5.1.3. Consultant rotas).

Echocardiography (ECHO)

Several interviewees described the limited access to appropriate equipment at HRI because the services are based at the cardiology department in CHH.

For example, the review team were informed that there is no dedicated room for echocardiography at the HRI and so often there are delays to ECHO whilst staff move the heavy equipment around the building to find a suitable location. The layout of the HRI is comprised of 13 floors “similar to a tower

[26] N-STEMI is a type of heart attack.

block" and often delays are caused by locating the machine and then transferring it from one floor to another via a busy lift. At times, staff have performed echocardiography on the wards or at bedsides.

Temporary pacing wires

The pathway for patients with temporary pacing wires was unclear, and several staff raised concerns that temporary wires are left in for too long whilst waiting for a permanent device.

Catheter laboratory

There were several issues raised by staff about the cath labs including the variability in carrying out WHO checklists, comments regarding inadequate staff resourcing (described in section 5.1.3) and poor behaviours/teamworking (described in section 6.1.1).

The review team received mixed feedback from staff about the consultant use of a WHO checklist before each procedure. There were accounts from three staff that some consultants are not present for, nor complete the WHO checklist.

Review team comments

From the staff interviews and statements, the review team would share the concerns raised by several staff regarding the quality of care provided to the chest pain and heart failure patients at the HRI. They considered that these patients were being less well served, and not receiving the equivalent standard of care compared to the patients at the CHH site. For example, patients admitted to A&E with chest pain or heart failure would be expected to see a consultant cardiologist within 24 hours. The recent heart failure audit showed that at HRI only 3% saw a consultant cardiologist during their admission which is very different from experience at CHH.

The review team shared the concerns raised by several staff that the current consultant rota at HRI does not provide the necessary support to registrars in- or out- of hours and should be reviewed as a priority (described in detail in section 5.1.3).

From the interviews it was evident that there is an urgent need for a review of the temporary pacing wire pathway. At present the wires are left in for too long. Often patients do not receive timely treatment to remove the wires which could potentially result in infection, perforation and risk of loss of capture. The review of the temporary pacing wire pathway should consider care in and out of hours and a standard operating procedure should be produced to include how the wires can be removed in time, in line with British Heart Rhythm Society (BHRS) guidance (BHRS, 2017).

The Trust should ensure that all staff are reminded of the importance and requirement to carry out the WHO checklist before and after the procedure for appropriate safety measures. Adherence to the WHO checklist should be regularly audited by the wider multidisciplinary catheter laboratory team.

5.1.2 Multidisciplinary team (MDT) meetings

Documentation review

The Trust provided the review team with document '2.5. MDT arrangements' which details a process overview of four MDT meetings (cardiac MDT – for coronary related issues, valve MDT – for valve related issues, EP MDT – for electrophysiology related issues and a TAVI MDT – transcatheter aortic valve replacement related issues). This gave limited information about how clinical decisions are captured or actioned at the MDTs. There was further uncertainty about whether the meetings are multidisciplinary in their format as details regarding attendance was not included. This theme was also consistent with the findings from the CRR (see section 4.2.5 clinical record keeping).

Minutes for MDT meetings were requested but not provided.

Comments from interviewees

Accounts of the purpose and formal process of the MDT meetings varied, for example, some staff described the MDTs as informal chats or lunchtime informal consultant meetings. The review team heard from several staff about the process for recording MDT meeting notes. During the EP MDT the notes are taken by one consultant and then uploaded onto an electronic database. However, this was not consistent across all MDTs.

Further to this, several interviewees reported that the multidisciplinary element is missing. The review team were informed that the MDTs are for cardiology consultants only and do not include the wider expertise and inclusion of other specialties such as physiologists, cardiac anaesthetics and cardiac surgeons. Attendance to the MDT meetings also varied and the review team heard from some staff that there is no formalised attendance register. Two members of staff reported that in most MDTs it is difficult to see patient information from across different centres.

Some staff reported that the multidisciplinary feature was also missing in other meetings (not just MDTs) for example the review team were informed that; the Stress ECHO sessions, valve clinics and transoesophageal echocardiogram (TOE) lists are led by a consultant or registrar and a Band 5 or 6 non-echo physiologist and it was felt by some staff that ECHO physiologists should also be included. The make-up of MDTs needs to be carefully considered to ensure all relevant opinions are available for optimal decision making.

Review team comments

From the documentation review, staff interviews and statements the following key themes were raised: the need for MDT sessions with appropriate multidisciplinary representation, formalised recording of decisions and improved information sharing across centres.

There is a need to formalise the MDT meetings so that the cardiology teams have an opportunity to formally discuss and have a record of the patient plans, treatment options and rationale. The CRR findings demonstrated that in some cases the MDT meetings could have provided better opportunity to ensure accurate information sharing between specialties (for example in case RCP 10, see section 4.2.1 where the incorrect access site was used without any documented rationale for this decision). The review team also considered that the MDT meetings could have been better used to urgently expedite patients to reduce delays for corrections to their devices (RCP 1 and RCP 10, see section. 4.2.1 Investigations, treatment plans and implementation).

The review team agreed with staff that the lack of multidisciplinary working (without adequate representation from other specialties) can perpetuate poor team working across the department and that improvements to this is key.

There is an urgent need to formalise the MDT meeting structure with ring fenced time to attend and forattendance to be mandatory and registered. The Trust should seek to ensure the ‘multidisciplinary’ element of the meeting is actioned by ensuring appropriate representation from across the specialties including physiologists, surgery and imaging.

5.1.3 Consultant rotas and workload

Documentation review

The Trust provided the review team with document '2.4 Consultant cover rota' for January 2020 – December 2020.

The rota is described below:

CHH

In hours (Mon – Fri: 8am – 5pm)

- The cardiology wards (CMU/ward C28 and ward C26) at CHH are covered by two non-interventional consultant cardiologist consultants as 'consultant of the week', where one of the two consultants is allocated to a full day at CHH, the other to the morning slot at CHH and the afternoon at HRI.
- The following are covered by interventional consultant cardiologists at CHH; Day (PCI) (1 consultant cardiology interventionist), rapid access chest pain clinic (RACPC) (1 consultant cardiology interventionist), and afternoon-cath labs (4 consultant cardiology interventionists).
- The interventional cardiologist rota changes daily except for the RACPC where there is a consultant for the week (Mon-Thurs). There is no cover for RACPC on a Friday.

Out of hours (Mon – Fri: 5pm – 8am)

- The CCH cardiology wards are staffed by an out of hours on-call rota, managed by interventional cardiologists and the allocated consultant changes daily, two consultants will split the week, alternating days.

Weekends

- The weekend cover across the cardiology wards at CHH is covered by one non-interventional consultant cardiologist.
- The interventional consultant cardiologists cover the Night-PM PCI (1 interventional consultant cardiologist) and morning-AM cath labs (4 interventional consultant cardiologists).

HRI

In hours (Mon – Fri: 8am – 5pm)

- The HRI cardiology patients at HRI are seen by consultant non-interventional cardiologists Monday – Friday (from 2pm for half day). Outside of this consultant rota, the cardiology patients are managed by the cardiology registrar.

Out of hours (Mon – Fri: 5pm – 8am)

- Out of hours, there is no cardiology consultant presence at the HRI, and no ward rounds undertaken.

Weekends

- The review team did not see the on-call rota for the HRI site and where there was an on-call rota provided in the documentation, it was unclear which site this was for.

It was unclear from the documentation provided whether the out of hours and weekend on-call rota provides support for the two sites (CHH and HRI) or just one.

Comments from interviewees

Consultant rotas and workload

During the interviews, several staff explained that the HRI site is not adequately staffed. At present the cardiology registrar manages patients Monday – Friday (9am – 2pm) and a consultant is mainly present to support the registrar and review patients in person from 2pm-5pm. There was no consistent approach to consultant review of the patients located there and at the weekends, we were told telephone advice was generally offered.

The rotas have produced some unease among some consultant staff, where there is a perceived inequality in workload. For example, the review team were informed that non-interventional consultant cardiologists are responsible for 8 weeks of cover (1 in 8), and interventional cardiologists responsible for 5 weeks of cover (1 in 5). Further to this, the review team were informed by several staff that there is a lack of non-interventional consultant cardiology OOHs rotas and that the pacing doctors do not have time ringfenced in their job plans to support out of hours cover.

The on-call rota was reported as 'skeleton' and where the rota is not formalised, staff reported that often it results in junior members of the team feeling uncomfortable with calling consultants out of hours, for support. The review team heard suggestions for a general cardiology and pacing out of hours rota and where possible staff felt that this should be supported by allocated time off after a weekend on call to limit 'burn-out'.

There was mixed feedback regarding the consultant cardiologists' workload at the HRI. Some consultants felt that their time is best placed at CHH where there is a greater workload. On the other hand, many staff felt that the lack of consultant presence at HRI may lead to possible delays in patients receiving a consultant review, and timely escalation of care.

The review team heard from staff that registrars complete most of the workload in the morning at HRI (without consultant support) and so when consultants arrive in the afternoon most of the duties have been completed. Some staff reported on "pushback" from the consultants in not wanting to attend the HRI site outside of the 2-5pm slots.

The review team were provided with examples of occasions where a complex device consultant could not be reached out of hours leading to some patient safety concerns. For example, three out of hours patient safety concerns were detailed by one member of staff. One incident reportedly involved junior staff who came across some challenges with managing a patient's rhythm out of hours (in the evening). They could not reach the consultant listed on the on-call rota which led to the patient waiting until the next day for an ICD interrogation and reprogramming (February 2020). In the second example the review team were informed of a physiologist who was required to turn off the patient's device and counsel the patient without any consultant input (December 2019). Lastly, there was an account of a physiologist who did not have the required consultant support to check a patient's device (as per the standard operative procedure (SOP) for Complex Cardiac Implantable Electronic device (CIED) on-call 2020[27]) and so this was delayed by three days. The review team had not been asked to review these cases as part of the ToR 1 CRR.

[27] The review team did not review the SOP as part of the documentation as it was provided by a member of staff following the interviews.

Resourcing

Resourcing of consultant posts was also described as an area for improvement by the consultant body and without this there was a perceived serious risk of burnout of colleagues. One staff member detailed that two additional interventional consultants, two additional imaging consultants, two additional heart failure consultants, and one additional EP consultant was required to support the service and rotas.

Resourcing of other specialist roles such as chest pain nurses within the department was raised by several staff. Some staff were of the view that the lack of chest pain nurses to support the service resulted in poor progression and expansion of a modern service. The review team heard from two members of staff of a need to recruit at least five chest pain nurses to appropriately support the patients entering the pathway through the RACPC and HRI.

The review team were also informed of a poorly staffed echocardiography department, where staff described that the current resource allocation did not always support safe care. The review team were provided with a statement which reported that at present, there is a need to support appropriate high grade leaders, the need to implement formal ECHO training plans, and better development of job descriptions that provide ring fenced time to carry out clinical sessions and ECHO reporting (and writingout reports). At present there is only time allocated to carry out clinical sessions.

Review team comments

From the documentation, staff interviews and statements, many staff raised concern about the out of hours rota to support safe patient care and the appropriate resourcing and work planning within the cardiology department (including the echocardiography service).

The review team report the urgent need to address the out of hours on-call rota to provide safe and effective care to patients at the HRI and CHH. Although an on-call rota was provided to the review team by the Trust, it was unclear whether the rota was for HRI or CHH. Coupled with this, the review team heard accounts of a 'skeleton' on-call rota and were of the view the on-call rota for evening and weekends should be formalised to provide more effective management of patients and for better support to junior staff across the two sites. The statements highlight some potential serious concerns about possible delays to patient care because of an inadequate on-call rota and the cases raised in this section should be explored further by the Trust.

The perceived attitudes regarding the "push back" for attending the HRI site outside of the 2pm-5pm timeframe should be urgently addressed with a focus on patient need. The review team have developed an example rota which may help provide some guidance, also included is a breakdown of rotas within cardiology departments of a similar size (see section 10.4 Appendix 4).

5.1.4 Waiting lists

Documentation review

The Trust provided data from the primary care dashboard which showed that the average wait in the cardiology specialty is 32 weeks. The information also reported the follow up backlog where a total of 4857 patients have an overdue follow up appointment (ranging from 0-3 months to 2-3 years). Thirty eight percent (n=1861) of patients are overdue a follow up appointment by 0-3 months, 21% are overdue by 4-6 months (n=1032), 25% (n=1214) are 7-12 months overdue, and 15% (n=750) are more than a year overdue.

Interviewee comments

There was mixed feedback and varying accounts from staff about the patient waiting lists and delays to treatment. The review team were informed that some members of staff felt that administrative challenges have contributed to long waiting lists. For example, it was described to the review team that an admin review identified issues with the IT system including loss of patient follow up and no method to capture surveillance of patients through the service. Several staff reported that the admin review of the IT system was part of an ongoing project, but that the next steps and planning for this was unclear.

A statement provided by one member of staff highlighted that electro-physiologist weekend working is impacting on the support for colleagues, during the week. There were examples of how this has also contributed to delays to the outpatient waiting lists. For example, the review team were informed by one member of staff that the decision to reduce the clinical sessions by one day per week, has increased waiting times for patient and outpatient echocardiograms.

Reviewer comments

From the information provided during the interviews and the review of clinical records (RCP 7 and RCP 8), the review team reported administration errors as a potential factor underpinning delays to treatment and follow up. The review team would recommend that the 'admin review' (term reported by interviewees) provides a roadmap for ensuring that the IT system adequately supports the scheduling of cardiology procedures and follow up appointments to avoid unnecessary delays to patient care.

