Trust Board in Public
Tuesday 10 May 2022

Item	Description/Presenter	Note/ Approve	Time	Ref
	Business Matters			
1	**Apologies and Welcome** Sean Lyons, Chair		09:00	Verbal
2	**Chair's Opening Remarks** Sean Lyons, Chair			Verbal
3	**Declarations of Interest** 3.1 Changes to Directors' interests since the last meeting Sean Lyons, Chair			Verbal
	3.2 To consider any conflicts of interest arising from this agenda Sean Lyons, Chair			Verbal
4	**Minutes of the meeting held 9 March 2022** Sean Lyons, Chair	Approval		Attached
	4.1 Board Work Programme 2022/23 Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.2 Board Development Framework Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.3 Matters Arising Sean Lyons, Chair			Verbal
	4.4 Action Tracker Sean Lyons, Chair	Approval		Attached
	Patient Story			
5	**Patient Story** Makani Purva, Chief Medical Officer	Assurance	09:15	Verbal
	Governance			
6	**CEO Report/Covid Update** Chris Long, Chief Executive Officer	Assurance	09.30	Attached
	6.1 Committees in Common Summary Sean Lyons, Chair	Assurance		Attached
	6.2 Standing Orders Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	6.3 Audit Committee Summary Tracey Christmas, Audit Chair	Assurance		Verbal
	6.4 Annual Report Progress Report Rebecca Thompson, Head of Corporate Affairs	Assurance		Attached
	6.5 Trust Self Certification Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	6.6 Fit and Proper Persons Test Report Rebecca Thompson, Head of Corporate Affairs	Assurance		Attached
	6.7 Statement of Mixed Sex Accommodation Jo Ledger, Acting Chief Nurse	Approval		Attached

	Strategy			
7	**Operating/Financial Plan** Ellen Ryabov, Chief Operating Officer/Lee Bond, Chief Financial Officer and Michelle Cady, Director of Strategy and Planning	Approval	10.15	Attached
	7.1 Board Assurance Framework Q4 Year-End Report Suzanne Rostron, Director of Quality Governance and Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	Quality			
8	**Quality Update** Jo Ledger, Acting Chief Nurse/Suzanne Rostron, Director of Quality Governance **8.1.1 Maternity Update** Lorraine Cooper, Head of Midwifery	Assurance	10:25	Attached
	8.2 Learning from Deaths Makani Purva, Chief Medical Officer			
	8.3 Research and Innovation Annual Report/Strategy Thozhukat Sathyapalan, Director of Research and Innovation	Assurance		Attached
	8.4 Summary and Minutes from the Quality Committee David Hughes, Quality Chair	Assurance		Attached
	Performance			
9	**Performance Report** Ellen Ryabov, Chief Operating Officer **9.1 Finance Report** Lee Bond, Chief Financial Officer	Assurance Assurance	11.00	Attached Attached
	9.2 Summary and minutes from the Performance and Finance Committee Mike Robson, Chair of Performance and Finance	Assurance		Attached
	Workforce			
10	**Workforce Report** Simon Nearney, Director of Workforce and OD **10.1 Summary and minutes from the Workforce, Education and Culture Committee** Una Macleod, Chair of Workforce, Education and Culture Committee	Assurance Assurance	11:30	Attached Attached
11	**Questions from the public relating to today's agenda** Sean Lyons, Chair		11:50	Verbal
12	**Chairman's summary of the meeting** Sean Lyons, Chair			Verbal
13	**Any Other Business** Sean Lyons, Chair			Verbal
14	**Date and time of the next meeting:** Thursday 16 June 2022 to approve the Annual Accounts		12:00	Verbal

Attendance 2022/23

Name	10/5	16/06	12/07	13/09	08/11	10/01	14/03	Total
Sean Lyons								
S Hall								
T Christmas								
T Curry								
U MacLeod								
M Robson								
L Jackson								
A Pathak								
D Hughes								
C Long								
L Bond								
M Purva								
J Ledger								
S Nearney								
E Ryabov								
M Cady								
S Rostron								
S McMahon								
R Thompson								

Attendance 2021/22

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

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board meeting
Held on 8th March 2022

Present:	Mr S Lyons	Chair
	Mr S Hall	Vice Chair
	Mrs T Christmas	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Dr D Hughes	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs B Geary	Chief Nurse
	Dr M Purva	Chief Medical Officer
	Mrs E Ryabov	Chief Operating Officer
	Mrs S Rostron	Director of Quality Governance
	Mrs M Cady	Director of Strategy and Planning
	Mr S Nearney	Director of Workforce and OD
In Attendance:	Mrs J Chambers	Lead Midwife
	Mrs F Moverley	Head of Freedom to Speak Up
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies and welcome** Apologies were received from Mr T Curry, Non-Executive Director and Mrs T Christmas, Non-Executive Director Mr Lyons asked that any questions from members of the public be added to the chat facility. **Chair's Opening Remarks** Mr Lyons thanked Trust staff for welcoming him to the Trust. He was looking forward to working with staff at HUTH in the future. He stated that the last 2 years had impacted greatly on all staff and this had affected performance greatly. He thanked staff for their continued efforts to recover after the pandemic. He added that the ambition set out in the Trust and other strategies was commendable and would move the Trust into a more stable situation to recognise its 'Outstanding' aim.	
2	**Declarations of Interest** **2.1 Changes to Directors' interests since the last meeting** Dr Hughes declared his employment as a Consultant Pathologist at Sheffield Teaching Hospitals NHS Foundation Trust. **2.2 To consider any conflicts of interest arising from this agenda** There were no declarations made.	
3	**Minutes of the previous meeting held on 9th November 2021** Mr Long asked that the number of Covid patients being treated in the hospital in November 2021 be changed from 45 to 145.	

Mr Hall asked that the following comments be added to the minutes:

- Cardiology report – page 8 – Mr Hall was disappointed in the report findings as there was great work being carried out by the department.
- The behaviours displayed by some did not fit with the Trust values and standards.

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Mrs Geary asked that the paragraph relating to the Quality Delivery Group clarified that the group was commissioner led and that the regulator also attended. It was an external Group not established by the Trust.

Dr Purva asked that on page 8 it was made clear that the Cardiology lead was a joint leadership role with Northern Lincolnshire and Goole NHS Foundation Trust.

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

3.1 Board Reporting Framework

Mrs Thompson presented the Board Reporting Framework and advised that the Guardian of Safe Working report was now required quarterly rather than annually at the Board.

3.2 Board Development Framework

Mr Thompson presented the Board Development Framework and advised that the April session will comprise the Trust Strategy refresh and the Board Assurance Framework workshop.

Action: An updated Board Development Framework to be presented to the Board in May 2022. **RT**

4 Matters Arising

4.1 Action Tracker

There were no items to discuss on the action tracker.

4.2 Any other matters arising

There were no other matters arising.

5 Patient Story

Dr Purva presented a patient story that detailed a number of delays to treatments to demonstrate the patient backlog situation. It related to a patient waiting for a cardiothoracic procedure but with other health complications compounding the issue. She added that it captured perfectly the issues around getting appointments, cancellations and how patients are becoming more complex to manage due to co-morbidities.

Dr Hughes commented on the patients compassion and recognition of the staff who are having to manage complex patients in challenging situations.

Mrs Ryabov advised that capacity plans had been stepped up but due to Omicron December and January had been particularly challenged.

The Trust had many P2 patients and some had faced multiple cancellations. Prof Macleod was keen to understand the numbers of patients cancelled multiple times. Mrs Ryabov advised that cancellations were reported daily and were common due to major trauma and cancer taking up a large amount of resource.

Mr Lyons asked how the patient was and Dr Purva advised that he was waiting for his renal operation.

Dr Hughes thanked the patience for the eloquence in the way he told his story and his compassion and kindness.

6 Standing Orders and Governance

6.1 Chief Executive/Covid Report

Mr Long advised that there were 150 Covid patients in the hospital at the moment. Many were ready for discharge but there was no social care facility to receive them. There were also 150 patients with no criteria to reside waiting to be discharged into a package of care but again no social care facilities available. These patients were staying in hospital longer and were taking up bed days for 4-5 patients which was challenging.

Mr Long also reported that the Paediatric Team were carrying mental health older children that required specific facilities and secure care.

He added that the number of patients in the Emergency Department were rising due to the lack of Primary Care provision.

These out of hospital issues were impacting on staff as they are unable to provide the appropriate care for these patients that should be cared for elsewhere.

Mr Long advised that the Allam Diabetes Centre was now open and thanked Dr Allam for everything he had done for the Trust. The Radiology team had been accredited for a new model of care and the Zero 30 ambition initiative had begun.

Dr Pathak asked what was being done to support staff and Mr Long advised that free lunches were being given to staff and the Trust was being as relaxed as it could be regarding car parking.

Mr Lyons endorsed the comment about Dr Allam and encouraged staff to ‘wear the bear’ for the Zero 30 initiative.

6.1.1 Collaboration of Acute Providers Report

Mr Long updated the Board regarding the drive for the 4 acute Trusts were taking to work together to review waiting lists, offer mutual aid and share capacity were it was appropriate.

The Board was chaired by Mr Long and he reported that there was now a requirement to formalise the structure for the coming year.