6.0 Terms of reference 3

ToR 3: To review the quality of team working and leadership within the department and to give a view on whether this supports the delivery of high quality and safe care (see 6.1.2). Consideration will be given to clinical and managerial leadership, culture, individual behaviours (6.1.1), interactions with members of the wider medical team, multidisciplinary team working and job planning (see 6.1.3).
The review team have also included teaching and training in this section relating to team working and culture.

6.1 Team working and leadership within the department

Recommendations in relation to this section: 10, 11, 12, 13, 14, 15, 16.

6.1.1 Culture and individual behaviours

Documentation review

The review team requested examples of the meeting notes from discussions between staff members (e.g. mediation meetings) and a chronology of events, however these were not made available. The chronology of events was provided verbally by the CEO at the initial meeting in August 2020.

Comments from interviewees

Staff described accounts of distrust and disengagement between colleagues, examples of colleagues feeling bullied and humiliated, situations of bypassing formal routes of communication to undermine others, along with a poor approach to clinical safety and shared learning (discussed in section 7.1 Clinical governance).

The junior grade doctors described accounts where they had been humiliated in front of their peers by consultant cardiologists. The doctors used the terms “undermining”, “disrespectful” and “humiliating” when describing three cardiology consultants. There was a feeling among some staff that they could not approach said consultants for support or advice.

These behaviours were also described by other staff (including the physiologists and nurses). Some behaviours included the lack of professionalism before carrying out procedures where the staff were made to feel belittled and uncomfortable with the negative attitude exhibited by the consultant. For example, the review team were informed that one consultant is not present for the WHO checklist before the start of a procedure. This has led some staff to feel worried and anxious before the start of a procedure, without the confidence to raise this as an issue directly to the consultant.

The review team heard that some of these behaviours had been reported as formal complaints, but it was noted by interviewees that no action had come of it. Two members of staff noted the positive change in one of the consultant’s behaviour following a formal complaint process.

The review team heard of an historical divide between the non-interventional consultant cardiologists and the interventional consultant cardiologists that over time became engrained in the culture of the department. Several interviewees described that two consultants did not get on and that their poor working relationships have continued to affect the department. Whilst there were some accounts of

good working relationships between the interventional and non-interventional consultant cardiologists, there were also some examples of poorer relationships. The review team heard accounts of an historical divide between the two sub-specialties which had continued to manifest and had never fully been resolved. Although some consultants within the department were unaware of or unaffected by the conflict there were others who felt that the conflict created two distinct camps and divided the department. The clear divide in the department between the two groups was noted by some staff to impact on team working but suggested this did not affect patient care.

Review Team comments

It is well known that poor team working and relationships within a department can lead to patient safety being compromised. Whilst the review team cannot directly attribute poor team working in this department to patient safety issues there are some major concerns.

The CRR (ToR 1) identified that in all four 'unsatisfactory' cases, communication between colleagues fell short of 'good care'. Although the review team cannot attribute cause and effect of the poor working relationships to the breakdown of care, it is was reported as a contributing factor (RCP 1 and RCP 10).

The relationships between the consultants and junior grade doctors is fraught and should be reviewed. Bullying and humiliating behaviour should be stamped out and staff should be reminded of the GMC code of conduct regarding the need for respect between colleagues. There are trainee doctors and clinical fellows who are there to learn and so that reinforces the need for a supportive and positive relationship between consultants and more junior staff.

The relationships between the non-interventional and interventional consultant cardiologists is poor. Whilst there are some good working relationships between the two groups, there are also some that have impacted on morale and team working across the department. The review team were of the view that issues surrounding inequity in workload (i.e. consultant on-call rotas and a lack of understanding of colleagues job plans) and the inappropriate use of datix (as a tool for reprisal rather than learning) have further deepened this divide. Reports of datix being used to 'settle scores' is unacceptable and not in line with the expectations of the GMC and working with colleagues. There needs to be openness and transparency around the datix and an urgent need to develop a clear process for its use (described in detail in section 7.1. clinical governance).

Despite these challenges raised above, the review team were told that there have been limited team building or organisational team improvement exercises carried out to aid mutual working. Where these had happened there was little engagement by medical staff.

6.1.2 Clinical and managerial leadership

Documentation review

The Trust provided the review team with the document '1.1 Leadership organogram' which outlines the leadership model for the Trust, and the cardiology service sits within the division called 'medicine health group'. The cardiology department along with general medicine, specialist medicine and frailty and acute medicine is overseen by the nurse director, medical director and operations director. The cardiology clinical director reports directly to this team and is supported by a team of (1 WTE 8b senior matron, 1 WTE district general manager, 1 WTE 8a business manager and 1 WTE Band 7b Business support manager).

Prior to the review, the review team were informed that the cardiology clinical director and cardiology clinical lead (and deputy clinical lead) had all stepped down from post and that an interim clinical director (a surgeon) was in post. There had been some additional managerial changes including a new appointment to the chief operating officer role and to the operations director role.

Comments from interviewees

Clinical leadership

Several members of staff reported very positively on the appointment of a new interim clinical director, and, for the decision of the cardiology clinical director and clinical lead to step down. The review team were informed that the clinical leads stepped or were stepped down from post as part of the process to improve team working across the department.

It was evident from interviews that the appointment of a non-cardiologist to the leadership role provided neutrality between the interventional and non-interventional clinical cardiologists. Many staff reported that they agreed with the leadership changes and that improvement can be made to the department going forward.

A number of staff noted the positive impact of the cardiology consultants who are at the early stages of their career, as they show the enthusiasm for a new leadership and have not yet been recruited to 'sides' in the department. However, succession planning was described by staff during the interviews and within statements as "ineffective." The review team heard that younger consultants should be better supported to take on clinical leadership roles with improved mentorship and time allocated to carry out the duties.

Other than the historical divide which had contributed to the department's factions, there was also the issue of job planning and perceived inequity of workload (described in section 6.1.3 Job planning). Clinical leads and colleagues reported that there was not enough ring fenced time in their job plans tosupport job planning and thus impacted on how rotas could be effectively managed, and rotas developed.

Some consultants were of the view that there was a lack of ownership to support the cardiology department to progress into a modern unit. With the increased availability of technology to aid patient care, in coronary, valve and arrhythmic pathology, there is a risk that departments can get left behind if there isn't sufficient oversight and planning, and each subspecialty needs to ensure there is appropriate representation to the new leadership to keep the department contemporary.

Managerial leadership

Overall, there was a feeling from most clinical staff that senior management do not proactively manage concerns. For example, the concerns described by staff included the need to better support a culture of learning from serious incidents, the development of a cardiology specific strategy, and better support for recruitment.

The review team understand that the Datix system can sometimes be perceived to promote grievances rather than genuinely highlight issues of care which need evaluation, and we did hear examples from staff about this.

Several staff shared the view that the current executive leadership may not have appropriately dealt with concerns regarding datix incidents, one staff member reported that the response of an executive team member to a datix incident had been unprofessional, managed poorly, and further fuelled the divide within the department. However, others in the department disagreed with this.

Some staff noted issues regarding geographic separation, for example the management team are located at the HRI site and cardiology is located primarily at CHH and so there is a sense among some staff that the department is neglected. The review team were informed during the interviews and from the confidential statements that there is no clear departmental strategy, goals or plans.

Many staff highlighted the lack of support for business cases including the case for recruitment to consultant posts (i.e. heart failure, interventions) and to ensure safe standards of care are provided to cardiology patients through the recruitment of specialist heart failure nurses.

Review team comments

Clinical leadership

The review team positively acknowledge the decision to step down the cardiology leadership roles and to appoint a new interim cardiology clinical director whilst these posts are advertised. The Trust should now develop clinical leadership posts with specific responsibilities. For example, the Trust should consider appointing a clinical lead responsible for governance, and, a clinical lead responsible for job planning. These require appropriate time ring fenced in their job plans. There should be a greater emphasis on the responsibility for job planning. All job planning should be based on patient need, with a focus on ensuring key audit criteria and good practice is met. Once the appropriate appointments have been made, the role(s) should be provided with peer support and mentorship. The clinical leads should have the opportunity to report directly to the clinical director on a regular basis to ensure open and clear lines of communication.

Managerial leadership

The executive and divisional leadership team need to reflect on comments made by staff regarding the level of support provided to the cardiology team and the culture within it. More needs to be done to support a culture within the department of openness and transparency. There is an opportunity with a newly appointed clinical leadership team and this invited service review to help drive change within the service. However, this will require support (in particular for business cases and service improvement) and training being made available.

The review team agreed with staff that there is a lack of a shared vision and direction for the department. There was feedback from staff that the attempts to progress the unit have been unsuccessful, the review team recommend that the executive management work with the department to create a collective strategy with shared goals that the department can be proud of delivering cardiology care to the local population of Hull.

6.1.3 Job planning

Documentation review

Job plans were provided for 14 of the 17 consultant cardiologists, three job plans were not provided because they had not yet been agreed (for one HF consultant and for one consultant who had retired and recently returned part-time), along with a locum interventional consultant cardiologist).

- 5 interventional consultant cardiologists support a 1 in 6/6.5 on call rota
- 4 non-interventional consultant cardiologists support a 1 in 8 on call rota (the breakdown includes; 3 EP consultants and 1 HF consultant)

- 2 interventional cardiologist consultants work fewer on call rotas (e.g. one works 1 in 12 on-call both weekend and weekdays, and the other works 1 in 13 on-call weekdays, and 1 in 6.5 on call weekends).

From the job plans it appeared that five consultants are not job planned to provide out of hours cover either because it is not included in their job plans (one congenital, one imaging, one EP), or because their job plans were unavailable to view.

A summary of the job plans is presented below:

- DCC average per week: 9 (14 consultants– 3 without job plans)
- On call out of hours: 1 in 6 (5 interventional cardiologists); 1 in 8 (4 non-interventional cardiologist), two interventional cardiologists (1 in 12) and (1 in 13 and 1 in 6)
- Average PAs: 11.5 (with a range of 12.6 – congenital, to 7 – retire and return interventional cardiologist).

It appeared that two of the consultant's job plans (one interventional cardiologist and one EP consultant) did not have allocated time to attend MDT sessions.

Interview comments

The statements and interviews described an overnight on-call service that is run by interventional cardiologists and that there is a need to better distribute the on-call and weekend rotas across both interventional consultant cardiologists and non-interventional consultant cardiologists (see section 5.1.3 consultant rotas).

When challenged about job planning, some staff felt that there had not been enough time ring fenced for management to review job plans. In addition, the review team heard that on occasion one consultant would exclude the clinical leadership from the discussion about job plans and instead write directly to the medical director rather than discussing directly with the lead. The review team were made aware of some personal conflict where behaviours displayed by certain members of staff regarding job planning had led others to feel undermined and confused about the appropriate processes for escalation.

During the interviews there were several consultants who identified that an additional heart failure consultant is needed and an additional interventional cardiologist to support good patient care.

Reviewer comments

The documentation review has highlighted that in fact five interventional cardiologists run an on-call rota 1 in 6 (in addition to two who have 1 in 12 and 1 in 13 and 1 in 1.6). Four non-interventional cardiologists run an on-call rota 1 in 8. The service would benefit from revising the rota to ensure that out of hours patient care is met across both the CHH and HRI sites and that there is appropriate support provided by complex device consultants as per the SOP (described in section 5.1.3 Consultant rotas).

The review team would recommend that any clinical leadership role with a responsibility for job planning be appropriately trained and supported by management to develop job plans based on patient need and not consultant choice. There is a need to address and support the recruitment of sufficient additional colleagues to make a rota sustainable while improving subspecialty care in heart failure and probably imaging.

6.2 Teaching and training

Documentation review

The review team were provided with the document '5.3 Overview of GMC trainee survey results 2019.' The key areas for concern that required improvement in the cardiology department for trainees included the overall satisfaction, clinical supervision out of hours, teamwork, adequate experience and curriculum coverage along with the need for a supportive environment.

Comments from interviewees

Formal teaching

The feedback regarding teaching and training varied, there were some good examples provided by junior staff particularly in relation to Dr Chelliah's teaching. However, there were some poorer examples where junior staff felt that regular meetings with educational supervisors could be improved, and that there had been previous issues with ECHO training requiring improvements in facilitating the curriculum.

One staff member made suggestions on how things for trainees could be improved. This included the option for trainees to submit anonymous feedback to the training programme director (TPD) after the conclusion of each module so consultants in charge of each module can review the feedback and make changes as necessary.

Further to this, another non-consultant grade staff member reported that outside of the Tuesday afternoon for 1 hour, other teaching opportunities are difficult to fit in, the review team heard that there was meant to be 4 hours self-development for integrated multidisciplinary teams (IMTs) per week but this was not allocated in this way.

Clinical fellows and support for registering

Clinical fellows reported on the lack of a defined pathway to register as a cardiologist specialist from countries outside of the UK with the GMC. There was discussion and feedback on how there is a greater need to support clinical fellows in this process.

Assessments appear to have variable standards with some interviewees reporting that more "favoured" registrars are signed off quicker than others. The review team heard that this leads to some registrar's assessment forms expiring.

Review team comments

The review team advise that the GMC trainee survey results are reviewed and a plan is made to work with trainees to improve the key areas specific to; clinical supervision out of hours, teamwork, experience and curriculum coverage along with encouraging a supportive environment. Further to this, there is a need to ensure the ECHO training curriculum is reviewed and juniors are provided with enough time to attend training opportunities.

7.0 Terms of reference 4

ToR 4: To evaluate the quality of clinical governance arrangements currently in place to support and maintain oversight of the service. Consideration will be given to raising and responding to concerns, audits, clinical incident reporting (such as datix and serious incident reporting) (see 7.1.1), reviews of morbidity and mortality and patient complaints/feedback (see 7.1.2).

7.1 Clinical governance

Recommendations made in relation to this section: 1,2,17,18, 19

7.1.1 Concerns, audits and clinical incident reporting

Documentation review

Medicine Health Group (MHG) Governance structure

The MHG governance committee oversees four specialties frailty and acute medicine, specialist medicine, general medicine, and cardiology. Between the MHG governance committee (MHGGC) and the Trust Board, there are an additional three committees the hierarchy is as follows; the MHGGC reports into the Operational Quality Committee, reporting to the Executive Management Committee there are links between the Operational Quality Committee and the Quality Committee. The purpose and scope for each of the committees were not reviewed.

MHG governance meetings

The review team received the actions tracker and agendas for the monthly cardiology governance meetings. There were no governance meetings between October 2019 and January 2020, further to this due to covid-19 there were no meetings between March – May 2020. The quorum for attendance was to be agreed and there was a note that attendance was to be reviewed, there was reference to an attendance tracker however this was unavailable to view. The key issues reported in the meetings included the reporting of serious incidents (SI's) and sharing the lessons learned (unavailable to review); risks including the risk of the 'admin review' which may have resulted in the loss of patients for their follow up (described in section 5.1.1 pathways and protocols); complaints and patient advisory liaison service (PALS) (reported on in section 7.1.2); staffing levels; concerns regarding the heart failure service in particular the prioritisation of workload; the WHO checklist was discussed as any other business but there were no actions as a result; audits appeared in the notes to be 'on track' but without details of findings or shared learning.

MHG governance reports

The review team received the medicine health group (MHG) governance report which includes detailed items specific to serious incidents, never events, areas for escalation, lessons learned and recommendations. There is further discussion in the report to capture duty of candour, a risk register, along with claims and a coroner's inquest. Document '4.3 The MHG governance report August 2020' reports on the SI TAVI procedure (the clinical case notes were reviewed in ToR 1 – RCP 10), however there was no discussion regarding the lessons learned and recommendations for this SI in the documentation provided. The review team requested the SI report for this case, but it was not made

available to review. It was unclear from the documentation whether these detailed governance reports are presented at each governance meeting and how learning from SI's are shared.

Incident reporting

The review team were provided with document '4.7 serious incident log' which included one SI from July 2020 (the TAVI case – reviewed as part of the CRR RCP 10). The report includes the incident date, the date it was reported and a brief description of the event. There was no complete SI report provided, although this was requested. Upon factual accuracy checking with the Trust, it was confirmed that the SI report was undertaken whilst the RCP IR report was in drafting stages. The team did not see any other datix listing reports.

Comments from interviewees

Governance meetings

Several staff raised concerns regarding the arrangements to support effective patient safety and clinical governance. There were examples of a lack of professionalism and leadership from senior management in the handling of governance concerns, along with the poor support from clinical leads to deal with issues raised. The responses were described by some staff as secretive and unprofessional. Raising concerns sometimes felt uncomfortable, particularly for non-medical staff. Some staff said there was a perceived tendency to downplay clinical incidents, and, to undermine those who wanted to raise patient safety issues. Many staff described a lack of transparency when talking about serious incidents and that there was no meaningful forum to talk through lessons learned. The review team were informed of post-event debrief discussions in the cath lab but that these were not always followed up on.

Incident reporting

Some staff explained how they felt SI processes could be improved, using the SI TAVI case as an example. Those staff highlighted that there was no clear formal pathway for reporting the incident, no clear examples of lessons learned, or any significance placed on shared learning. Staff felt as though there was no "safe space" to openly talk with the departmental colleagues about serious incidents. Further to this, the lines of reporting were unclear, the review team heard of mixed communication lines, and routes for raising and responding to SI's which had further bought about tension within the department, without constructive action. Many staff advised that the current informal datix processes needed formalising and that all staff should follow the same procedure for reporting for the benefit of patient safety and good team working.

The review team received statements where some staff outlined examples of cases that they felt should have been investigated as serious incidents but were not. For example, in March 2020, it was reported that there was an issue of a retained swab, where the patient underwent a pacemaker procedure and following the procedure the swab count was incorrect, the patient was x-rayed, and it was found that there was a retained swab within the patient. The patient reportedly had the wound reopened to remove the retained swab. According to staff there was no record of this being listed as a potential never event nor investigated as one with any learning shared. In February 2020, it was reported that a clinical fellow undertook a pacemaker procedure on their own without any consultant support, the subclavian artery was entered instead of the subclavian vein and up to the left rather than right ventricle (which was indicated for use by imaging) resulting in heavy internal bleeding, unfortunately the responsible consultant was not around to support the fellow at the time of the incident. The staff were informed this event was raised as an SI but was not followed up on. There were no lessons learned or recommendations shared with the cardiology team regarding this case.

During the interviews the team were further informed of an incident where a patient was incorrectly allocated to the list of a non-complex device patient, the patient was implanted with a non-complex instead of a complex device. This resulted in the patient requiring an additional procedure (reopening and reclosure of the incision) to change their incorrectly implanted device. Nursing staff had ensured duty of candour with the patient and their family but there was debate as to whether this met the criteria to be classed as a never event.

The review team did not review these latter cases as part of the clinical record review and asked the Trust to consider the retained swab and wrong device implanted cases urgently in the immediate feedback letter.

Review team comments

The interviews and documentation review highlight the urgent need to review the governance framework to better support patient safety concerns. There are four busy cath-labs, and, the review team believe current incident reporting seems likely to be underrepresenting when things go wrong, thereby missing the opportunities for joint learning. Therefore, there is a need for a formalised, transparent, and supportive environment for staff to raise serious incidents, and to ensure that lessons are shared, and good quality recommendations are implemented. The review team heard accounts of a culture of perceived secrecy around serious incidents and examples of cases that should have been investigated either as never events or SI's but were not. Cases should be formally reviewed so that lessons can be learned, policies and protocols can be adjusted to improve the care for patients. The whole leadership team should be reminded of the importance of promoting a transparent and open learning culture which should be embedded in the workforce.

The Trust should consider reviewing their current SI and never event protocols and ensure these are managed in line with good practice.

7.1.2 Reviews of morbidity and mortality and patient complaints/feedback

Documentation review

Morbidity and mortality

The review team requested notes from the morbidity and mortality meetings however these were not made available. In the documentation, there was a standing agenda item within the governance meetings, although there was no formal discussion documented within these.

Patient complaints/feedback

Formal complaints log

The review team were provided with document '4.7 formal complaints log, from March 2020 to October 2020', there were a total of 10 patient complaints (9 cardiology and 1 cardiac surgery). Six were reported as complaints regarding treatment (2 – outcome of treatment/surgery; 2 – treatment delayed; 1 – diagnosis not informed; 1 – not satisfied with plan). One complaint was reported as a delay in receiving results, two were reported as issues with communication/record keeping (1 - breaking bad news, poorly handled and 1 - patient complaint regarding the TAVI SI which was processed by the Trust and the matter was considered closed by the family). Lastly, one was reported as an unprofessional attitude, by the delay in recognising the patient's internal bleeding and the lack of communication on the outcome of treatment.

PALS log

There were a total 42 cardiology entries of which 8 were compliments. The 34 complaints were reported as follows; four were regarding poor communication/record keeping; 18 complaints were raised about delays, waiting times, cancellations (the two most common were delays in outpatients including follow up (FU) n=8; and the delays in the notification of results n=5). The remaining complaints were regarding general advice n=5; special needs n=1; or patients were not satisfied with their treatment plan n=5.

Comments from interviewees

Many staff reported on a lack of a formal governance process surrounding morbidity and mortality (M&M), patient feedback or complaints. An example was provided by one member of staff in relation to a discussion that occurred within a week of the case being reported. However, the review team were informed that following this, there was no clear discussion about how the event was to be fed back to staff.

Some consultant and non-medical staff reported that although the debrief process for deaths was getting better, there was a lack of formal M&M reviews and that there is a need to strengthen the process. Several staff commented that they would like to see cases openly reviewed in a meeting so that procedural complications can be discussed and learned from.

Review team comments

There is an urgent need to address the formal process for M&M meetings to ensure that learnings from procedural complications can be embedded and shared with the workforce. There needs to be better continued support to debrief staff when there is a complication or death. Further, there needs to be a review of the waiting times as this was raised as one of the most common complaints logged by PALs.

8.0 Overall conclusion

The key themes from the clinical record review included the need for formalised MDT discussions to support and challenge clinical decision making, and to expedite patients where urgent treatment is required. There is a need to better support the timely review of patients, and to ensure that their information on the administration databases is accurate so that treatment and follow up are logged and appointed appropriately.

In most modern services a cardiology patient would expect to be seen by a consultant cardiologist within the first 24 hours of being admitted and for a daily consultant led ward round to take place thereafter. Further to this, the responsibility of the most junior trainees managing the cardiology patients at the HRI site, with limited consultant support is deemed unacceptable both from a patient care point of view and doctors' training.

The review team were also informed of the poor echocardiography facilities at the HRI site, where there is no appropriate room for the equipment causing inefficiency and unnecessary delays to patient care.

There was concern from a number of staff that some patients have temporary pacing wires that are left in for too long and it would be advisable for the Trust to review a subset of cases and develop a standard operating procedure for temporary pacing wires.

In some cases (from interviews or reviewed as part of the CRR) not all consultant staff properly participate in WHO checklists at the start and end of each procedure.

The review team heard accounts of two potential Never Events. One event related to a possible retained swab and the other where the wrong device was implanted in a patient. The Trust should consider urgently reviewing their serious incident and never event protocols to ensure that these two cases have been investigated appropriately. These matters were raised in the preliminary feedback letter and acted on by the executive.

There were several allegations of belittling, intimidation, and undermining. The review team believe this behaviour is impacting on patient care and therefore, all medical staff should be reminded of Good Medical Practice as the GMC code of conduct of how doctors must work collaboratively with colleagues.

Job planning in the department requires urgent review of all the consultant job plans including the equitable allocation of resource across the CHH and HRI sites. There are too few specialist nurses to support the cardiology department compared to other modern cardiology services, and so it is vital that the Trust review the cardiology workforce. Additional consultants maybe needed in specific areas e.g. the management of heart failure. Despite these limitations, the review team believe new working patterns and team job planning could deliver better care for patients at HRI in the short term and we will include an example rota as an appendix in the full report.

The review team welcomed the appointment of Mr Sedman as the interim associate medical director, he has perceived impartiality and received very positive feedback from managers and clinicians. The review team were of the view that there should be a move to a separate cardiology directorate, recognising weaknesses in the previous management from a large division predominantly at HRI. More focused management support and clinical leadership roles with appropriate time allocation and training should further help to drive change in the department.

More should be done to ensure transparency across the department and a move away from incident reporting being viewed as a tool for reprisal. Meetings should include all multi-professional staff and should demonstrate the importance and seriousness of an open and transparent patient safety culture.

There should be regular mortality and morbidity meetings to encourage a culture of learning. There should be time ringfenced in job plans for formal MDTs, M&M meetings and governance meetings.

9.0 References

BHRS. (2017). *Standards for implantation and follow up of cardiac rhythm management devices.* Retrieved from https://bhrs.com/wp-content/uploads/2019/03/180122-sp-BHRS-Standards-Implantation-and-Follow-Up-of-CRM-Devices-in-Adults.pdf

CQC. (2020). *Hull University Teaching Hospitals NHS Trust*. Retrieved from Care Quality Commission: https://www.cqc.org.uk/provider/RWA/reports

GMC. (2014). *Good Medical Practice: Working collaboratively with colleagues.* Retrieved 2020, from https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-20200128_pdf-51527435.pdf?la=en&hash=DA1263358CCA88F298785FE2BD7610EB4EE9A530

10.0 Appendices

10.1 Appendix 1: Documents received and reviewed

Service review documentation	
Organisational level information	
	• Organisational structure chart
Strategic and business plans for the service	• Cath Lab Replacement • TAVI business case • Divisional Operational Plan 2020/21 • HUTH Cardiology RTT Recovery Plan (v1 dated 28 August 2020) • Cardiology Recovery presentation slides (28 August 2020)
The most recent Trust Board report	• Medicine Health Group Board report (MHG) • MHG Board Agenda (September 2020) • Business case for the replacement of the Cardiac Catheter Laboratory Equipment (September 2020) • MHG Board minutes (September 2020)
Divisional Performance Meeting	• Performance Review presentation slides (June 2020) • Cardiology Performance Review (August 2020) • Cardiology Divisional Update (21 September 2020)
Divisional Business Meeting	• Cardiology Business Meeting presentation slides (June 2020) • Minutes (12 June 2020) • Cardiology Business Meeting presentation slides (July 2020) • Minutes (10 July 2020) • Cardiology Business Meeting presentation slides (August 2020) – this meeting was cancelled/no minutes available • Cardiology Business Meeting presentation slides (September 2020) • Minutes (18 September 2020)
Chronology of issues, concerns and actions taken	• Provided verbally by CMO and referred to in Terms of Reference for the invited review
Service specific information	
	• List of consultants and relevant members of the clinical dedicated to the service • Clinical audit plan – Cardiology • Monthly bed number request for Medicine • Site map of cardiology service