Mr Bond asked if posts from the CCGs would be redeployed into the Acute Providers Board and Mr Long advised that they would be if they had the correct skills and experience.

Prof Macleod asked if there was enough senior leadership available with everything that was going on and Mr Long admitted that it would be challenging.

6.2 Committees in Common Summary
The summary was taken for information only.

6.3 Standing Orders
Mrs Thompson presented the report and asked the Board to approve the retrospective use of the Trust seal.

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

6.4 Audit Committee Summary
Mr Robson presented the summary and highlighted the areas of assurance. He highlighted the Doctor's Leave Audit as this had been given minimal assurance by the Internal Auditors. Mr Robson advised that it would be presented to the Workforce, Education and Culture Committee for further scrutiny.

Dr Hughes advised that the themes relating to medical leave were very familiar to him and the e-rostering system would not happen overnight.

Dr Pathak expressed his concern regarding the business being set up by the Radiographers to provide overseas training. Mr Robson advised that further information and scrutiny had been required by the Audit Committee.

Mr Nearney advised that e-rostering was being rolled out for the doctors and Mr Bond added that the speed of the roll out was an issue. However there were actions in the Audit report and these were being implemented.

7 Strategy

7.1 Refreshed Trust Strategy
Mrs Cady presented the refreshed Trust Strategy and thanked colleagues for their help in preparing it. She advised that a number of groups had been consulted and the Strategy now reflected the collaborative and partnership working and was connected with the ICS and Health and Wellbeing Boards.

There were some risks to delivery due to the investment required and workforce capacity but these were being managed.

Prof Macleod stated that the Strategy was a great read and suggested the Trust and the University linking in to ensure the two strategies overlapped and were complimentary.

Action: Prof Macleod and Mrs Cady to meet to discuss alignment of the strategies **UMc/MC**

Resolved: The Board approved the Trust Strategy Refresh document

7.2 Quality Strategy
Mrs Rostron presented the Quality Strategy and advised that although it was a new strategy it built on existing quality improvement programmes and priorities outlined in the Trust's Quality Accounts.

Feedback had been received from the Strategic Delivery Group and the strategy had also been presented at the CQC engagement meeting.

The acronym SEEP had been changed to SELF following feedback from the Patient Council and this stood for Safe, Effective, Learning and Focus.

The strategy also included the plan for the Trust to become an accredited faculty for QSIR training.

Mr Hall advised that the Strategy had been presented to the Quality Committee and endorsed. He added that the Quality Committee were happy to recommend approval.

Resolved: The Trust Board approved the Quality Strategy

7.3 Risk Management Strategy
Mrs Rostron presented the Risk Management Strategy for information. The Strategy was approved virtually by the Board in January 2022.

7.4 Board Assurance Framework
Mrs Thompson presented the Q3 Board Assurance Framework which had been approved virtually in January 2022 by the Board. Mrs Thompson set out the plan for the year-end target risk rating review and the Board Development Session in April where the new Board Assurance Framework for 2022/23 would be developed.

Both the year-end BAF and the new 2022/23 BAF would be presented to the May 2022 Board.

Mr Bond asked if risk appetite aligning with the target risks would be discussed at the development session and Mrs Thompson advised that it would.

Resolved: The Board agreed the approach for closing the year-end BAF and developing the new 2022/23 BAF.

8.1 Integrated Performance Report
8.2 Quality Update
Mrs Geary presented the Quality report and advised that there had been an overall reduction in hospital acquired pressure ulcers as well as a reduction in device related pressure ulcers.
There had been one Never Event declared in January relating to a retained foreign object.

There was an increase in Serious Incidents, which included a 12 hour trolley wait and patients being harmed due to waiting for long periods before treatment. The Serious Incident backlog was still significant and the Trust was not achieving its reporting timeframes but there was a plan in place to address it.

There had been an increase in Falls in January 2022 but low harm reported. This suggested that the reporting culture was positive.

There had been 2 Trust apportioned MRSA cases but these had been deemed unavoidable, a MSSA case and C Difficile cases were being scrutinised by the commissioners and the Infection Reduction Committee.

Mrs Geary spoke of the issues around the number of Covid patients, in particular the challenges around isolating patients.

There was a high number of PALS contacts (230) and 76% of these were in relation to waiting times.

Mrs Geary also advised that staff were spending lots of time safeguarding patients with mental health issues such as eating disorders and self-harming behaviours so training was being rolled out and the issue had been escalated to the regulators.

Dr Hughes advised that the number of teenage mental health patients was small but the impact they had on staff was massive. He asked if the Trust was working with the Humber Mental Health Trust to work to develop a plan. Mrs Geary advised that she was but there were issues around staffing capacity and that it was a national issue.

Mrs Jackson asked about the Standardised Hospital Mortality Index and Dr Purva advised that the rolling average meant that the Trust was still and outlier even though the issue and increased deaths happened in 2021. Due to the reporting timeframes the Trust would remain an outlier for the next 3 months. She added that the Trust had completed more Structured Judgement Reviews than ever before and the Medical Examiners were reviewing the Trusts outlier status.

Mrs Rostron advised that the Integrated Performance Report had come on another step and thanked the BI Team and Mrs Thompson for their work on it. It was the intention to work with the NLAG BI Team to standardise the report both in format and content where appropriate.

8.3 Minutes from the Quality Committee
Mr Hall presented the minutes from the Committees in February, January and December.

Dr Pathak asked if the non-vaccinated staff had been approached due to the turnaround in the law and Mr Long advised that they had and were working as normal.

8.4 Hull University Covid Report
Dr Purva presented the report and advised that it had been commissioned in 2021 and had been scrutinised in detail at the Quality Committee and Private Board.

A number of actions had been recommended in the report and these were being worked through and implemented.

Mr Robson asked if the Omicron wave had been dealt with differently due to the report and Dr Purva advised that activities were retained which was a lesson learned from the first wave.

Dr Purva added that communication to staff had been commended during Covid and this had been taken as good practice to be replicated.

9 Maternity Services

9.1 Ockenden Report, 9.2 CNST, 9.3 PMRT

Mrs Chambers gave a presentation which highlighted the action plan following the gap analysis carried out by the Trust and evidence submitted in June 2021.

A working group had been developed to work on the robust action plan. Other actions included a review of the Morecombe Bay Report and inclusion on the Birthrate Plus initiative.

There had been positive feedback received from Tracey Cooper the Lead Midwife and investment for the Saving Babies Lives initiative of £250k.

Work was ongoing to recruit a 24/7 consultant for maternity services, QR codes were being developed and implementation of a Maternity digital system across the Humber Coast and Vale.

Mrs Chambers advised that there was a midwifery staffing gap of 28wte and this was mainly due to the changing complexities of women coming through the service.

Year 4 of the clinical negligence schemes for Trusts was challenging and there was lots of work to do. Years 1, 2 and 3 had achieved all 10 action points. Year 4 submission had been pushed back due to the pandemic.

The Trust had bid for Ockenden funding and had received £179k. Enhanced safety investigation training was being rolled out as was multi-professional working.

The Trust had halved its still birth rate since 2016 which was a positive message for patients and staff.

Mrs Geary thanked the midwifery team for their continuing work and advised that the staffing issues were being worked through as recruiting to midwife posts was becoming increasingly difficult. Midwifery Assistant posts were being reviewed.

The Board discussed interpreters and the challenges around languages and availability of them.

Resolved: The Board retrospectively approved the HUTH 7 criteria assessment.

9.4 Midwifery Staffing Report
Mrs Geary presented the report to the Board for information. She advised that the detailed nurse staffing report including the establishment review would be presented to the Board in May 2022.

10.1 Performance Update
Mrs Ryabov presented the report and highlighted the following areas: urgent care, elective care and the significant challenges faced, cancellations and the new ED metrics.

Urgent care had seen an increase in pressure which was continuing into March. CHCP were supporting the Urgent Treatment Centre and benefits were being seen in paediatric waits but there was not the impact expected in ED. The reasons for this were primarily workforce issues and staffing gaps in other UTCs.

Overall performance had reduced from 68% to 58% with an increasing number of patients lodged. There was also an increase in 12 hour trolley breaches. There were also significant challenged in mental health provision in the hospital and ED.

There were an increasing number of Covid patients and the Community had spot purchased some community beds which had reduced the burden briefly but patient numbers had increased again.

Mrs Ryabov reported that the Medicine Bed Base was 376 beds increasing to 400 beds in the winter months. The Trust currently had 500 beds open with 40% of patients having delayed discharges due to Covid or no criteria to reside. Patient flow is significantly compromised by the issues in Social Care. This is a National issue and work was ongoing with Local Authorities and Community Partners find the solution.

Mrs Ryabov spoke about elective care and patients waiting 104 weeks or more and the target of zero for June 2022. She expressed her concern regarding the achievement of this target as the Trust had 942 patients currently.

The waiting list was currently 63,000 and there had been 631 cancellations in February with 98 patients being cancelled on the day of their treatment. This had increased by 50% from last year's figures. Mrs Ryabov added that 7 patients had their treatment cancelled 7 times.

Mrs Ryabov advised that there were new ED metrics being discussed but no technical guidance had been released yet.