	• Details of the arrangements for the cover rota (from 30/12/2019 to 24/12/2020) • MDT arrangements (overview)
Details of the arrangements for clinics that support the service	• Clinic Catalogue Cardiology • Appointment waiting times – Cardiology • Population figures – geographic and where patients are referred from
Activity data	• Activity data for the individual physicians within the service / Outcome data for the service relevant to addressing the Terms of Reference • Hospital Standardised Mortality Ratio (HSMR) data for the specialty service (from April 2019 to March 2020 • Mortality rates (from April 2019 to March 2020) • Complication rates (from April 2019 to March 2020) • Readmission rates/follow up appointments/events (from April 2019 to March 2020) • Heart Failure Audit – NICOR submission example (27 December 2019) • MINAP: Data collection form; MINAP extract • BCIS: PCI extract
Clinical team	
Staff dedicated to the service	• Dr Ali Ali • Dr Renjith Antony • Dr Matthew Balerdi • Dr Thanjavur Bragadeesh • Dr Jane Caldwell • Dr Raj Chelliah • Dr Ben Davison • Dr Neil Hobson • Professor Angela Hoye • Dr Joseph John • Dr Alex Kouloumpinis • Dr Richard Oliver • Dr Manish Ramlall • Dr Pad Shakkottai • Dr Imran Sunderji • Dr Ann Tweddel
Job plans	• Dr Ali Ali • Dr Renjith Antony • Dr Matthew Balerdi • Dr Thanjavur Bragadeesh • Dr Jane Caldwell • Dr Raj Chelliah • Dr Ben Davison • Dr Neil Hobson • Professor Angela Hoye

	• Dr Joseph John • Dr Alex Kouloumpinis • Dr Richard Oliver • Dr Pad Shakkottai • Dr Imran Sunderji
	• Appraisals information (list provided)
Clinical governance	
	• MHG Governance Structure • MHG Governance report
Cardiology Specialty Governance meetings	• Action/minutes tracker (October 2019) / Minutes (July 2019 meeting) • Agenda (31 January 2020) • Action/minutes tracker (31 January 2020) / Minutes (January 2020 meeting) • Agenda (28 February 2020) • Agenda (26 June 2020) • Action/minutes tracker (26 June 2020) / Minutes (June 2020 meeting) • Agenda (24 July 2020)
Complaints SI's and feedback on service	• Serious incident log • Formal complaints log (from July 2020 to October 2020) • PALS log
Quality improvement initiatives	• Cardiology clinic poster on waiting times • QIP Aims • Cardiology Huddle • Presentation slides: Home for lunch, a multi professional approach to earlier discharge • Presentation slides: Devices – the same day discharge project • VTE Assessment and IDL completion in Cardiology • Optimise 2 action tracker
Doctors in training	
	• Details of junior medical staffing • Summary of education programmes (from September to January) • Overview of GMC Survey 2019 • HUTH GMC Survey 2019 FAQs • Cardiology TA Outlier Post Specification by Trust Board • Trainer Specialty by Trust Board
Statements	

- Seven statements received from clinical staff

10.2 Appendix 2: Interviews

Thursday 17 December 2020 (day 1)	
Pre-ISR meeting:	• Mr Chris Long, chief executive • Dr Purva Makani, chief medical officer • Mrs Ellen Ryabov, chief operating officer • Mrs Beverly Geary, chief nurse
Group interview	• Dr Jacquelyn Smithson, medical director, Medicine Health Group • Ms Wendy Page, nurse director, Medicine Health Group • Ms Aswathi Shanker, director of operations, Medicine Health Group • Mrs Ellen Ryabov, chief operating officer
Individual interview	• Dr Thanjavur Bragadeesh, cardiology clinical director (stepped down Sept/Oct 2020).
Individual interview	• Dr Neil Hobson, cardiology clinical lead (stepped down from Sept/Oct 2020)
Individual interview	• Dr Ben Davison, cardiology deputy clinical lead and governance lead (stepped down Sept/Oct 2020)
Individual interview	• Mr Peter Sedman, newly appointed associate medical director (Oct 2020)
Individual interview	• Dr Raj Chelliah, TAVI service lead
Individual interview	• Dr Joseph John, interventional cardiologist
Group interview	• Dr Ali Ali, interventional cardiologist • Dr Richard Oliver, interventional cardiologist
Group interview	• Dr Alex Kouloumpinis, interventional cardiologist • Dr Manish Ramlall, interventional cardiologist
Individual interview	• Dr Angela Hoye, interventional cardiologist
Group interview	• Dr Pad Shakkottai, EP • Dr Jane Caldwell, EP
Individual interview	• Dr Simon May, cardiac anaesthetist
Group interview: cath lab nurses	• Ms Marie Potter, cath lab manager • Ms Mandy Renner, staff nurse • Ms Debbie Leggott, EP specialist nurse • Mr Alan Fussey, TAVI specialist nurse
Group interview: ward nurses	• Ms Tracie Drewery, charge nurse • Ms Debbie Shann, charge nurse • Ms Leanne Simants, charge nurse • Ms Kristy Bowsley, charge nurse • Ms Kristie Costa, charge nurse

Thursday 17 December 2020 (day 1)	
Group interview: Cardiology management team	• Ms Carole Joyce, divisional general manager, cardiology • Ms Andrea Gray, senior matron cardiology • Ms Caroline Wood, business manager cardiology • Mr Matthew Cooper, finance business partner • Ms Paula Longley, planning manager • Ms Sarah Addleshaw, HR business partner

Friday 18 December 2020 (day 2)	
Individual interview	• Dr Matt Balerdi, Imaging & Congenital
Group interview	• Dr Renjith Antony, Heart Failure • Professor Andrew Clark, Heart Failure
Group interview	• Dr Imran Sunderji, Imaging • Dr Ann Tweddel, Imaging & Cardio-Oncology
Group interview: clinical fellows	• Dr Sidhesh Wagh • Dr Elif Ustun • Dr Sherif Gouda • Dr Nikolaos Vogiatzakis • Dr Yousaf Rehman
Group interview: Core trainees and junior doctors	• Dr Tayyaba Mehmood • Dr Christopher Nwoko • Dr Saw San Ti • Dr Oliver Van Den Linden • Dr Callum Forbes • Dr Henrietta Pinhol • Dr Khudaim Mobeen
Group interview: x5 Registrar grade doctors (ST5-7)	• Dr Usha Rao (ST7) • Dr Elena Volkova (ST6) • Dr Sally Hickman (ST5) • Dr Usman Shah (ST5) • Dr Adnan Faisal (ST5)
Group interview: x5 Registrar grade doctors (ST3-ST5)	• Dr Chin Soo (ST5) • Dr Krishna Poudyal (ST5) • Dr Joe Cuthbert (ST5a) • Dr Ayse (ST3a) • Dr Tin (ST3)
Group interview: Cardiothoracic surgeons	• Prof Mahmoud Loubani • Mr Martin Jarvis
Individual interview	• Mr Richard Owen Smith, anaesthetist
Group interview: Lead physiologist and senior	• Ms Carron Painter, lead physiologist

Friday 18 December 2020 (day 2)	
technicians	• Mr Gowan Beddoes • Ms Vanessa Brown • Ms Claire Clabby • Ms Melanie Garner • Ms Elizabeth Graham • Ms Sarah Hurren
Group interview: Lab technical staff	• Ms Kristina Reynolds • Mr Jason Simpkin • Ms Rachel Waters • Mr Lee Wise
Individual interview	• Dr Simon Thackray, consultant NLAG
Feedback given to the executive team	• Dr Jacquelyn Smithson, medical director, Medicine Health Group • Ms Wendy Page, nurse director, Medicine Health Group • Ms Aswathi Shanker, director of operations, Medicine Health Group • Mrs Ellen Ryabov, chief operating officer • Mr Lee Bond, chief finance officer • Dr Peter Sedman, cardiology clinical lead

10.3 Appendix 3: Letter summarising initial feedback, dated 11 Jan 2021

Dr Purva Makani
Chief Medical Officer
Hull University Teaching Hospitals NHS Trust

BY EMAIL ONLY

11 January 2021

PRIVATE AND CONFIDENTIAL

Royal College of Physicians: Hull University Teaching Hospitals NHS Trust, cardiology

Dear Dr Makani,

I am writing following the Royal College of Physicians, Invited Review of the cardiology service at Hull University Teaching Hospitals NHS Trust on 17 and 18 December 2020. As you know we held this review visit virtually using Microsoft Teams and overall, we believe this worked well.

The reviewers gathered a substantial amount of information from the clinical record review (CRR) prior to the visit, Trust documentation and interviews with staff. Using this information, in due course we will provide you with a final considered report which addresses the agreed terms of reference (ToR).

However, I wanted to ensure you had a written record of the preliminary feedback so that you have an early opportunity to consider the headlines from our review and actions that we believe are necessary to ensure that patient safety is not compromised in the cardiology service. This is based on the verbal feedback provided at the end of the two-day visit, to yourself, Ellen Ryabov, chief operating officer, Mr Peter Sedman, cardiology clinical lead, Lee Bond, chief finance officer, Dr Jacquelyn Smithson, medical director and Wendy Page, nurse director both of the medicine health group.

The reviewers wish to commend the staff, we met during the review visit for the frank and open way they engaged with the review. We'd also like to thank Ellen Ryabov, Caroline Wood and Carole Joyce for their co-ordination and facilitation of the interviews and collation of information. We met a number of excellent staff who represented the Trust very positively, those who stood out to us included Dr Ben Davison, Dr Matt Balerdi, Mr Peter Sedman, Dr Simon May, the ward and cath lab nurses and other cath lab staff.

Please see below the preliminary feedback.

Terms of reference (ToR) 1 – Clinical record review

This term of reference concerned the clinical review of 14 cases of patients who were selected as either they had experienced long waits for treatment or had suffered known complications. Details of the cases and the judgements reached by the review team will be given in the full report.

The clinical reviewers used a structured form adapted from the RCP National Mortality Case Record Review (NMCRR) programme to independently examine phases of care that the patient received, in

addition to a grading system originally developed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) to give an overall perspective on the quality of care. Views were reached after a confirm and challenge meeting chaired by the medical director of invited reviews.

Five cases were graded unsatisfactory, two were graded room for improvement both clinical and organisational, five were graded good practice and two could not be graded due to insufficient information. The team, however, did not receive consent forms for most of the cases (until after the grading) as these were not integrated into the records sent to us, and in many cases, there were gaps in information. This will be reported on in detail, in the full report.

The main themes that arose from the cases graded as unsatisfactory were; the limited evidence of thorough MDT discussions, long delays for treatment, a lack of consultant ownership and poor co-ordination of the patient pathway.

Other cases that raised concerns during our interviews and triangulated by more than one member of staff:

Temporary pacing wires
There was concern from a number of staff that some patients have temporary pacing wires that are left in for too long. Although the review team did not consider these cases within the CRR, it would be advisable that the Trust review its acute pacing processes and check whether the anecdotes we heard of cardiac perforation and tamponade leading to harm, were confirmed.

Never events
During the interviews with staff, we also heard accounts of two potential Never Events. One event related to a possible retained swab and the other where the wrong device was implanted in a patient, which then required the patient to have a further procedure to rectify. We did not have access to the clinical notes of these cases and brief information was provided from a number of different staff in the catheter laboratory, excluding medical staff.

We had little detail of the incident where a swab was retained and simply suggest there are further enquiries.

Regarding the implantation of an incorrect device - from the interviews the review team were informed that the patient was planned to receive a complex device (CRTP/D) however the patient was incorrectly allocated to a consultant whose skill set was in implantation of non-complex devices. The consultant was reportedly not present or did not participate at the WHO checklist and so the circumstances in which the consultant proceeded to implant the non-complex device (PPM) were unclear. It was not clear how and when the implantation of the incorrect device was realised, or at which point the device was changed. From accounts we heard we were of the understanding that the wound was reopened and subsequently after this a pressure bandage was required. We also heard that there had been follow up of the case when the patient returned home and some staff had undertaken a duty of candour.

From our limited understanding of these events, they may meet the criteria of a Never Event however the investigation of them is the responsibility of the Trust. The identified weaknesses of departmental governance (ToR 4) suggest this needs a degree of externality from a senior investigator in the Trust. Although outside the remit of the original RCP ToR, a CRR review of any of these cases can be requested separately, which would give some external assurance of what had been documented in the records. Alternatively, on this occasion we could scrutinise a completed serious incident investigation, if this was

thought to be helpful. Following this, the Trust should discuss with NHSE as to whether these cases would be categorised as Never Events.

These events underlined some of the significant weaknesses of local cardiology clinical governance, with little evidence of structured multi-professional learning. We believe Dr Davison, with managerial support and help from Mr Sedman will improve this assuming "buy in" from his consultant colleagues.

In some cases, we heard about or reviewed appeared to underline that not all consultant staff properly participate in WHO checklists at the start of each procedure. We also heard of other behaviours within the cath lab, from more than one individual, which had the potential to adversely affect patient care.

ToR 2 – service design

We repeatedly heard of the difficulty of running the major cardiology service at Castle Hill (CH) not on the main acute site at Hull Royal Infirmary (HRI). This separation does cause major difficulties, but these are not insurmountable.

The review team noted the need for some aspects of the cardiology service at the Trust to be modernised and be brought up to the standard of cardiology care patients need in 2021. At present the patients in need of cardiology care at HRI are in receipt of an inferior service compared to those patients at CH. Review of patients with a cardiology problem at HRI relies on a bleep system to a single registrar throughout the day. At present the patients at HRI are seen by a consultant in the afternoons (Monday-Friday), although we heard accounts of how this was variable. The recent heart failure audit (data from 2018 – 2019) showed that of 450 heart failure patients at HRI only 3% saw a consultant cardiologist compared to 98% at CH. In most modern services a cardiology patient would expect to be seen by a consultant cardiologist within the first 24 hours of being admitted and for a daily consultant led ward to take place thereafter. Further to this, the responsibility of the most junior registrars managing the cardiology patients at the HRI site, with limited consultant support is deemed unacceptable both from a patient care point of view and training. The cardiologists normally have a significant bed base at CH, however, during the pandemic this has been reduced to one ward which inevitably will lead to more cardiology patients at HRI.

The review team were also informed of the poor echocardiography facilities at the HRI site, where there is no appropriate room for the equipment. This often results in heavy machinery trundled around the tower block to multiple different wards, causing inefficiency and unnecessary delays to patient care.

ToR 3 – team working and leadership

We met a group of individual consultants who did not work well as a team. There is a culture of distrust, a lack of departmental cohesion and allegations of bullying in the department. All of which reinforce a clear divide between the interventional and non-interventional consultant cardiologists. There also appears to be a divide between some of the coronary and TAVI interventionalists and their electrophysiology colleagues. Issues regarding equity of job planning, on call arrangements and a lack of collaboration make life difficult and diminish patient services. There have been a number of allegations of belittling, intimidation and undermining. The review team believe this behaviour is impacting on patient care and therefore, all medical staff should be reminded of Good Medical Practice as the GMC code of conduct of how doctors must work collaboratively with colleagues[1].
Job planning in the department is weak and the Trust should review all the consultant job plans including the equitable allocation of resource across the CH and HRI sites (supported by findings under ToR 2). There are too few specialist nurses to support the cardiology department compared to other

modern cardiology services, and so it is vital that the Trust review the cardiology workforce. Additional consultants maybe needed in specific areas of weakness e.g. the management of heart failure. Despite these limitations, the review team believe new working patterns and team job planning could deliver better care for patients for patients at HRI in the short term and we will include an example rota as an appendix in the full report.

We support the decision to stand down the existing clinical leadership team (as stated Dr Davison should continue to be developed and receive support in his governance role). We welcomed the appointment of Mr Sedman as the interim cardiology lead, he has time, experience and perceived impartiality on his side and received very positive feedback from managers and clinicians alike. Our report should give him a 'roadmap' to improving the cardiology service. We strongly support the move to a separate cardiology directorate, recognising weaknesses in the previous management from a large division predominantly at HRI. More focused management support and clinical leadership roles with appropriate time allocation and training should further help to drive change in the department.

Being positive, there is a lot of talent within the department and the review team felt that the younger consultants who are at the early stages of their career can, with support and encouragement, drive forward change.

ToR 4 – clinical governance

Clinical governance in the department is very weak. There should be regular mortality and morbidity meetings to encourage a culture of learning. There are four busy cath-labs, and, the review team believe current incident reporting seems likely to be underrepresenting when things go wrong, thereby missing the opportunities for joint learning. More should be done to ensure transparency across the department and a move away from incident reporting being viewed as a way of "tit for tat" to manage grievances. Meetings should include all multi-professional staff and should demonstrate the importance and seriousness of an open and transparent patient safety culture.

There is no clear ringfenced time for the consultants to meet formally, and this should be urgently addressed. This includes time for formal MDTs, M&M meetings and governance meetings.

ToR 5 - any new area of concern that arises during the ISR

Dr Chelliah gained positive reviews about his role in improving training in cardiology, however a number of training concerns remain. Inexperienced trainees at ST3 feel isolated and variably supported at HRI. We heard accounts of previous perceived belittling and bullying which were too often portrayed as unchangeable as "they had always been like that" or due to "personality". Behaviour can and must be modified. We heard that the inpatient bed base at CH was poorly covered by core and foundation trainees at weekends.

Separate to this the Department, needs a clear medium-term strategy for Cardiology focused first on improving its weakest services, building workforce in key areas and bringing together services across both sides of the Humber.

In conclusion, the immediate recommendations are listed below. Further recommendations will be presented in the final report.

Immediate recommendations – implementation to start prior to the issue of the final report

1. There is a lack of respect among consultant cardiologists and some behaviours are still reported as being either unacceptable or borderline. The consultant body should be reminded of Good Medical Practice and the need for doctors to work collaboratively with colleagues[1.] Documented poor behaviours should be dealt with under MHPS[2] or appropriate organisational conduct policies.
2. There is an urgent need to ensure a better safety culture in the cath lab. WHO checklists are used by some consultants but not all. All staff (including consultants) must use the WHO checklist at the start of each procedure.
3. There is a need to develop a clear process to investigate serious incidents that may be never events, and to consider those potential events that were raised in the interviews. Corporate oversight and with independent investigation from trained reviewers from other parts of the Trust is likely to be required.
4. There needs to be a standard operating procedure around acute pacing (specifically temporary pacing wires) including how quickly they should be converted to a permanent device.
5. The consultants need to develop a rota to ensure there is a morning ward round for the cardiology inpatients at the HRI.
6. There is a need for a dedicated room for echocardiography near to the inpatients at the HRI site.
7. There is a need for an urgent review of the heart failure service taking into account data from the heart failure audit.

I hope this letter is clear and helpful in summarising the review team's immediate feedback on these matters at the conclusion of the review visit. The team will now work to prepare and finalise the invited service review report, which will be sent to you in due course.

Yours sincerely,

Dr Peter Belfield
Medical Director for Invited Service Reviews

10.4 Appendix 4: A proposed example rota

Based on 14 WTE consultants

- 1 in 14 week general cardiology rota.

During PCI consultant of the week- 9 non-interventional consultants could share HRI morning ward round and appropriate transfers to CHH with registrar support. This will help with prompt NSTEMI care, heart failure input and pacing.

This would be a:

- Non Interventional cardiologist: 1 in 9 In-reach + 1 in 17 gen cardiology
- Interventional cardiologists: 1 in 7 PPCI + 1 in 17 gen cardiology

Three consultants on every week, should work:

- Consultant A. On CCU and ward 1 at CH 8-8 (all 17 consultants part of this rota i.e. 1:17)
- Consultant B. On ward 2 CH am only Mon -Fri (non PCI consultants part of this rota)
- Consultant C. at HRI am only Mon-Fri (Interventional cardiologist part of this rota & pm RACPC/ HOT)

OOH

- The Non PCI doctor doing B does weekend ward round at CH. I.e. 1:9
- The PCI doctor does PPCI 1:7

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board Meeting	**Meeting Date**	9th November 2021
Title	Emergency Planning Resilience and Response Annual Report 2021				
Lead Director	Michelle Cady, Director of Strategy and Planning/Accountable Emergency Officer				
Authors	David Roney, Head of Emergency Planning Jackie Railton, Assistant Director, Strategy and Planning/Emergency Planning Lead				
Report previously considered by (date)	Non Clinical Quality Safety Committee (4th 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 the contents of this Report.

Hull University Teaching Hospitals NHS Trust

Emergency Planning Resilience and Response

Annual Report 2021

1. Background

This report provides an outline of activity relating to Emergency Planning Resilience and Response (EPRR) within Hull University Teaching Hospitals NHS Trust (HUTH) for the period November 2020 to October 2021.

The report includes an overview of compliance levels with the EPRR Assurance Framework, the Trust response to the pandemic, the current position regarding emergency planning, major incident planning, business continuity management, testing and exercising, and other Trust responsibilities under the Civil Contingencies Act 2004.

2. EPRR Assurance Framework 2020/21

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

In 2021, a total of 46 EPRR standards were applicable to the Trust as an acute provider. The Trust achieved full compliance against 44 of the 46 standards and therefore reported a 95.7% compliance rate, resulting in an overall assessment of 'substantially compliant'. A summary of the compliance against the core standards is given below.

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

The areas of partial compliance were in relation to:

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

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

sequential and links to NHS/Hey numbers. This is preferable to a fully paper-based system.

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

An EPRR action plan has been developed to address areas where attention is required and to strengthen areas where the Trust is already compliant. Progress against the actions identified will be monitored through the Trust Resilience Committee and reported quarterly at the Trust Non-Clinical Quality Committee.

The level of compliance with the core standards was agreed by the Trust Board on 14th September 2021.

3. Trust Response to Covid-19 Pandemic

The first UK patients with Coronavirus Disease 2019 (Covid-19) were admitted to Castle Hill Hospital on 30th January 2020. The first Covid-19 related death at HUTH occurred on 19th March 2020. The first wave of the pandemic continued until June 2020 with a peak of 112 Covid positive patients on 1st April 2020.

To manage the response to the pandemic a command structure was established, with Gold Command meetings commencing on 29th January 2020. A full command structure was established from 16th March 2020. This command structure as continued in various formats until the present.

The number of Covid-19 positive patients reduced throughout the summer, both nationally and locally. National infection rates began to increase in September and a second wave started to have a major impact from October 2020, with a peak of 183 positive patients on 16th November 2020.

Following a slight drop in positive patients from mid-December (because of the national lockdown in November), positive patient numbers peaked at 264 on 25th January 2021. Thereafter numbers gradually decreased.

Prior to national restrictions being removed on 19th July 2021, and since that date, there has been a steady rise in the number of Covid positive patients again. At the time of writing this report, the Trust has between 30-40 Covid positive inpatients.

HUTH has experienced in excess of 950 deaths as a result of Covid-19 (September 2021). The highest daily death toll was 16 patients on 7th January 2021. The excess death surge plan was implemented between January and early March 2021 using a temporary mortuary erected at Castle Hill Hospital.

The pandemic has been managed as a national (Level 4) or regional (Level 3) incident throughout with extensive work being undertaken from an EPRR perspective to support the Trust and regional response.

From an EPRR perspective some key elements of the HUTH response to the pandemic have been:

- Establishment of an Incident Coordination Centre for Covid-19 from March 2020 based in Alderson House, Hull Royal Infirmary. The physical location was stood down in May 2021 and the ICC has been run as a ‘virtual ICC’ since that date.

- Attendance at Local Resilience Forum (LRF) Strategic Coordinating Group and LRF Tactical Coordinating Group meetings throughout the pandemic.
- Establishment and monitoring a dedicated Covid-19 inbox as a single point of contact for all Covid-19 NHSE/I and PHE issued correspondence and guidance for the Trust. The mailbox has been managed by members of the Strategy and Planning Directorate on a rota basis since April 2020 and has included weekend and bank holiday working to ensure that guidance is disseminated within the Trust and acted upon.
- Provision of support to Silver and Gold meetings at weekends and bank holidays during the highest peaks of the pandemic.
- Reporting of all deaths recorded within 28 days of a positive Covid-19 test on the Covid-19 Patient Notification System (CPNS) website.
- Liaison with partner agencies in relation to mutual aid (eg PPE, repatriation of patients)
- Engagement with NHSE NE&Y EPRR colleagues and points of contact for the NHSE Joint Regional Operations Centre (JROC)
- Provision of a Commonly Recognised Information Picture (CRIP) to inform the command structure members' situational awareness.

4. Transition from the European Union

The United Kingdom left the European Union at 11pm on 31st December 2020. Risks in respect of the supply of medicines and clinical equipment, workforce and delays within the supply chain were planned for on a national and local level and contingencies put in place. In HUTH, the risks were managed by an EU Transition Planning Group.

Prior to the transition date, the imposition of border controls by the EU because of Covid-19 was a 'dry run' for anticipated issues, but no issues were forthcoming across the NHS at that time.

The new employment rules came into place in April 2021 and so far there has been no impact upon the Trust, with the vast majority of staff from the EU signing up to the EU Settlement Scheme.

The border control changes were postponed, initially to July 2021, and further delayed until October 2021 to allow businesses to adapt to the changes. The Emergency Planning Team continue to monitor any likely impact of these changes when they come into effect.

5. Business Continuity Management

In October 2020 the Trust adopted a new format for Business Continuity Plans (BCPs) based upon a Business Impact Assessment Model recommended by NHSEI. The model ensures that all critical and priority activities are recorded and BCPs put in place to ensure they are resilient.

The model requires each function to have a clear maximum tolerable period of disruption and recovery time objectives, which are understood by the relevant Directorate or Health Group and reflected in BCPs, and service contracts where appropriate.

The new model is easier for authors to complete and review, but to assist in the change, the Head of Emergency Planning held three workshops for authors and holds regular BCP surgeries with BCP authors.

There is a hierarchy of Business Continuity Management, with a Business Continuity Policy that sets out Trust priorities and legal obligations, and an overarching BCP that catalogues critical and priority functions, including IT systems and clinical specialties.

BCPs are reviewed annually at Health Group or Directorate level and progress reported through the Trust Resilience Committee to the Non Clinical Quality Committee.

6. Major Incident Plan

The Trust Major Incident Plan has undergone a major review. The new Major Incident Plan will be published in November 2021.

The new plan includes a clearer process for the management of casualties, in particular within the Emergency Department. It also includes a cascade communications process for Health Groups at the declaration of a major incident. The plan has been stripped back and much of the legal and procedural processes removed from the main body of the plan and included as appendices. This will make the plan easier to read and to update.

A substantial communications campaign and training package will support the launch of the new plan in November 2021

7. Other Trust-wide Plans

In October 2020 the Trust approved a Full and Partial Evacuation Plan supported by a Lockdown Plan. This was tested with partners through a series of internal and external table top exercises and has been updated in the light of changes to Infection Prevention and Control guidance following the Covid-19 pandemic. The plans were reviewed further to take account of the fire risk associated with the increased supply of piped oxygen across the Trust, in particular at HRI.

Because of a high risk of evacuation at Airedale Hospital owing to a long-term failure of Reinforced Aerated Autoclaved Concrete (RAAC) across a large part of the hospital, Trusts likely to receive evacuated patients have been required to develop plans for the receipt of evacuated patients. Although HUTH would only be required to accept some tertiary care patients, the Trust has developed a full plan for the receipt of evacuated patients from any other Trust.

The HUTH Adverse Weather Plan has undergone a significant review to bring it in line with national guidance.

A separate Heatwave Plan was developed for 2020 in response to the higher number of staff wearing Personal Protective Equipment (PPE) during the summer due to the Covid-19 pandemic. The Heatwave plan included a reduction in the heatwave temperature trigger point from 26°C to 23°C. This plan was refreshed for the summer of 2021.