Dr Hughes asked if the number of patients with no criteria to reside were halved would this help with patient flow. Mrs Ryabov advised that it would but there were too many other issues to completely address the problem.

The Board discussed the new Day Surgery unit at Castle Hill and Mrs Ryabov reported that it would give the Trust an additional 38 sessions per week. The unit should be ready in Q3 2022/23.

10.2 Finance Update
Mr Bond highlighted that at month 10 the Trust was expecting to hit its year-end target and was revising the Board Assurance Framework target risk accordingly.

There had been underspends in Surgery and Family and Women's Health Groups resulting in savings on non-pay items. This had been offset by pass through drugs and pressures in Clinical Support due to staffing and volume of work. Mr Bond added that the pressures seemed to be more recurrent in nature.

Mr Bond reported that the Trust would hit its forecast outturn for 2021/22. From a Capital perspective the Trust had spend £80m to date and £200m over the last 5 years.

The Trust had a healthy liquidity position but there were issues around stock levels (£17m) due to behaviours learned during the pandemic. Procurement to work with

Mr Hall asked about Covid funding and the 2022/23 plan. Mr Bond advised that the system was forecasting a £245m deficit for 2022/23 and need to find £11m in cash releasing efficiency savings.

10.3 Minutes from Performance and Finance Committee
Mr Robson presented the minutes and advised that the January and February meetings had been stood down. He highlighted that the committee had received reasonable assurance relating to performance as although the Trust was not achieving its standards there were actions in place and being implemented.

The Committee had received good assurance relating to Finance and the 2021/22 year-end target as it was likely that the financial targets would be met.

11.1 Workforce Update
Mr Nearney presented the report and advised the sickness absence was now at 5.1% which was better than most Trusts. The overall vacancy rate was 2.9%.

Mr Nearney also reported that the Staff Survey was still embargoed but would be shared with the Board when available.

Mr Lyons asked why nursing establishments were so well staffed and Mr Nearney advised that the Trust was gearing up for winter and turnover had also been factored in.

Mr Bond asked if there was a dedicated programme for clerical vacancies and Mr Nearney advised that the admin vacancies were complex and had a high turnover, but there was no LB – admin and clerical vacancies – dedicated programme to address those. SN – really complex we are recruiting high turnover, flexible working lot of training and investment time

Dr Purva advised that some specialities were struggling with consultant recruitment but the Trust was getting support from the GMC and a unique international fellowship scheme was being implemented.

Mr Hall asked if there was any moves to bring back any staff who had left because of the vaccination issues and Mr Nearney advised that there had not.

11.2 Minutes from the Workforce Education and Culture Committee
The minutes were received for information.

11.3 Freedom to Speak up Report
Mrs Moverley presented the report which highlighted the Q3 activities for the Freedom to Speak up Guardian.

October 2021 was national awareness month and due to operational pressures videos were added to Pattie and were also linked to Black History month. Mrs Moverley had carried out both virtual and face to face sessions, she had also put on extra sessions in the evenings for shift workers or staff that could not attend the daytime sessions.

Work was ongoing with the networks including the Trade Unions and she was meeting with the Chief Pharmacist to engage with the Team.

In Q3 there had been an increase of cases to 25 and this has increased again in Q4. There were a number of patient safety concerns being reported and Mrs Moverley had included a consented case study in her report as an example.

11.4 Gender Pay Gap
Mr Nearney presented the report and advised that men's earnings on average were 25.9% higher than women's.

This was mainly due to 40% of the 24% men at the Trust were consultants/doctors and on a much higher rate of pay. If these were removed the percentage would reduce to 3%.

Mr Bond asked if the 5 year position could be added to the next report and Mr Nearney agreed to do this.

Dr Hughes advised that there were more women training as medics but as it took many years to work through the changes would not be seen quickly.

Resolved: The Board approved the report for publication.

12 Questions from the Public relating to today's agenda
There were no questions received.

13 Chair's summary of the meeting
Mr Lyons thanked the Board and other presenters for their contributions. He highlighted the Collaboration of Acute Providers and the work ongoing, the strategies presented and approved, the good assurance from the Maternity service, the massive challenges in

performance and the staff survey and the good news that the Trust's finances were on track to deliver this year.

He also thanked the patient for sharing his story stating it was a brave thing to do.

14 Any Other Business

Mr Lyons thanked Mrs Geary on behalf of the Board for all her commitment and hard work during her time at the Trust. This Board meeting would be her last as she was due to leave at the end of March 2022.

15 Date and time of the next meeting:

Tuesday 10 May 2022, 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 appropriate 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 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 2022/23

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 2023

Board Development Dates 2022/23	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
7 June 2022				BAF 3.2 – Patient Harm/Recovery	BAF 4: Risks to recovery plan				Staff Survey
9 August 2022		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
11 October 2022	Strategic drivers/balanced scorecard review			BAF 3.1: Risk that the Trust is not able to make progress in continuously improving quality					Patient Safety
13 December 2022							BAF 6: Research and Innovation		IPC End of Life Care
14 February 2023			BAF 2: Valued, skilled and sufficient workforce					BAF 7: Financial Sustainability	

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 (May 2022)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
March 2022						
03.01	Board Development Framework	Updated framework to be presented to the Trust Board	RT	May 2022		
03.02	Trust Strategy	Meeting to discuss alignment of HUTH and UoH strategies	MC/UMc	May 2022		
COMPLETED						

Actions referred to other Committees

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

May Trust Board Story

Jane and Catherine's story

Jane and Catherine's mum was admitted during the COVID pandemic with a pelvic fracture. She had a prolonged inpatient stay including movement between different wards. During her stay she also caught COVID from which she fortunately recovered.

Whilst Jane and Catherine were very grateful for the care she received the inability to visit their mum due to restrictions at that time highlighted some key areas where communication could have been improved.

Following their concerns being raised a lot of work has been done to support improvements in this area.

We have put a structure in place to ensure that nominated family members are informed of any ward moves within the hospital setting, and work is being done to ensure that communication is more consistent and effective.

HUTH volunteers service has introduced dementia activity companions, ward communicators to help with answering phones and passing on messages on the ward, "voice from home" volunteers to help elderly relatives in having video communication with their relatives at home and dining companions. In addition the chaplaincy service has a "letters from home" service to support friends and family in staying in touch with their loved ones when they can not visit.

A big change will be the new essential care giver work that is being introduced. This will involve special visiting for patients with dementia and delirium. This will have a huge impact on these patients and could help in the treatment of delirium.

[see relevant paperwork]

healthwatch East Riding of Yorkshire

healthwatch Kingston upon Hull

NHS Hull University Teaching Hospitals NHS Trust

Essential Care Giver (key visitor) Myth-buster

"It's too risky to allow people to come in."

Feeling anxious is natural. However, given that essential care givers will only be visiting one person and have limited access to the ward and hospital, the risks will be minimised. They will also have to follow the same robust Infection Prevention and Control (IPC) procedures and testing regimes as staff which further reduces the risk.

"It will take up too much staff time."

Planning and risk assessing will take extra time, but families should be seen as a resource worth investing in. Family and friends can be a huge asset during an outbreak when staff may need to isolate. By supporting their own relative, they can free up limited staff time to deal with other patients.

"Visiting is restricted to set times."

No. The guidance states that essential care givers are welcome to help maintain the patients health and wellbeing; this includes meal times. All we ask is that visits are arranged with the nursing team to avoid over-crowding during outbreaks.

"It's only for personal care."

No. The term 'essential care giver' can be misleading, but current guidance is clear that an essential care giver can be simply someone who provides companionship, and all the enormous benefits to wellbeing that this brings.

"Essential care giver visits need to stop if there's a Covid outbreak."

Not correct. Visits will only stop if the essential care giver or patient they are visiting tests positive for COVID, or, if the ward has an infectious outbreak.

I AM AN ESSENTIAL CARE GIVER

NHS
Hull University Teaching Hospitals
NHS Trust

I am the main carer for this patient.
This badge entitles me to visit them outside of visiting hours.

BADGE NUMBER.....

WARD.....

DATE ISSUED.....

ISSUED BY.....

Please remember to **return your badge** at the time of discharge for other carers to use.

WHERE TO GET HELP

Patient Advice and Liaison Service (PALS): hyp-tr.pals.mailbox@nhs.net | 01482 623065

My Choice My Care: mychoicemycare.org.uk | 01522 782155

Carers UK: www.carersuk.org

Hull University Teaching Hospitals NHS Trust

Trust Board

10 MAY 2022

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 media coverage.	
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:	International recruitment, P&O recruitment campaign, launch of RDI campaign, EV charging on site	

Recommendation:	That the board note significant communications items for the Trust and media coverage

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 10 May 2022

Communications strategic objective:
To support the Trust's mission statement, which is: "to be a provider of outstanding treatment and care and contribute to improved population health, by being a great employer and partner, living our values and using resources wisely"

Priority areas 2021-2025:

- Compassionate care of patients and staff
- Equality, diversity and inclusion
- Research, development and innovation
- Sustainability – Zero30

1. KEY MESSAGES FROM JANUARY/FEBRUARY 2022

COMPASSIONATE CARE

HUTH welcomes hundreds of overseas nurses
Hundreds of international nurses are now settling in Hull after finding rewarding careers in East Yorkshire.