The Adverse Weather Plan is overseen by an Adverse Weather Planning Group, chaired by the Head of Emergency Planning with membership from across the Trust, including all Health Groups.

The Chemical, Biological, Radiological or Nuclear (CBRN) Plan is being reviewed in order to reflect changes to procedures following the purchase of a new CBRN decontamination tent this year. The new plan will also include learning from two recent incidents that highlighted some gaps in the current plan.

All plans have a review cycle, dependent on a number of factors. Other Trust plans that have undergone a significant review in the past year include:

- Pandemic Influenza Plan
- Flood Plan
- Industrial Action Framework
- Fuel Disruption Plan.

8. EPRR Training

8.1 Strategic Leadership in a Crisis (SLiC) Training

Two SLiC training events were held in 2020/21 for managers within the Trust. The training encourages delegates to:

- Practice the use of the UK's incident management model.
- Consider the implications of good practice in record keeping.
- Provide the knowledge to evaluate the Board's state of readiness with regard to disruptive challenges
- Practice the use of the Joint Decision Model
- Discuss the legal requirements of the Civil Contingencies Act 2004, together with EPRR guidance arrangements.

8.2 On Call Command Training Framework

In October 2020, the Trust Resilience Committee approved the development of a Command Training Framework to be undertaken by all those who undertake First On Call and Director on Call duties. Also included were members of the Site Team and those managers identified by the Trust as likely to play a significant role in a major or critical incident.

The training is built around National Occupational Standards (NOS) for Command as recommended for all organisations who are Category One responders under the Civil Contingencies Act 2004 and who operate within the Joint Emergency Service Interoperability Programme (JESIP).

In April 2021, the HUTH Executive Directors Group agreed that the training should become mandatory for those highlighted above. The training was developed as a face-to-face training package, but, owing to severe pressures across the Trust, an on-line version of the training is being developed and will be available on Hey247 from October 2021.

8.3 EPRR Training

The HUTH EPRR initial training package is in the process of being refreshed to reflect the new Major Incident Plan from November 2021 and a refresher course will be made available for all staff to undertake every three years.

8.4 CBRN Training

An on-line training programme has been developed to assist staff in responding to CBRN incidents.

9. Testing and Exercising

The Civil Contingencies Act (CCA) 2004 requires Category One responders to test their capability to respond to incidents. We are required to hold a Trust tabletop exercise annually and a live exercise every three years. The Trust last held a live exercise in June 2017. Trusts were not required to hold a live exercise in 2020 because of the pandemic.

Trusts demonstrating that they had managed Covid-19 as a major incident and identified lessons learned from that incident are currently exempt from holding a live exercise. However, we are still required to hold a live CBRN exercise as recommended by the 2019 CBRN audit. To comply with this requirement, HUTH has worked with the Yorkshire Ambulance Service to develop a multi-agency CBRN exercise. This was due to take place on 18th September 2021, but was postponed until 14th May 2022 because of operational pressures experienced by YAS and HUTH. The incident, based around an accident at a local factory, will be played out at Hull College with participation from Humberside Police, Humberside Fire and Rescue Service, NHSEI and other Local Resilience Forum partners.

Because of the impact of Covid-19, and instruction from NHSEI to cancel all other activity during the first wave of the pandemic, no exercising took place in the early part of 2020. Exercising recommenced from September 2020. During the past year, highlights have included:

- HUTH collaboration with other Trusts across the region to develop a tabletop exercise to test the capability of Trusts to manage an incident involving loss of oxygen on a respiratory ward (H37).
- A tabletop exercise with partners to test the 2020/21 winter plan
- A tabletop exercise to test resilience of the Trust to the transition of the UK form the European Union.
- A Trust-wide IT systems tabletop exercise to inform the BCP prioritisation of systems.
- A series of tabletop exercises to test Site Team management of an incident.
- Live simulation exercise to test the new CBRN decontamination tent.

The Trust has also been involved in exercising with local sites controlled by the Control of Major Accident Hazards (COMAH) regulations. There are nearly thirty such sites (factories, gas and chemical plants etc) across the region so joint awareness is essential.

The Trust will also play a lead role in an exercise to test the response of the Local Resilience Forum, emergency services and other partner agency to a coastal flood, which will take place in September 2022 (postponed from October 2020).

The Trust has an exercise calendar, which currently runs until March 2023.

10. Incident Debriefing and EPRR Action Plan
Similar to the CCA requirement to test our capability to respond to incidents, we are also required to conduct debriefing to ensure lessons learned from the management of incidents are included in future plans. The record of debriefing and actions (as well as actions from exercises) are included in a HUTH EPRR Action Plan.

Examples of incidents debriefed and included in the Action Plan include:

- Covid-19 response (waves one and two)
- Supply disruption on Becton Dickinson Infusion pumps
- Fire in ward H1.

11. Other Issues
Other issues that fall within the EPRR remit have been addressed in the past year:

11.1 Medical Emergency Response Intervention Team (MERIT)
The Trust has been a member of the Yorkshire Ambulance Service MERIT since 2018. Following some amendments, a formal agreement with Yorkshire Ambulance Service (YAS) for MERIT was signed in August 2021. YAS provides funding of £37,000 per year to HUTH to pay for training, equipment and back filling of staff deployed on MERIT. The Trust has recently purchased equipment (overalls, warm clothing, PPE) for Trust members of staff who would participate in MERIT.

The Trust now has a MERIT Standard Operating Procedure that highlights the process for training, equipping and deploying staff as part of the regional MERIT response.

The YAS MERIT Steering Group is reviewing MERIT training to make it available on-line. This should be in place later this year.

YAS are planning a MERIT deployment exercise for mid-March 2022. This will be the first of three, annual, MERIT exercises intended to culminate in a full exercise in late 2023.

11.2 Local Resilience Forum (LRF) Engagement
The Assistant Director, Strategy and Planning, attends LRF Strategic Coordination Group meetings and the Head of Emergency Planning attends the LRF Tactical Coordinating Group. Both attend the LRF General Working Group and the Head of Emergency Planning is a member of the LRF Interoperability Sub-Group.

The Director of Strategy and Planning attends the Local Health Resilience Partnership (LHRP) meetings.

11.3 Regional EPRR Engagement
The Assistant Director, Strategy and Planning, and Head of Emergency Planning both attend weekly Yorkshire and Humber EPRR meetings in order to keep abreast of regional EPRR issues and latest guidance and direction.

The Head of Emergency Planning is a member of Regional EPRR led working groups in respect of Command and Control, Testing and Exercising and Tidal Inundation Planning. He is also chairing a small group of EPRR Leads developing a training package for on call managers for the region. He also chairs a monthly meeting of other Heads of Emergency planning from across the Humber Coast and Vale ICS.

This engagement provides the opportunity to share good practice and ensures an effective peer assessment of plans.

12. Future Developments
The Government is currently conducting the five yearly review of the Civil Contingencies Act. The Trust has contributed to the local review meeting hosted by the LRF. Likewise, the Trust has provided feedback to the national resilience review. Both of these reviews are likely to reinforce the requirement on organisations to become more resilient in the face of climate change, global terrorism, an ageing population and economic uncertainty.

With the formal statutory establishment of Integrated Care Systems anticipated in 2022, it is expected that ICSs will be considered as Category One responders under the Civil Contingencies Act. Conformation of the change is awaited.

In anticipation, the LHRP has established a working group to assess the implications of the change and to develop ICS procedures to embed Category One status once the changes have been confirmed. HUTH is represented on this working group by the Head of Emergency Planning.

13. Recommendation
The Trust Board is asked to note the contents of this Report.

Michelle Cady
Accountable Emergency Officer
Director of Strategy and Planning

15 October 2021

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee

Agenda Item	8.6	**Meeting**	Trust Board Meeting	**Meeting Date**	9/11/2021
Title	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4				
Lead Director	Beverley Geary Chief Nurse				
Author	Lorraine Cooper Head of Midwifery				
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	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 the details of the deaths reviewed and the action plans.
- Decide if any further information and/or assurance are required.

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee

CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)
MATERNITY INCENTIVE SCHEME – YEAR 4
November 2021

1. PURPOSE OF THE REPORT

The purpose of this report is to provide information following a review of the impact of Covid-19, and readiness to apply for a 10% reduction in the Clinical Negligence Scheme for Trusts (CNST) Maternity premium in 2021/22.

This report presents the following:

- Background
- Covid-19 impact on reporting
- Review of the year three CNST safety actions

2. BACKGROUND

As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the Clinical Negligence Scheme for Trusts (CNST), administered by NHS Resolution. The Maternity CNST rebate in 2019 was £470k with a further £21k allocation from Trusts who were not compliant with all ten-safety actions.

3. COVID-19 IMPACT ON REPORTING

The 10 maternity safety actions are, as follows:

1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care (TC) services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? (ATAIN)
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2 (SBLCBv2)?
7. 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?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification (NHSEN) scheme?

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee

Pause in reporting procedure regarding the maternity incentive scheme

March 2020 NHSR contacted all Trusts to inform that in recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme 10 safety actions would be paused with immediate effect **until Monday 31 August 2020**. Trusts are asked to continue to apply the principles of the 10 safety actions, given that the aim of the maternity incentive scheme is to support the delivery of safer maternity care.

There was still a requirement to report perinatal deaths to MBRRACE-UK and eligible cases to the Early Notification (EN) scheme. With a reasonable effort made to make a monthly Maternity Services Data Set submission to NHS Digital.
There was a requirement to comply with the following:
Notification of all deaths;

Complete the surveillance information for COVID-19 related perinatal deaths
Complete the perinatal surveillance information for all other deaths, depending on capacity
Complete the reviews using the Perinatal Mortality Review Tool, depending on capacity

The reporting period has been extended although we are awaiting confirmation of the reporting and submission periods. In response to the current situation, the 10% uplift to the Clinical Negligence Scheme for Trusts (CNST) for the maternity incentive scheme has not been collected for the year 2020/2021.

Safety Action	Compliance	Board Request
1	**Perinatal Mortality Review Tool Partial COMPLIANT**	All perinatal deaths eligible to be notified to MBRRACEUK from 1 September 2021 onwards must be notified to MBRRACE-UK within two working days and the surveillance information where required must be completed within one month of the death. Quarterly reports submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports discussed with the Trust maternity safety and Board level safety champions.
2	**MSDS Not Compliant**	Trust Board to confirm that they have either 1)already procured a Maternity Information System complying with the forthcoming commercial framework (to be published by NHSX) and are complying with Information Standard Notices DCB1513 and DCB3066 or 2) Have a fully funded plan to procure a Maternity Information System from the forthcoming commercial framework, comply with the above Information Standard Notices, and attend at least one engagement session organised by NHSX. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022. The data for January 2022 will be available on the dashboard during April 2022. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022 for the following 5 metrics:

3	**TRANSITIONAL CARE PARTIAL COMPLIANCE**	The pathway of care into transitional fully implemented and audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter
4	**Medical Staffing PARTIAL COMPLIANCE**	**Obstetric medical workforce** The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/ **Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1) **Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements are not met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. **Neonatal nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If the requirements are not met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead.
5	**Midwifery Staffing PARTIAL COMPLIANCE**	**Bi Annual Chief Nurse staffing report to Trust Board outlining:** a) A systematic, evidence-based process to calculate midwifery staffing establishment completed. b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service c) All women in active labour receive one-to-one midwifery care d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.
6	**SBLV2 PARTIAL COMPLIANCE**	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.

		2. Each element of the SBLCBv2 should have been implemented; Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. 3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.
7	**Maternity Voices Partnership PARTIAL COMPLIANCE**	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 (MVP) to coproduce local maternity services?
8	**Mandatory Training PARTIAL COMPLIANCE**	90% of each relevant maternity unit staff group have attended an 'in-house' one-day multiprofessional training day, to include maternity emergencies starting from the launch of MIS year four in August 2021. 90% of each relevant maternity unit staff group have attended an 'in-house' one day multiprofessional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four in August 2021. Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021.
9	**Safety Champions PARTIAL COMPLIANCE**	Safety Champion meetings were suspended but have now recommenced with dates for Chief Nurse surgeries to be agreed. Monthly Safety Champion meeting continue
10	**NHS Resolution PARTIAL COMPLIANCE**	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and number reported to NHS Resolution

7. SUMMARY

In summary, following a review of the current position the service is declaring partial compliance with seven of the required CNST Incentive safety actions, full compliance with one, partial compliance with eight and non-compliance with one standard. A quarterly update will be provided, and the final evidence to be signed off by the Chief Executive will be submitted once the submission dates have been agreed with NHSR.

Attached APPENDIX 1 is a comparison of the year 3 & 4 standards and challenges to achieving year 4 safety standards.

8. RECOMMENDATIONS

The Trust Board is requested to:

- Agree that the review of the position at this current time demonstrates partial achievement of eight of the maternity safety actions, non-compliance with two safety actions.
- Decide if any further information and/or assurance is required.

Lorraine Cooper
Head of Midwifery
November 2021

Beverley Geary
Executive Chief Nurse

APPENDIX 1

Briefing Paper
Clinical Negligence Schemes for Trust
Year Three and Four Comparison

Background

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions.

Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Rationale

The purpose of this paper is to identify to the Trust Board and Executive team the main comparisons and potential resource required between year three and year four of the CNST scheme. On review of year four CNST scheme, there are significant changes to the following identified safety actions:

Safety Action 1 - Perinatal Mortality Review Tool

- Notification to MBRRACE-UK, changed from 7 working days to 2 working days
- Surveillance form must be completed, changed from within 4 months of the death to within 1 month of the death.
- Timeframe for review using PMRT changed to will have been started within two months of each death.
- PMRT cannot be completed until the HSIB report is complete
- Draft report timeframe changed to within four months of each death and the report published within six months of each death.
- Quarterly reports discussed with Trust Maternity Safety Champions, now includes Board Level Safety Champions.