Our Trust began an international recruitment campaign almost five years ago to offer internationally educated nurses the chance to work in East Yorkshire. Since then, 316 nurses, mainly from the Philippines but also from Nepal, have started working at Hull Royal Infirmary and Castle Hill Hospital and once they arrive in Hull, they are happy to stay. Our retention rate for overseas nurses is 97 per cent, meaning they are enjoying working for the trust and living in East Yorkshire.

The nurses go on to work in every area of our hospitals, from oncology and theatres to critical care and elderly medicine. They are required to pass an International English Language Testing System (IELTS) and a computer-based test to ensure their communication skills are of a very high standard before they fly to England in groups of around 20 at a time.

They are a fantastic asset and we are really lucky to have them here to look after our patients.

Trust reaches out to former P&O staff with new job opportunities
HUTH has reached out to former P&O workers to consider a career in health.

The NHS is no stranger to timetables, to keeping people happy, to managing resources and problem solving on a daily basis. That's why we have approached former ferry workers to help fill more than 30 clinical administration vacancies plus many other roles across Castle Hill and Hull Royal Infirmary.

The Trust's Clinical Administration Service is a 900-strong team which collectively provides the support that hospital doctors, nurses and other clinical teams need to provide great care to patients.

In support of this approach the Trust celebrated Administrative Professionals Day on 27 April with a high profile online campaign; a pre-cursor to an open recruitment day in May where

details of all current admin vacancies will be up for discussion. Interviews will also be held on the day for the right candidates.

Anlaby Road redevelopment consultation underway
People living in Hull are among those being asked for their views on proposals to redevelop and redesign the area.

New hospital wards, car parking options, more green space and safer cycling routes are among the ideas being put forward in a new Masterplan covering the Hull Royal Infirmary site and surrounding streets.

Our Trust is seeking to develop facilities on the HRI site, creating purpose-built inpatient wards that will replace the outdated wards in the Hull Royal Infirmary tower block. The plans also involve re-purposing some of the vacated space in the tower block for non-clinical use.

The work would form part of a wider masterplan, developed with Hull City Council, which could open up opportunities for new developments on the current Argyle Street car park, such as new housing for hospital staff or a multi-storey car park. Proposals also suggest that, over the next 15 years, the nature of the Anlaby Road area could change significantly, making the route greener and more environmentally friendly to make it more attractive to users, encouraging more staff and visitors to travel other than by car.

The local authority and the Trust are now urging hospital staff, patients and visitors, local residents, landowners, business owners and anyone else with an interest in the future of the area to review the plans and feed back their thoughts.

RESEARCH DEVELOPMENT AND INNOVATION

Hull celebrates ground-breaking research that transforms lives
Friday 8th April marked the start of RDI Week: Research, Development and Innovation; a week where local health professionals, academics, research teams and practising clinicians came together to celebrate the city's collective achievements and promote ongoing research which has the potential to transform lives.

From being the first UK trust to perform mitral valve surgery to pioneering the use of robotic surgery in treating prostate and other cancers, Hull boasts a research record to be proud of, and one which is only getting stronger. We have some 450 studies going on in our area at any one time. These are supported by 65 key staff working across 27 different specialties, including many areas where Hull and East Yorkshire already excels, such as oncology and haematology; respiratory; metabolic and endocrine; renal; paediatrics; gastroenterology and hepatology;, vascular; and infectious diseases.

What's more, our track record combined with our cutting edge research facilities continues to get us noticed, enabling us to attract high quality research colleagues to continue putting Hull on the map and further cementing our international reputation as a leader in healthcare and biomedical research.

Among the latest local facilities to open is the Allam Diabetes Centre on the Hull Royal Infirmary site. Generously supported with a £3m donation from local businessman and philanthropist, Dr Assem Allam, the facility includes a whole floor dedicated to supporting research into the fields of diabetes and endocrinology.

RDI Week was promoted with an online campaign and a new website showcasing the work of local research teams and the difference which the people of Hull and East Yorkshire; both research teams and trial participants; make to others across the world. It began with a

special Celebration of Research event at the University of Hull this Friday 8 April, where leading academics and clinicians such as Dr Michael Crooks of the nationally acclaimed SENTINEL programme and Dr Lynsey Corless, recently appointed as the NIHR's National Specialty Lead for Hepatology Research, were key speakers.

ZERO30

Electric vehicle charging at HRI and Castle Hill
To help support those who are already doing their bit when it comes to cars, and to make it easier for staff and visitors to contribute to our Trust-wide net zero ambitions, we've now installed a number of electric vehicle charging points across our two main hospital sites.

A total of 30 charging points are now in operation across HRI and Castle Hill Hospital and are available in both staff and public areas. We are asking people to use these fairly and responsibly. Most people will have facilities to charge at home, but for those who don't have the means to top up at home, for example if you have no off road parking, or for those whose battery is running low, these spaces are ideal.

As with any Trust parking space, users will need to display a valid permit or ticket to park there and electricity used to charge will be payable separately. Users can either use a pay as they charge portal or the Swarco eConnect app to pay for use of the charging point.

Bays are available for both staff and patient use.

2. MEDIA/SOCIAL MEDIA ACTIVITY

In March there were 37 articles published about the Trust:

- 26 positive (70%)
- 7 factual (19%)
- 4 negative (11%)
- 0 neutral (0%)

Most negative coverage related to car parking, including "app-only" parking payments at Castle Hill following the removal of cash pay machines.

Social media

Facebook
Total "reach" for Facebook posts on all Trust pages in March – 222,609

- Hull Women and Children's Hospital – 68,151
- Castle Hill Hospital – 58,320
- HEY Jobs page – 8,695
- Hull Royal Infirmary – 47,574
- Hull University Teaching Hospitals NHS Trust – 39,869

Twitter @HullHospitals

- 118,000 impressions in March 2022
- 9,957 followers
- Tweets with highest number of impressions related to Dr Lynsey Corless's appointment to a senior research role with the NIHR and the completion of the Covid-19 tribute mural on the side of the Eye Hospital.

Five news releases issued by HUTH this month:

- 7 March - Help for those on hospital waiting lists
- 17 March - Work begins on nurse mural to thank NHS staff

- 18 March - Hospitals step up and say Oh Yes! Net Zero
- 24 March - Sustainability project is a breath of fresh air
- 24 March - Planting now for a brighter tomorrow

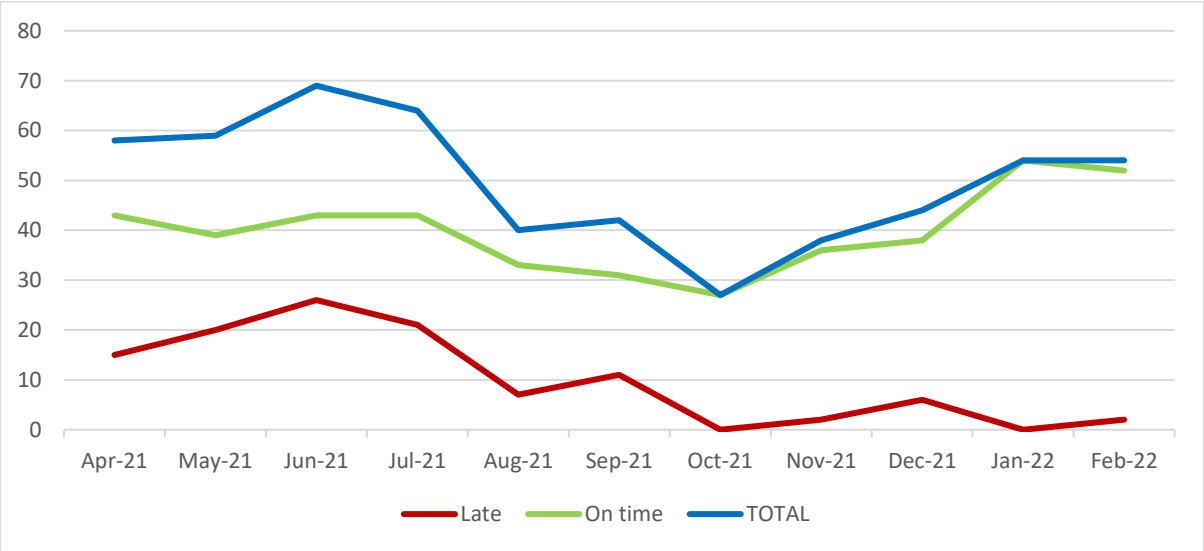
Four reactive media statements issued this month:

- 29 March – Appointment cancellations in relation to Covid absence
- 30 March – Complaint from the son of patient about staff miscommunication
- 31 March – Reintroduction of staff parking charges
- 31 March – Concern over implementation of 'phone only' car parking payment system

3. FREEDOM OF INFORMATION

The Trust has a legal duty to respond to Freedom of Information requests within 20 working days. Monthly compliance data is available up to February:

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Late	15	20	26	21	7	11	0	2	6	0	2
On time	43	39	43	43	33	31	27	36	38	54	52
TOTAL	58	59	69	64	40	42	27	38	44	54	54



Report to the Board in Public
Humber Acute Services Development Committee held on 20 April 2022

Item: Director Overview Report P2 Update	Level of assurance gained: Substantial
Work was ongoing regarding the programme and changes to clinical models and the economic and social impact of moving services was being reviewed. Statutory reviews such as Ockenden was being included in the planning process. A number of briefings had taken place with the Local Authority private cabinet, MPs and Overview and Scrutiny Committees. Engagement work with the Primary Care Networks was positive and clinical leaders were working collaboratively with the teams. Following a Gateway review in July and sign off my DHSC and NHS E/I, the consultation was planned for September 2022.	
Item: P3 Capital Update	Level of assurance gained: Substantial
The Committee received a presentation that highlighted the capital investment objectives and their evaluations. The options ranged from 'business as usual' to 'do maximum' and what each of these options meant. The option chosen will depend on the amount of funding the Trusts get. Every scenario was being explored and strategic business cases developed.	
Item: Integrated Care Programme Update	Level of assurance gained: Reasonable
Resourcing and the future of the digital clinical admin of the ICP was discussed. Concerns were raised regarding programme slippage, clinical engagement, what was expected of the leadership roles and how the Joint Development Board was progressing. It was agreed that the leadership model for the ICP was discussed at the Joint Development Board and an update presented to the HASDEC in June 2022.	

Hull University Teaching Hospitals NHS Trust

Agenda Item	6.2	**Meeting**	Trust Board	**Meeting Date**	12.05.22
Title	Standing Orders				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The report was previously considered at the March 2022 Trust Board				

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

Key Recommendations to be considered:
The Trust Board is requested to: • Authorise the use of the Trust's seal

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders March 2022

1 Purpose of the Report

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

2 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows: This paper summarises all use of the Trust seal since March 2022.

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2022/04	Hull University Teaching Hospitals NHS Trust and Boston Renewables Ltd – Design and install a new 4MW Photovoltaic Power Station, Castle Hill Hospital, Cottingham	16/03/22	Chris Long – Chief Executive Officer Lee Bond – Chief Financial Officer
2022/05	Hull University Teaching Hospitals NHS Trust and Ashcourt Construction Ltd – Front entrance work at HRI, Hull	16/03/22	Chris Long – Chief Executive Officer Lee Bond – Chief Financial Officer
2022/06	Hull University Teaching Hospitals NHS Trust and Martin Patrick May, John Ingram May, Keith Ingram May – Farm Business Tenancy re land to the south of Castle Road, Cottingham	16/03/22	Lee Bond – Chief Financial Officer Suzanne Rostron – Director of Quality Governance
2022/07	Hull University Teaching Hospitals NHS Trust Ashcourt Construction Ltd – Foundations to Intensive care unit (ICU)	22/03/22	Chris Long – Chief Executive Officer Suzanne Rostron – Director of Quality Governance
2022/08	Hull University Teaching Hospitals NHS Trust and Ashcourt Construction Ltd – Modular units for intensive care units Hybrid Alternative	22/03/22	Chris Long – Chief Executive Officer Suzanne Rostron – Director of Quality Governance
2022/09	Hull University Teaching Hospitals NHS Trust and Ashcourt Group – Allam Diabetes Centre – External envelope design and build	22/03/22	Chris Long – Chief Executive Officer Suzanne Rostron – Director of Quality Governance
2022/10	Hull University Teaching Hospitals NHS Trust and Novum Structures UK Ltd and Zenith Development Group Ltd – Sub-contractor collateral warranty – new build Diabetes Centre	22/03/22	Chris Long – Chief Executive Officer Suzanne Rostron – Director of Quality Governance
2022/11	Hull University Teaching Hospitals NHS Trust and Intex Systems Ltd and Zenith	22/03/22	Chris Long – Chief Executive Officer

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
	Developments Group Ltd – Sub-contractor collateral warranty new build Diabetes Centre, HRI		Suzanne Rostron – Director of Quality Governance

3 Recommendation

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Rebecca Thompson
Head of Corporate Affairs
May 2022

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.05.22
Title	Annual Report Update and Plan				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report is received by the Trust Board annually				

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:
This report outlines a plan for production that meets the Annual Report deadlines.

Hull University Teaching Hospitals NHS Trust

Trust Board

Update on Annual Report Production

1. Purpose of the paper

The purpose of this paper is provide an update on the production of the Trust's Annual Report, in line with revised national guidance.

2. Introduction

Each NHS Trust is required by statute to produce an annual report that meets the requirements of guidance issued by the Department of Health and Social Care.

3. Summary of position to date

Colleagues in the Trust have responded well to the call for their sections of the annual report, and their assistance during these capacity constrained times is much appreciated.

The main sections of the annual report remain:

- Overview of performance and quality*
- Overview of governance including Trust Board and Committee arrangements and how these duties have been discharged, and the Annual Governance Statement, submitted in the report by the Trust's Chief Executive as Accountable Officer
- Overview of staffing and remuneration
- Annual accounts (produced and submitted separately to the Audit Committee by the Finance Team)

*This includes the Trust's NHS Constitutional and operational performance standards, the NHS staff survey results and action plan, the Trust's quality standards and delivery of safe patient care, the annual Eliminating Mixed Sex Accommodation statement, the annual Modern Slavery statement.

4. Timetable for production

The Head of Corporate Affairs will be in a position to circulate a draft of the sections submitted to date to Audit Committee members, the internal and external auditors and Trust Board members to review by close of business Friday 13 May 2022. The sections submitted to date include significant sections that allow for the assessment of risks and internal control issues for the Annual Governance Statement, which is positive progress so close to year-end.

The Head of Corporate Affairs will release an updated draft at the end of May for further review and input, particularly mindful of the external auditor's work.

A final draft will be circulated by 9 June 2022, prior to the Extraordinary Audit Committee and Trust Board meetings scheduled 16 June 2022 for its sign-off. The Chief Executive, as in previous years, is scheduled to attend the Audit Committee to present the Annual Governance Statement part of the report.

Working with colleagues who submit relevant elements of the annual report, there are currently no anticipated risks to the completion of the annual report to the original deadline of the end of May 2022. The performance section will also take into account that any elements included in previous years have been stepped down nationally for annual reporting (previously the Workforce Race and Disability Equality Schemes).

4. Conclusion

The Trust is able to meet this year's annual reporting requirements and a schedule for production of draft version for review is outlined above. The Trust is aiming to submit its report for the original deadline of the end of May 2022.

5. Recommendation

The Committee is asked to receive and accept this update, and to request any further information or areas of assurance

Rebecca Thompson
Head of Corporate Affairs
April 2022

Agenda Item	6.6	**Meeting**	Trust Board	**Meeting Date**	12.06.22
Title	2021-22 Self Assessment against Standards G6 and FT4				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report is received by the Trust Board annually				

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:

Each year, The Trust Board is required to provide two self-assessment declarations covering 2021/22; this is a requirement from NHS Improvement and mirrors the self-assessment process and standards that applied previously to NHS Foundation Trusts. With the merger of NHS regulators, these self-assessments apply the same requirements across the acute provider sector. These require Trust Board review and approval.

The Board is able to declare compliance against all requirements in these two self-assessments, which cover corporate governance and assurance processes within the organisation.

The Trust Board is asked to approve the two attached self-assessments covering 2021/22.

Hull University Teaching Hospitals NHS Trust

NHS Improvement Self-Assessments 2021/22

1. Purpose of this report

The purpose of the report is to present two self-certification templates and an assessment of supporting evidence to enable the Trust to self-certify against NHS improvement requirements.

2. Background

Monitor, when it was the regulator of NHS Foundation Trusts, put in place an self-assessment process against the Monitor licence conditions. Although NHS trusts are exempt from needing the provider licence, directions from the Secretary of State require the NHS Improvement to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate.

As stated by NHS Improvement:
[The Trust is subject to] the Single Oversight Framework, which bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.

All Trusts are required to complete two self-certifications and have these confirmed by their Trust Boards. Both are being completed and presented to the Board today. There may be a spot-check audit completed by NHS Improvement during the financial year. The Trust is also required to publish one of the self-certification declarations, however for openness and transparency, the Trust has always published both and will do the same this year.

3. Self-Assessments Requirements

The Trust needs to self-certify the following after the financial year-end that:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
- The provider has complied with required governance arrangements (Condition FT4(8))

The template declarations are included at Appendix 2 and Appendix 3.

The Head of Corporate Affairs has reviewed these requirements and the Trust's evidence against these and recommends that the Trust Board is able to self-certify as meeting the requirements of both self-certifications.

3.1 Condition G6

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))

<u>NHS licence</u>
Attached at Appendix 1 is a review of the Trust's position against the NHS I provider licence. Some of these requirements are specific to NHS Foundation Trusts and reference the previous Monitor regime; where this is the case, the spirit and equivalent requirements in non-Foundation Trusts have been applied in the Trust's evidence.

The Trust meets all the requirements of the licence.

NHS Acts

For all its NHS services, the Trust has in place the NHS Standard Contract. This requires the Trust to act in accordance with relevant NHS Acts in the delivery of its services. These safeguard the public to receive NHS services free of charge at the point of delivery (except for charges agreed by Parliament, such as NHS prescription charges) and also require the Trust to act in accordance with relevant legislation (safeguarding, mental capacity act requirements, mental health act requirements, etc) and be subject to NHS regulatory requirements, including CQC registration requirements. These requirements are embedded in the daily delivery of the Trust.