Safety Action 2 - MSDS data

There are significant detailed targets and dates that are listed for Year 4 for MSDS data ensuring that Maternity Information System procured or fully funded. Data quality criteria for at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs), data submission by January 2022.

Safety Action 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?

- Pathways of care into transitional care reintroduce with a focus on minimising separation of mothers and babies.
- Reintroduce with audit period changed from every other month to quarterly. Audit to also be shared with LMNS, Commissioners and ICS at quality surveillance meeting each quarter.

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee

Safety action 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

- The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: "Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology" https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/. (By January 2022 and monitored monthly from then).
- Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.
- A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times.
- The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year three of MIS as well include new relevant actions to address deficiencies.

Safety action 6

Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

- There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.
- They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).
- Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.
- They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems.

Safety action 8

Can you evidence that a local training plan is in place to ensure that all six-core modules of the Core Competency Framework will be included in your unit-training programme over the next 3 years, starting from the launch of MIS year 4?

- A training plan should be in place to cover all six-core modules of the Core Competency Framework. The training plan will span a 3-year time period and will include;
  - 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
  - Neonatal life support
- A multi-professional 'in house' training day should be reinstated as face-to-face training no later than the 30th September 2021 (in line with Public Health England COVID-19 guidance).
  - Fetal monitoring and surveillance (in the antenatal and intrapartum period)
  - Maternity emergencies training scenarios,
  - Neonatal life support

- Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum:
  - Risk assessment
  - Intermittent auscultation
  - Electronic fetal monitoring
  - System level issues e.g. human factors, classification, escalation and situational awareness
  - Use of local case histories
  - Using their local CTG machines

Safety action 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

- The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the 'implementing-a-revised-perinatal-quality surveillance-model.pdf'(england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.
- Board level safety champions present a locally agreed dashboard to the Board on a quarterly basis. To include, as a minimum, the measures set out in Appendix 2 of the perinatal quality surveillance model, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.
- Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes.

Conclusion

There are significant detailed targets and dates that are listed for Year 4 MSDS data ensuring that Maternity Information System procured or fully funded. Data quality criteria for at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs), data submission by January 2022. HUTH will be transferring over to an LMS system wide maternity IT system, which may affect data capture and submission.

The service has identified that Safety Action 4 will require investment in consultant obstetricians to meet the recommendation in the RCOG workforce document by January 2022.

The neonatal Nurse staffing is an ongoing priority for Safety Action 4 to ensure the service meets the service specifications for nursing standards.

Safety Action 8 will require the release of midwifery, neonatal, anaesthetic, ODPs and medical staff for mandatory training compliance against Ockenden standards.

Safety Action 9 will require a robust plan in line with national guidance to delivery wholescale continuity of carer and sufficient midwifery workforce.

Recommendations

The Executives are asked:

1. Review the paper to meet the year 4 safety actions
2. Decide if any further information and/or assurance are required.

Lorraine Cooper
Head of Midwifery

Agenda Item	8.7	**Meeting**	Trust Board Meeting	**Meeting Date**	9/11/2021
Title	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				
Lead Director	Beverley Geary Chief Nurse				
Author	Lorraine Cooper Head of Midwifery				
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	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 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.

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, to the standard required by the Clinical Negligence Scheme for Trusts (CNST), is completing the national Perinatal Review Tool.

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 two 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. **All** perinatal deaths in the Trust in the reporting period were notified to MBRRACE-UK within 7 working days up to the 31 August 2021. From the 1 September, all deaths have been notified with 2 working days.

ii.**100%** of all deaths of babies, suitable for review using the PMRT, have been started within two months of each death in the Trust reporting period

b) 73% of all deaths of babies (suitable for review using the PMRT) who were born and died in the Trust, including home births, in 2021 up to the present time have been reviewed using the PMRT, by a multidisciplinary review team as required by CNST. These cases were completed to the point that at least the tool has generated a draft report, 64% have a completed published report. More complex cases have required more than 4 months to complete.

c) In 100% of all deaths of babies who were born and died in the Trust Quarter 2 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.

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 November 2021

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee

APPENDIX 1 September 2021 PMRT Update

Hull University Teaching Hospitals NHS Trust Perinatal Mortality Review Tool Review update September 2021								
Outstanding and completed Neonatal cases upto September 2021								
	MBRRACE ID	**Stillbirth/ Neonatal Death**	**Date of death**	**PMRT commenced**	**Target for completion**	**PMRT Completed**	**Grading**	**Actions / Good practice**
1	**73630**	NND @ 9 days 24+5 weeks	13/02/2021	**15/03/2021**	13/06/2021	**31/08/2021**	**A/C/A**	SI investigation
2	**74352**	NND @ 4 weeks 37+3 weeks	16/03/2021	**24/03/2021**	16/07/2021	**27/09/2021**	**D/A/A**	Refered to the Coroner
3	**74488**	NND 22+2 weeks	17/03/2021	**30/03/2021**	17/07/2021	**26/08/2021**	**B/B/A**	Report published
4	**75197**	NND 24+3 week Twin	09/05/2021	**11/05/2021**	09/09/2021			Joint review with York
5	**75315**	NND 22+3 weeks	17/05/2021	**09/06/2021**	17/09/2021	**31/08/2021**	**A/B/A**	Issues with thermal management
6	**75708**	NND @ 4 months	07/06/2021	**11/06/2021**	07/10/2021			Under review
7	**76028**	NND 23 weeks	01/07/2021	**25/07/2021**	01/11/2021	**27/09/2021**	**C/B/A**	Writing report- SI investigation
8	**77473**	NND @ 6 weeks	25/09/2021	**27/09/2021**	25/01/2022			Joint review withYork - assigned to York
	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 September 2021								
1	**75266**	SB 36+4 weeks	14/05/2021	**17/05/2021**	14/09/2021	**30/07/2021**	**D/A**	PMRT report published -SI
2	**75364**	Term SB 40+2 weeks	19/05/2021	**21/05/2021**	19/09/2021	**30/07/2021**	**C/A**	PMRT report published -HSIB
3	**75416**	Term SB 38+6 weeks	22/05/2021	**26/05/2021**	22/09/2021	**30/07/2021**	**C/B**	PMRT report published -SI
4	**75484**	SB 36+6 weeks	26/05/2021	**17/06/2021**	17/09/2021	**08/09/2021**	**B/A**	Complete , writing report- Aspirin guideline to be reviewed
5	**75490**	Late miscarriage 23 weeks	28/05/2021	**11/06/2021**	28/09/2021	**30/07/2021**	**B/A**	Report published - feedback re risk assessment at booking
6	**76086**	Twin 1 SB Twin 2 LB	06/07/2021	**04/08/2021**	06/11/2021	**01/09/2021**	**A/A**	Complete- no issues identified
7	**76348**	24 week SB	22/07/2021	**26/07/2021**	22/11/2021	**24/09/2021**	**A/A**	Complete -no issues
8	**76538**	34+6 week SB	02/08/2021	**04/08/2021**	02/12/2021			Under review
9	**76761**	27+2 week SB	18/08/2021	**23/08/2021**	18/12/2021			Under joint review with Wales

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee

APPENDIX 2
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
PMRT ACTION MATERNITYTRACKER SEPTEMBER 2021

MBRRACE ID	ACTIONS	Lead	Due date	RAG
74352	External investigation by HSIB and The Coroner			
75266	RRR completed – escalated as an SI			
75364	External investigation by HSIB			
75416	RRR completed – escalated as an SI			
75484	Review the evidence and guidance on prescribing Aspirin at booking when previous SGA suspected	JG	31/12/21	
	Review the guidance for advice when women report an intolerance to aspirin	JG	31/12/21	
	Reminder to staff the importance of recording conversations and concerns raised by women	SC	29/10/21	
75490	Reminder to midwifery staff on the monthly PMRT newsletter re risk allocation when women book after 12 weeks	SC		
	Reminder to staff on monthly PMRT newsletter re completion of partograms	SC		
76028	Reminder to staff on the monthly PMRT newsletter re ensuring women receive written information on reduced fetal movements and that this is recorded in the hand held records	SC	29/10/21	
	Issues referred for an SI investigations related to management of reduced movements and diagnosis of preterm labour			
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 Front Sheet

Agenda Item	8.8	**Meeting**	Trust Board	**Meeting Date**	9.11.21
Title	Research and Innovation Strategy Update				
Lead Director	Makani Purva, Chief Medical Officer				
Author	Thozhukat Sathyapalan R&D Director				
Report previously considered by (date)	The report is considered at the Board and 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 asked to acknowledge the tireless efforts of all staff (research and non-research) in ensuring all possible opportunities to participate have been made available for our patients, staff and carers.

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

The ongoing support of the Trust Board is sought in the pursuit of the outlined strategic initiatives.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

RESEARCH AND INNOVATION STRATEGY UPDATE

1. PURPOSE OF PAPER

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

2. BACKGROUND

The Trust Board approved the 2018-2023 Research and Innovation Strategy in July 2018. A focussed, high-level three-year plan that takes account of the impact of COVID-19 is outlined in Appendix *1*.

The ambitious HUTH R&I Strategy seeks the creation of a well-led 'research active and aware' workforce enabling high quality care for every patient through research opportunities. To achieve this, it is fundamental that there are mechanisms to increase our capacity and capability for research in order to recruit and retain remarkable staff and high-quality researchers and develop the research potential further in all professional groups, service users and carers.

The opportunity to seize the momentum for engagement and growth in research among senior clinical colleagues is now. Underpinning this aim is the requirement for investment in people to deliver research that will translate into the provision of safe, high quality care with greater clinical outcomes than those organisations that do not support research investment.

A national programme of 'managed recovery' has been implemented to ensure that non-COVID 19 research activity resumes to pre-pandemic levels as rapidly as possible. The Trust has achieved 105% of its 2021-22 participant recruitment target in the first half of this year with over 4,500 recruits. A strategic focus on the restart and recovery of commercially-led research has seen the Trust deliver the third highest commercial trial participants in Yorkshire and Humber (in the year to date), and is currently second only to Leeds Teaching Hospitals in terms of the number of open and recruiting commercial studies.

Appendices 2–5 provide an overview of the Trust's current research activity as at 4th November 2021.

Following the Trust's tremendous contribution to COVID-19 research over the past 18 months, is it critical that it can build on this momentum and champion research as a treatment option for those who have to use our services within both our acute setting and the wider Humber Coast and Vale ICS.

3. PROGRESS TO DATE ON KEY STRATEGIC PRIORITIES

There are a number of initiatives that are currently underpinning the delivery of the R&I Strategy:

a) Reputation through Research:

- **Significantly increasing Trust-led research undertaken nationally** - as our research activity and workforce capacity incrementally expands, our success in securing externally funded grant income from the NIHR continues. We can now boast to lead multi-centre national research in the areas of Vascular Surgery, Gastroenterology (IBD and Hepatology), Renal, Orthopaedics, Respiratory, Infection and Haematology.
- **Expanding our 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. This will initially support the delivery of a specific commercial trial but will open up the possibility of further work seen as critical to the ability of the Trust to participate in this emerging field across both Infection and Oncology.
- **Establishing research programmes with the potential to positively impact our key performance and quality indicators –** The Hull Lung Health Study builds on the fantastic work of the HCV ICS Hull Lung Health checks. This data collection study will generate a highly valuable cohort dataset that can help determine future research and influence the direction of service provision in this area.

- **Exploiting our research potential –** A concerted effort by our local partners (HYMS, UoH) to bring together all key stakeholders to embed pipeline of PET-CT research is gathering momentum with one study in the advance stages of negotiation with an international commercial company.

b) Research Aware Organisation:

- **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** – a number of initiatives are currently being enacted to support the aim of increasing visibility of our research activity, outputs and impact, including the overall dissemination of the added value to the delivery of high quality care provision. These include the rebranding of the R&D office, a refresh of the R&D Website, the creation of an e-newsletter, an external communications campaign, development of promotional materials and videos for social media.
- **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.

c) Positive Proactive Partnerships:

- ***Humber Coast and Vale ICS* -** The Trust wishes to lead the establishment of a Humber, Coast and Vale Integrated Care System 'Research Collaborative' initially of the Acute Providers in the patch; Harrogate, HUTH, NLAG and York. 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.
- **University of Hull/HYMS –** as our core academic partners, the Trust continues to be supported in ensuring our mutually beneficial strategic aims can be realised. Currently, a secondment opportunity for an Innovation Hub Manager is out to advert. Over the next 12 months, the post-holder will be crucial in identifying our collective innovation assets as well pulling together a prioritisation of innovation projects that would harness the academic and clinical synergies of our partnerships. In addition to this, further support from HYMS will be received over the next academic year to support the academic components of two senior clinical posts in imaging – a major boost to our collective efforts to build a platform from which to grow our ambition of Hull being at the forefront of imaging and specifically PET-CT research.
- **Cancer Data Network (IQVIA)** – The R&D Office is currently working with IT colleagues and the commercial company IQVIA to explore the possibility of implementing the infrastructure to host the 'Cancer Data Network'. This is multi-faceted with a focus on (1) advanced on-site cancer data analytics and benchmarking to identify variations in pathways and (2) research services and trial matching solutions to optimise research as a treatment option for these patients. Fundamentally, this is aimed at increasing treatment options of cancer patients (there are plans to extend beyond cancer but the focus initially would be oncology). The implementation would drive efficiencies in viewing data and making clinical decisions to reduce variations in practice but also from a research perspective, would save valuable hours of pre-screening that is currently done manually.
- **Donate For Research Initiative (DRI)** – The R&D Office is working with the company DRI to support the use of otherwise surplus tissue and bio-samples to researchers globally in the academic or commercial sector. It is hoped this will be a vehicle to increase the understanding of research in frontline clinical staff as well as communicating how patients can support research as part of their routine clinical pathways. An additional benefit is the potential to generate an income stream that could be re-invested in identified green shoots research areas across the Trust.