Through delivery of services via the NHS Standard Contract, the Trust is compliant with relevant NHS Acts. The Trust is not currently under notice by its commissioners or regulators of any significant breach of contractual requirements relating to a specific NHS act.

NHS Constitution

The Trust is required to have regard of the NHS Constitution in the delivery of NHS services. This is designed to ensure equity of service access to all patients, and that providers must strive to deliver high quality services and provide value for money to the taxpayer. The Trust is able to demonstrate it has regard of the NHS Constitution and that it is continually working to further improve quality and efficiency.

The NHS Constitution consists of two rights and a number of pledges around NHS care. The Trust has published its performance data with every set of Board papers during 2021/22 against these rights and pledges and the Board holds the Trust to account during the year on delivery.

More broadly, the Trust is expected to report against the NHS Priorities and Operational Planning Guidance, which includes the NHS Constitution rights and pledges. The Trust Board receives this information each meeting through the Integrated Performance Report, which includes all NHS Priorities and Operational Planning Guidance data requirements, and the Trust's year-to-date performance in all areas. A more detailed exception report is received and explored in more depth each month at the Performance and Finance Committee.

As reported to the Board and Performance and Finance Committee, the NHS Priorities and Operational Planning Guidance data 2021/22 show that Trust has not consistently met some of the waiting time standards that are included as rights to NHS patients in the NHS Constitution, specifically the 18-weeks Referral to Treatment standard, the ED four-hour standard, the diagnostic waiting times standard and the cancer 31- and 62 day standards.. The reasons for this have been detailed during Trust Board and Performance and Finance Committee meetings during the year.

The requirement is that the Trust has *taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))*

Whilst the Trust has not met the full suite of Constitutional targets, the Trust has complied with this requirement to take all precautions necessary: it has built its reporting framework around giving visibility of all NHS Constitution requirements and the broader suite of NHS Priorities and Operational Planning Guidance requirements to the Trust Board to provide an accurate and honest account of meeting its requirements and obligations, and has enacted this throughout the year.

Condition FT4

- The provider has complied with required governance arrangements (Condition FT4(8))

Condition FT4 is a more detailed governance self-certification for NHS Trusts. The attached appendix self-certification confirms that the Trust can confirm it meets all standards, with supporting information included, for Trust Board review and confirmation.

4. Recommendation

The Trust Board is recommended to review and approve the self-certification for GC6 and FT4 and to approve publication of the same by 30 June 2022.

Rebecca Thompson
Head of Corporate Affairs
May 2022

Appendix 1 - Actions to ensure compliance with the Monitor licence

Condition	Action	Evidence	Completed	Party responsible
G1 provision of information	Monitor will request information from time to time which must be accurate, complete and not misleading.	All requests for documents and information submitted as required to regulators – e.g. evidence to CQC, information to support NHS Improvement discussions	Per request	Director of Quality Governance
G2 publication of information	As directed by Monitor the Trust must publish information	The Trust has published all required information on its website: • Trust Board papers • Annual Reports • Quality Accounts • Modern Slavery Statement • Eliminating Mixed Sex Accommodation Statement • Safer Staffing • Public Sector Equality Duty, Workforce Race Equality Standard and Workforce Disability Equality Standard • Gender Pay Gap data • Publication Scheme • CQC rating and link to report • Freedom of Information Request guidance	Per requirement	Director of Quality Governance
G3 payment of fees	Trust must pay Monitor fee as required within 28 days of it becoming payable	Trust not required to pay a Monitor fee as it is not an NHS Foundation Trust however the Trust has paid all relevant fees as an acute Trust: CQC fees, NHS Litigation Authority contributions, registration costs with external agencies	Per invoice	Director of Quality Governance

Condition	Action	Evidence	Completed	Party responsible
G4 Fit and proper person	All those with the title of Director or equivalent shall complete the fit and proper person test and a register will be kept. This includes the Governors. This will be updated on an annual basis as part of the year end process.	Fit and Proper Persons Test updated and presented to the Trust Board May 2022 – no issues raised As a non-FT, the Trust does not have any Governors	May 2022	Director of Quality Governance/ Trust Board
G4 Fit and proper person	Term to be added to all Directors' employment contracts to state that a Director will have their employment as a Director summary terminated in the event of not being able to satisfy the fit and proper person test. This should be extended to those considered to be equivalent to a director, but not using the title.	Clause included in the updated Very Senior Manager contracts, agreed by the Remuneration Committee in April 2016; contract applicable to the most senior tier of trust management (not just Executive Directors)	April 2016	Director of Workforce and Organisational Development
G5 NHS E/I guidance	When NHS E/I releases guidance, the Trust is required to comply with that guidance or explain why it cannot comply. On the release of guidance a review will be undertaken and if there are any areas where the Trust cannot comply they will be reported to the Board. Where necessary a statement will be sent from the Board to NHS E/I to explain why the Trust is not complying with the guidance.	The Trust has applied this to NHS Improvement guidance and, before this, to Trust Development Authority guidance No issues raised with compliance to date; most recent changes have been use of the NHS Priorities and Operational Planning Guidance, which form the basis of the Trust's Integrated Performance Report, reviewed and published at each Trust Board meeting, and used on a monthly basis by Performance and Finance Committee	As per any new guidance	Director of Quality Governance/ Trust Board

Condition	Action	Evidence	Completed	Party responsible
G6 System for compliance	The Trust is required to take reasonable precautions against the risk of failure to complying with the licence and the conditions imposed under the NHS acts and required to have regard to the NHS Constitution No later than 2 months from the end of the financial year, the Trust must prepare and submit to Monitor a certificate to the effect that the Trust during the previous financial year has complied with the conditions in the licence. Trust must publish each certificate within 1 month of submission to Monitor in such a manner as would bring to the attention of anyone who may be interested.	The Trust's Annual Governance Statement identifies risks to compliance with the NHS Contracts it has in place and to NHS Constitution rights The Trust will complete and publish its annual report including annual financial statements by 16 June 2022	16 June 2022	Director of Quality Governance
G7 Registration with the CQC	Trust must at all times be registered with the CQC	The Trust has remained registered with the CQC at all times	In place	Director of Quality Governance
G7 Registration with the CQC	Trust to advise Monitor if the Trust does not maintain the CQC registration - the Trust must notify Monitor within 7 days	Not applicable – Trust has retained registration		
G8 Patient eligibility and selection criteria	Set transparent eligibility and section criteria and apply those criteria in a transparent way to persons who, having a choice of person from whom to receive health care services. Publish the criteria in such a manner as will make them accessible to those that are interested.	The Trust has the standard NHS Contract in place for all NHS services; patient choice arrangements are managed via local commissioners. The Trust provides a service to all patients referred under the NHS Contracts in place with commissioners. The Trust makes appointments available via Choose and Book at the point of choice and referral.	In place	Chief Operating Officer

Condition	Action	Evidence	Completed	Party responsible
G9 Application of Continuity of Services	Condition applies whenever the trust is subject to a contractual or other legally enforceable obligation to provide a service which is a Commissioner Requested Service	The Trust has Commissioner Requested Services included in contracts with local commissioners	In place	Chief Financial Officer
G9 Application of Continuity of Services	The Trust shall give NHS E/I not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to which no extension or renewal has been agreed.	The Trust would inform NHS Improvement if this were enacted – no such action taken for 21/22 contracts	If required	Chief Financial Officer
G9 Application of Continuity of Services	The Trust shall make available free of charge to any person a statement in writing setting out the description and quality of service which it is under a contractual or other legally enforceable obligation to provide as a Commissioner Requested Service (CRS).	The Trust publishes bi-monthly such statements through its Trust Board papers, and also through publications such as the Quality Accounts, all of which are available free of charge on line. The Trust has in place the NHS Standard Contract, including description of service and quality standards, in place for all NHS services provided	In place	Executive Directors
G9 Application of Continuity of Services	Within 28 days of a change to the description or quantity of services which the Trust is under a contractual obligation to provide as Commissioner Requested Services, the Trust shall provide to NHS E/I in writing a notice setting out the description and quantity of all services it is obliged to provide as CRS.	The Trust would inform NHS Improvement if this were enacted	In place	Chief Financial Officer

Condition	Action	Evidence	Completed	Party responsible
P1 Recording of information	If required by NHS E/I the trust shall obtain, record and maintain sufficient information about the cost which it expends in the course of providing services for the purpose of the NHS and other relevant information. The Trust will establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information.	The Trust publishes its accounts annually, which are subject to audit. The Trust can provide more detailed information on expenditure on request (and has done, for example, for commissioners). The Trust has in place relevant systems to upload and provide information to NHS Digital, used by commissioners and regulators.	In place	Chief Financial Officer
P1 Recording of information	The Trust is required to use the cost allocation methodology and procedures relating to other relevant information set out in the Approved Guidance.	The Trust is compliant with relevant guidance, for example, application of PbR and new HRG+ requirements	In place	Chief Financial Officer
P1 Recording of information	If the Trust sub contracts to the extent allowed by NHS E/I the Trust shall ensure the sub-contractors obtains, records and maintains information about the costs which it expends in the course of providing services as a sub-contractor, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of information. The sub-contractor will supply that information to NHS E/I as required within a timely manner.	The Trust has relevant processes in place for the sub-contracting it undertakes (i.e. using elective capacity in the private sector). The Trust, as a non-FT, does not submit this information to NHS Improvement but provides information as required	In place	Chief Operating Officer Chief Financial Officer
P1 Recording of information	The Trust will keep the information for not less than six years	All relevant Trust information available for more than six years – the Trust applies NHS Records Management Guidance to document and information retention	In place	Chief Financial Officer

P2 Provision of information	As G1 The Trust will supply NHS E/I with information as required.	Will do as and when required	In place	Chief Financial Officer
Condition	**Action**	**Evidence**	**Completed**	**Party responsible**
P3 Assurance report on submissions to NHS E/I	If NHS E/I requires the Trust to provide an assurance report in relation to a submission of information under P2 or by a third party. An Assurance Report must be completed by a person approved by NHS E/I or qualified to act as an auditor.	Will do as and when required	In place	Chief Financial Officer
P4 Compliance with the National Tariff	The Trust shall only provide healthcare services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by NHS E/I.	The Trust's contract management arrangements in place with local and specialised commissioners and the Trust's audited accounts confirm this is in place	In place	Chief Financial Officer
P5 Constructive engagement concerning local tariff modifications	The Trust is required to engage constructively with Commissioners, with a view to reaching agreement as provided in section 124 of 2012 Act (around price).	In place – local tariff agreed as part of NHS contracts in place	In place	Chief Financial Officer

C1 The right of patients to make choices	The Trust shall ensure that at every point where a patient has a choice under the NHS Constitution or a choice of provider conferred locally by commissioners, the patient is notified of that choice and told where they can find that information. The information provided must not be misleading. The information cannot prejudice any patient. Note: The Trust is strictly prevented from offering or giving gifts, benefits in kind or pecuniary or other advantage to clinicians, other health professionals, Commissioners or their administrative or other staff as inducement to refer patients to commissioned services.	Choice is primarily lead by commissioners and choice is offered at the point of referral – the Trust is in receipt of the referrals after choice has been made The Trust includes information on the NHS Constitution on its website and information on choice in information provided to patients following receipt of referral also. The Trust's Access Policy includes information of enactment of choice.	In place	Chief Operating Officer
Condition	**Action**	**Evidence**	**Completed**	**Party responsible**
C2 Competition oversight	The Trust shall not enter into any agreement or arrangement that prevents or distort competition in the provision of healthcare.	No such arrangements in place; NHS Standard Contract in place for all NHS services	N/A	Trust Board
IC1 Provision of Integrated Care	The Trust shall not do anything that would be regarded as against the interests of people who use healthcare services. The Trust shall aim to achieve the objectives as follows: - Improving the quality of health care services - Reduce inequalities between persons with respect to their ability to access services and the outcomes achieved for them.	The Trust has in place a Quality Improvement Plan to make specific improvements in services across the Trust The Trust complies with the Public Sector Equality Duty in respect of access to services	In place	Chief Medical Officer Chief Operating Officer

CoS1 Continuing provision of Commissioner Requested Services	The Trust is not allowed to materially alter the specification or means of provision of any CRS services except: • By agreement in writing from the Commissioner • If required to do so by, or in accordance with its terms of authorisation.	NHS Standard Contract in place, including clauses as to how amendments to the contract are made in agreement with commissioners	In place	Chief Financial Officer
CoS2 Restriction on the disposal of assets	Keep an asset register up to date which shall list every relevant assed used by the Trust. The Trust shall not dispose of or relinquish control over any relevant asset except with consent of Monitor. The Trust will supply NHS E/I with a copy of the register if requested.	[Assets taken as Estates in this context] The Trust would inform commissioners and NHS Improvement is any action on estates were being taken that would prevent the continuation of an NHS services	In place	Chief Financial Officer

Condition	Action	Evidence	Completed	Party responsible
CoS3 Standards of corporate governance and financial management	Trust is required at all times to maintain, adopt and apply systems and standards of corporate governance and of risk management which reasonably would be regarded as: Suitable for a provider of the CRS provided by the Trust Providing reasonable safeguards against the risk of the Trust being able to carry on as a going concern	Audit Committee and Trust Board have oversight of governance. Audit Committee and Trust Board signed off preparation of accounts on a going concern basis Trust Board has oversight and sign-off of Annual Governance Statement, confirming adequate governance arrangements are in place Head of Internal Audit Opinion gave a positive assurance opinion for 21/22 year-end position	April 2022	Chief Executive
CoS3 Standards of corporate governance and financial management	The Trust shall have regard to: Guidance from NHS E/I Trust rating using risk rating methodology Desirability of that rating being not less than the level regarded by NHS E/I as acceptable	The Trust has regard for NHS Improvement requirements and publishes its risk rating based on this methodology with each set of Trust Board papers, including explanatory notes	Bi-monthly	Chief Financial Officer
CoS4 Undertaking from the ultimate controller	The Trust shall procure from each company or other person which the trust knows or reasonably ought to know is at any time its ultimate controller	Not applicable	N/A	N/A

Condition	Action	Evidence	Completed	Party responsible
CoS5 Risk pool levy	The Trust shall pay to NHS E/I any sums required to be paid in consequence of any requirement imposed on providers, including sums payable by way of levy imposed and any interest payable. If no date given then within 28 days	Will be managed in line with the NHS standard contract, if applicable	N/A	Chief Financial Officer
CoS6 co-operation in the event of financial stress	If NHS E/I gives notice in writing to the Trust that it is concerned about the ability of the Trust to carry on as a going concern, The Trust shall: Provide information as NHS E/I my director to commissioners and to such other persons as Monitor may direct Allow such persons as NHS E/I may appoint to enter premises Cooperate with such persons	Such information exists and can be provided to NHS Improvement if such a concern was raised The Trust has a requirement under the NHS Standard contract to allow commissioners and regulators access to the Trust if significant concerns were formally raised	April 2022 In place	Chief Financial Officer Chief Executive
CoS7 Availability of resources	The Trust will at all times act in a manner calculated to secure the required resources Trust not later than 2 months after the year end shall submit to NHS E/I a certificate as to the availability of the required resources for the period of 12 months commencing on the date of the certificated using one of the following statements: After making enquires the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Going concern review submitted and accepted by the Audit Committee April 2022 Draft annual accounts shared with Audit Committee members in April 2022 and audited accounts shared June 2022 On track for review and acceptance by Trust Board members by 16 June 2022 deadline Annual report includes annual governance statement, including use of resources and anticipated risks to service delivery and resources	June 2022	Chief Executive / Trust Board

	or after making enquires the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) and distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in the certificate. However, they would like to draw attention to the following factors which may cast doubt ion the ability of the Licensee to provide CRS. **or** In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. The Trust shall submit to NHS E/I with that certificate a statement of the main factors which the Director of the Trust have taken into account in issuing that certificate. The certificate must be approved by a resolution of the BoD and signed by a Director the Trust pursuant to that resolution. Trust must tell NHS E/I immediately the Directors become aware of circumstances that cause them to no longer have the reasonable expectation referred			

Condition	Action	Evidence	Completed	Party responsible
FT1 Information to update the register of NHSFT	Trust must supply to NHS E/I or make sure they are available to NHS E/I the following: Current version of the Constitution Most recent published accounts and auditor report on them Most recent annual report Amended Constitutions must be supplied within 28 days Comply with any Direction given by NHS E/I When submitting documents to NHS E/I the Trust must provide a short written statement describing the document and specifying its electronic format and advising that the document is being sent for the purpose of updating the register.	No such equivalent exists for non-Foundation Trust The Trust publishes its annual report and accounts shortly after approval – this includes description of the Trust, its use of resources and audit opinion The Trust has published its key strategy documents The Trust publishes monthly performance, quality and financial information via Trust Board papers	In place	Trust Board
FT2 Payment to NHS E/I	Not applicable – equivalent requirements noted and evidenced above	N/A	N/A	N/A
FT3 provision of information to advisory panel	Trust must comply with any request from NHS E/I	The Trust complies with requests from regulators (NHS Improvement, CQC) as and when received	In place	Chief Executive

Condition	Action	Evidence	Completed	Party responsible
FT4 NHSFT governance arrangements	Trust will apply the principles, systems and standards of good corporate governance The Trust will have regard to such guidance as NHS E/I may issue. Comply with the following conditions - Trust will establish and implement: • An effective Board and committee structure • Clear responsibilities for its Boards and committees reporting to the Board and for staff reporting to the Board and those committees. • Have clear lines of accountabilities throughout the organisation The Trust shall establish and effectively implement systems and processes to: • Ensure compliance with the duty to operate efficiently, economically and effectively • For timely and effective scrutiny and oversight by the Board of the Trust's operations. • Ensure compliance with health care standards binding on the trust including but not restricted to standards specified by the CQC and NHS Commissioning Board and statutory regulators of health care professionals • To identify and manage material risks to compliance.	The Trust's Annual Governance Statement and Annual Report set out the Trusts' governance structure, which includes a Board and committee structure that meets statutory and good governance requirements, clear reporting lines up to the Trust Board through Standing Orders, and a triumvirate system for Health Group management, with Executive oversight of Health Groups and corporate services The Trust has Standing Orders, Standing Financial Instructions and other relevant policies, such as the Business Interests policy and financial management policies The Trust meets regularly and has a supporting committee structure in place for the scrutiny and management of quality in services, performance and financial oversight and accountability The Trust has in place policies and processes for financial management, deployment and management of human resources, which are subject to scrutiny by the Trust's internal and external auditors	In place	Chief Executive/ Trust Board