4. IMPACT

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

It should be acknowledged that our ongoing legacy of COVID-19 research activity will continue to be prioritised well into 2022-23 and plans for ensuring an agile and resilient workforce are being enacted.

Increasing awareness and visibility potentially increases a wider research appetite and in turn, this increases the volume of our research activity overall. This can then stimulate an upsurge in research income for reinvestment and growth, supporting clinical service development for high-quality care delivery and the appointment and retention of high-calibre staff.

5. CHALLENGES AND RISKS

There are a number of potential challenges and risks that may impact strategic progress if unresolved.

a) Risks:

- 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 accommodation issues.

b) Challenges/Risk Appetite:

The Trust must continue to risk-assess the balance of investment in R&I capacity against that of other competing priorities, taking into account the reputational momentum that has accrued over the last year in relation to the delivery of a comprehensive and highly effective COVID-19 research programme. Capitalising on this momentum with additional investment should be seen as a priority for the organisation to accelerate the goals of the R&I Strategy.

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

6. RECOMMENDATION

The Trust Board is asked to acknowledge the tireless efforts of all staff (research and non-research) in ensuring all possible opportunities to participate have been made available for our patients, staff and carers.

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

The ongoing support of the Trust Board is sought in the pursuit of the outlined strategic initiatives.

Prof Thozhukat Sathyapalan
R&D Director, Hull University Teaching Hospitals NHS Trust

November 2021

Appendix 1: R&I Strategic Focus 2021-2024

Goal	Element	Strategic Ambition	Measures	Yr1 Objective	Yr2 Objective	Yr3 Objective	AEO
Great Future	Research & Innovation	*We will create a well-led 'research active and aware' workforce enabling high quality care for every patient through research opportunities*	*Developing a research communications and engagement strategy.* *Actively pursue the integration of research and innovations activities into clinical services at all levels*	*Refreshed Research Website* *Rebranding launch of RDI Directorate* *'Research Celebration' Conference* *Establish a combined Trust and University partner annual review of current PA levels for and job planning for research components of our staffing groups.*	*Establish a Research Nurse Mentorship Programme.* *Establish a 'Research Ambassador' in each of our identified 'core, growth or developmental' research priority areas.* *Cohort of 10 Consultant PAs (20% protected time) allocated.*	*Establish 10 'Innovation Champions' throughout the Trust.* *Cohort of 10 Consultant PAs (20% protected time) allocated and established as long-term investment.*	MP
		We will lead collaborative partnerships in the region to realise the full potential of research and innovation	*Strategic and co-ordinated investment in research capacity and supporting the creation of major investment in clinical and translational research across UoH/HYMS and HC&V* *Development of an industry engagement document highlighting our facilities, expertise and capabilities.*	*Become a strategic leader in the HCV ICS Research Collaborative (formal research alliance with NLAG and Humber).* *Appointment of Hull Innovation Hub Manager with UoH.* *Create Industry Engagement Document.* *Increase income from commercially funded research by 20% year-on-year from baseline.*	*Support the UoH in securing full UKCRC accreditation status for the Hull Health Trials Unit by 2023.* *Functional 'Innovation Portal' cultivating priority innovation projects across the Trust.* *Secure one new long-term commercial research partnerships*	*Creation of a Joint HUTH and UoH R&I Support Service* *Secure one new long-term commercial research partnerships (with at least one of these from a Hull based company).*	MP
		We will create a positive reputation through our research, increasing R&I capability and demonstrably improving patient care and experience	*Develop mechanisms to ensure every patient is offered the opportunity to participate in research.* *Development of educational resources facilitated by an overseas exchange programme of staff and resources*	*Seek to establish research programmes with the potential to positively impact our key performance and quality indicators (i.e. A&E and cancer waiting times).* *Support the establishment of Hull as a national centre of excellence for research on PET-CT imaging and the development of radiopharmaceuticals.* *Achieve all Department of Health and NIHR research performance metrics* *Overseas simulation fellowship opportunities-to commence*	*Achieve all Department of Health and NIHR research performance metrics* *Portfolio of PET-CT research established.* *Develop currently established international links in Diabetes, Microfluidics, Sports Science (one joint grant awarded).*	*Achieve all Department of Health and NIHR research performance metrics.* *Secure a 'top 20' national ranking for number of patients recruited to studies (and number of studies) to studies in the NIHR Clinical Research Network (CRN) portfolio.* *Established exchange programme for doctors in key specialities.*	MP

Appendix 2: HUTH Research Activity Performance Summary 04.11.21

NIHR | Clinical Research Network Yorkshire and Humber

CRN: Yorkshire and Humber
Performance Summary FY2122
Hull University Teaching Hospitals NHS Trust

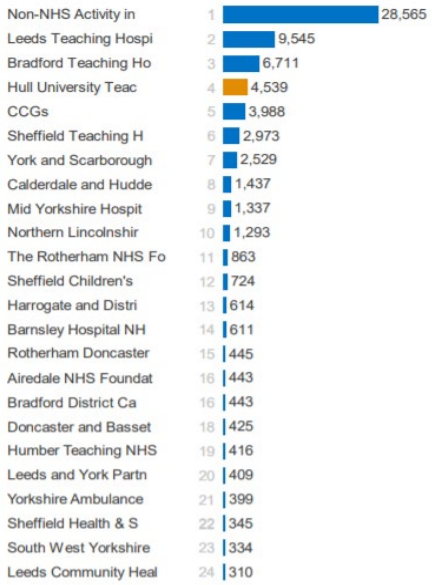
Recruitment Summary FY2122 (data cut 04/11/2021)

Recruitment	Total:	**4,539**	Queried: 54
Percentage of YTD Recruitment Targets *		**180%**	
Percentage of Year End Recruitment Targets **		**105%**	
Trust Share of LCRN Recruitment		**6.5%**	
Commercial : Non-Commercial Recruitment Ratio		**3% : 97%**	

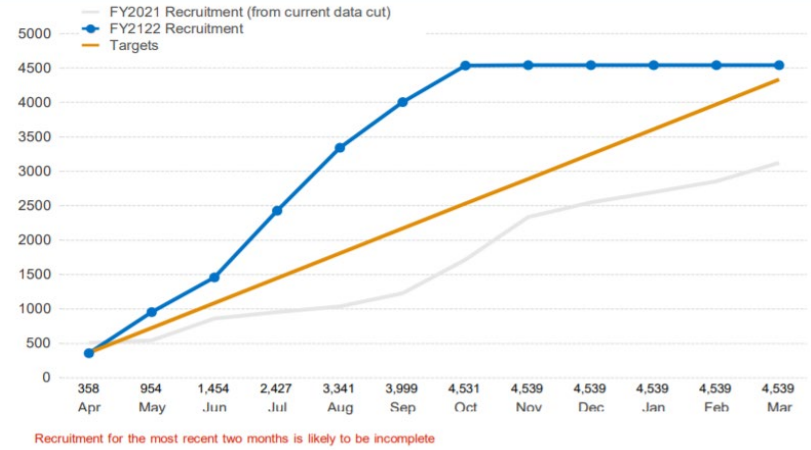
* YTD = Activity & Target to end of Oct. Performance against YTD target will be underestimated if data cut is early in month

** Year end Local Target = 4,331, 58% of year elapsed

LCRN Recruitment FY2122 (data cut 04/11/2021)



Monthly Recruitment Trend (data cut 04/11/2021)



Recruitment for the most recent two months is likely to be incomplete

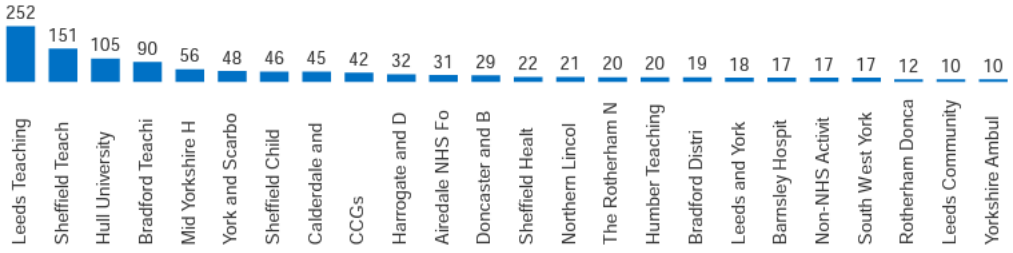
Recruitment by Specialty FY2122 (data cut 04/11/2021)

Appendix 3: Research Activity by study type as at 04.11.21

LCRN Recruitment by ABF Category
ABF Year: Apr 2021 to Mar 2022

TrustName	Large Observational	Observational	Large Interventional	Interventional	Commercial	Total Recruitment	Total Weighted Recruitment
Total						**69,698**	**176937.38**
Non-NHS Activ...	6,394	111	21,860	199	1	28,565	30831.5
Leeds Teachi...	777	3,258	3,929	942	639	9,545	45825.92
Bradford Teac...	2,892	2,119	949	707	44	6,711	20219.73
Hull Universi...	**2,909**	**732**	**161**	**580**	**157**	**4,539**	13442
CCGs	2,212	337	698	733	8	3,988	14482.5
Sheffield Teac...	145	1,738	121	721	248	2,973	14278.39
York and Scar...	1,949	249	151	110	70	2,529	4872.85
Calderdale and...	793	509	79	50	6	1,437	3263.18
Mid Yorkshire...	823	179	77	223	35	1,337	4099.5
Northern Linco...	510	752	1	27	3	1,293	3440
The Rotherh...	680	134	44	5	0	863	1248
Sheffield Child...	178	287	0	251	8	724	3943.5
Harrogate and...	258	197	9	132	18	614	2408.5
Barnsley Hosp...	372	114	0	11	114	611	892
Rotherham D...	415	18	0	12	0	445	610
Airedale NHS...	245	159	14	24	1	443	1438.81
Bradford Distri...	295	71	0	77	0	443	1390.5
Doncaster and...	200	40	0	180	5	425	2320
Humber Teach...	229	122	0	65	0	416	1371
Leeds and York...	165	106	0	138	0	409	2054
Yorkshire Am...	46	346	0	7	0	399	1334
Sheffield Heal...	152	128	0	65	0	345	1315
South West Yo...	244	45	0	45	0	334	896.5
Leeds Comm...	149	128	0	33	0	310	960

Recruiting Studies

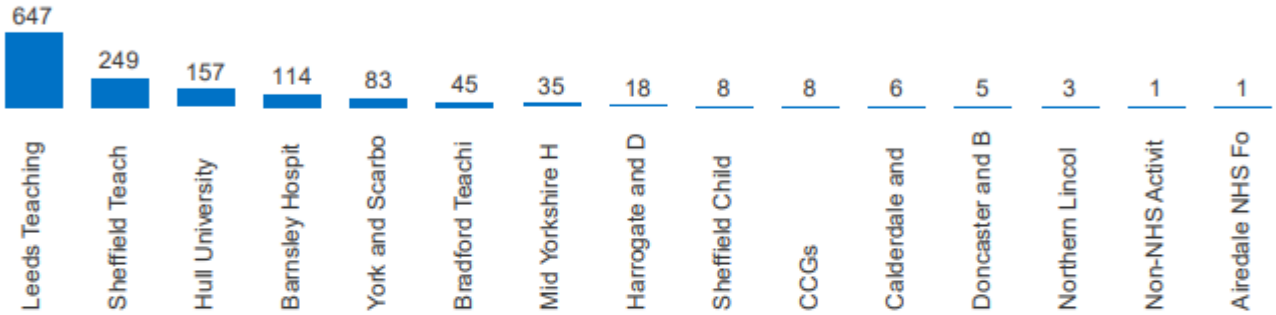


Appendix 4: Commercial Research Activity as at 04.11.21

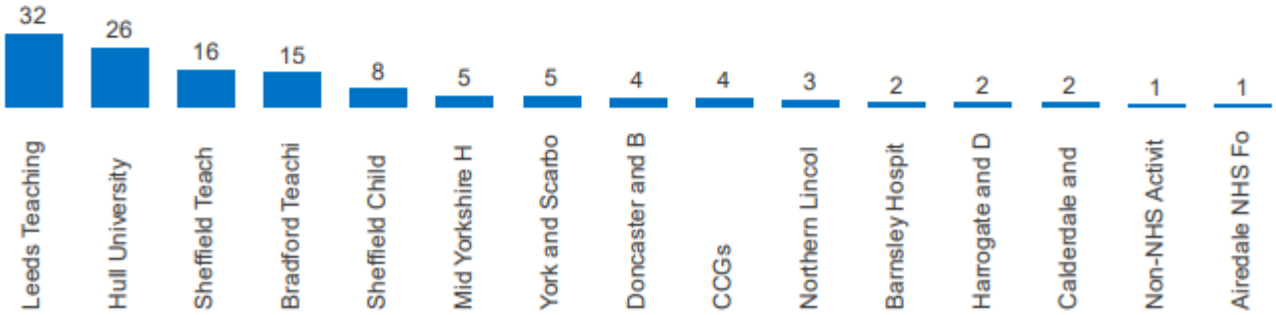
NIHR | Clinical Research Network Yorkshire and Humber

Recruitment by Trust FY2122 (data cut 05/11/2021)

Recruitment



Recruiting Studies



Appendix 5: R&D Summary Dashboard as at 04.11.21