	• To generate and monitor delivery of business plans. • To ensure compliance with all applicable legal requirements • To obtain and disseminate accurate, comprehensive, timely and up to date info for BoD and Committee decision making • For effective financial decision-making, management and control The Trust shall submit to NHS E/I within 3 months of the year end: • A corporate governance statement by and on behalf of its Board confirming compliance with this condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this condition in the next financial year and any action it proposed to take to manage such risks. • If required by NHS E/I a statement from the External Auditors will be included.	The Trust updated its Risk Policy in April 2022 to include a more robust 'ward to board' process for the management or organisational risk. The Risk Management Strategy was approved by the Board in January 2022. The Trust has in place a process to generate and monitor business plans, whether these are the annual operational plan for the organisation, individual business cases for capital or revenue equipment, a rolling capital programme or Trust strategies. The Trust's monitoring of quality and finance includes compliance with legal and regulatory requirements The Board and Committee timings are set in advance to receive the most current data available The Trust will have completed and published its annual report, including its annual governance statement and assessment of risks for the coming financial year by the end of June 2022, and will publish this to be available to the public, stakeholders and regulators		

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the **Confirmed** OK

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sean Lyons	**Name**	Chris Long
Capacity	Chairman	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Self-Certification Template - Condition FT4

Hull And East Yorkshire Hospitals NHS Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These Declarations are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Trust Board has regard for good governance principles - it has adopted model Standing Orders, it has all statutory governance requirements in place and is subject to internal and external audit on the robustness of its arrangements	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust Board reports at each meeting against the requirements of the NHS Priorities and Operational Planning Guidance and takes account of new guidance	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust has a well-established committee structure to support the Trust Board. There is a reporting process from Trust Board Committees to the Trust Board and 'ward to board' flows on quality and risk management. There is an established senior management tier, which reports up to Trust Board level.	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	See also self-certification for G6. The Trust has sufficient skills and capacity at Board level to undertake financial-decision making, management and control. The Trust Board receives timely information on the Trust's business operations and levels of performance across waiting times, finance and quality. Effective financial decision-making includes an annual position statement,scrutinised by the Trust's auditors, Audit Committee and Trust Board, on its going concern status. The Trust Board has a well-established Committee structure for more detailed review and scrutiny of financial reporting and other aspects of Trust perofrmance. The Trust Board reviews and signs off the Trust strategies and annual operational plan. The Board Reporting Framework is structured around the Trust Board's legal requirements.	Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Trust Board has mix of clinical, quality and performance expertise to provide leadership across the organisation and to take account of all Board accountabilitites in relation to quality (a). The Trust Board receives data at each meeting, from the preceding month or two months, on finance, performance and quality, which is subject to more detailed scrutinty by Board Committees as well as the Trust Board (b). There are specific reports monthly providing timely and accurate data on quality of care, using a variety of sources (c), which enable the Board to take an accurate, timely and accurate account of quality of care, and other reports throughout the year, which provide more comprehensive oversight of quality (for example, the Guardian of Safe Working quarterly reports) (d). The Trust Board concerns itself with quality of care at each Trust Board meeting including starting the substantive agenda with patient stories, and through its committee structure; Trust Board members 'walk the floor' regularly and speak with staff and patients about their experiences. The Trust Board receives intelligence on staff and patient experience through a number of routes during the year - annual staff survey , quarterly staff barometer, monthly Friends and Family test, monthly Patient Experience reporting (e) and (f). There is a focus on strategic risk through the Board Assurance Framework.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Trust Board receives data on staffing figures regularly. The Trust reports at each meeting on nursing staff fill-rates and receives regular updates on the Trust's People Strategy. The Performance and Finance Committee review more detailed staffing informating including medical staffing.	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Sean Lyons, Chair **Name** Chris Long, Chief Executive

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

NHS Improvement

Self-certification: guidance for NHS foundation trusts and NHS trusts

Updated March 2019

collaboration trust respect innovation courage compassion

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

1. Introduction

1. This document provides guidance on the annual self-certification that NHS trusts and foundation trusts ('NHS providers') must complete under the NHS provider licence.

2. The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

    a. effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
    b. complied with governance arrangements (condition FT4); and
    c. for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).

3. Although NHS trusts do not need to hold a provider licence, directions from the Secretary of State require NHS Improvement to ensure that NHS trusts comply with conditions equivalent to those in the licence as it deems appropriate.

4. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including conditions G6 and FT4) and must self-certify under these licence conditions. The CoS conditions do not apply to NHS trusts, so they are not required to self-certify under the CoS7 condition.

5. A template is provided to assist with recording of the self-certifications. Should you be audited by NHS Improvement this can be a useful tool to quickly illustrate compliance with some of the process. It is not mandatory to complete and is provided for record keeping purposes only. Please do not return to NHS Improvement unless specifically requested to do so.

2. What is required?

6. NHS providers need to self-certify the following conditions after the financial year end:

NHS provider licence conditions

Condition G6(3)	The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution.	By 31 May
Condition G6(4)	Publication of condition G6(3) self-certification.	By 30 June
Condition FT4(8)	The provider has complied with required governance arrangements.	By 30 June
Condition CoS7(3)	The provider has a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement. This only applies to foundation trusts that are providers of CRS.	By 31 May

7. It is up to the provider how they undertake their self-certification process. However, any process should ensure that the provider's board understands clearly whether or not the provider can confirm compliance.

8. Detailed guidance on the requirements of each of these conditions can be found in Section 4 of this document. In Section 6, you will find links to resources including self-certification and templates that boards may use to record their self-certification if they find them helpful.

3. NHS provider licence conditions

Condition G6

9. Condition G6(2) requires NHS providers to have processes and systems that:

    a. identify risks to compliance with the licence, NHS acts and the NHS Constitution

    b. guard against those risks occurring.

10. Providers must complete a self-certification after reviewing whether their processes and systems were implemented in the previous financial year and were effective (condition G6(3)).

11. Providers must publish their self-certification by 30 June (condition G6(4)).

Guidance on using the template

- Providers should choose ‘confirmed’ or ‘not confirmed’ as appropriate.
- Providers choosing ‘not confirmed’ should explain why in the free text box provided.

Condition FT4

12. Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4.

13. Before making the statement, providers should review whether their governance systems and processes enable them to achieve compliance with condition FT4. There is no set approach, but we expect any compliant approach to involve a review of the effectiveness of board and committee structures, reporting lines and performance and risk management systems.

14. NHS providers can find further information on governance by referring to:

    a. the well-led framework for governance reviews (last updated June 2017)
    b. the NHS foundation trust code of governance (July 2014)
    c. Single Oversight Framework (last updated November 2017)
    d. contacting their NHS Improvement regional regulation lead.

Guidance on using the template

- Providers should select 'confirmed' or 'not confirmed' for each certification as appropriate and set out relevant risks and mitigating actions in each case.
- Providers choosing 'not confirmed' for any certification should explain why in the free text box provided.

Condition CoS7 (only NHS foundation trusts that have CRS designated services)

15. Only NHS foundation trusts designated as providing CRS must self-certify under condition CoS7(3).

What is commissioner requested service designation?

16. A CRS designation is not simply a standard contract with a commissioner to provide services. CRS are services commissioners consider should continue to be provided locally even if the provider is at risk of failing financially and, as such, are subject to closer regulation by NHS Improvement. Providers can be designated as providing CRS because:

    - there is no alternative provider close enough
    - removing the services would increase health inequalities
    - removing the services would make other related services unviable.

17. For more detailed guidance, refer to the designation framework: defining CRS and location specific services (28 March 2013).

How do I know if my foundation trust is a CRS provider

18. NHS foundation trusts authorised before 1 April 2016 will have been specifically notified by their commissioner if they have been designated a CRS provider. They do not need to complete the CoS7 certification if they have not been notified.

19. Foundation trusts authorised on or after 1 April 2016 are automatically CRS designated for all services for 12 months from the date of authorisation. During this period, they must complete the CoS7 certification. After 12 months, unless they receive a specific designation from a commissioner, they are not designated a CRS provider and the CoS7 certification is not required.

Guidance on using the template

- The template requires CRS-designated NHS foundation trusts to select 'confirmed' for one of three statements about the availability of resources required to provide commissioner designated services:
  a. the required resources will be available for 12 months from the date of the statement;
  b. the required resources will be available over the next 12 months, but specific factors may cast may doubt on this; or
  c. the required resources will not be available over the next 12 months.
- Required resources include: management resources, financial resources and facilities, personnel, physical and relevant asset guidance.
- Only one statement should be confirmed (and providers do not need to state the other two are not confirmed). Providers should explain the reasons for the chosen statement in the free text box provided (condition CoS7(4)).

4. Other self-certifications

Training of governors (NHS foundation trusts only)

20. NHS foundations trusts must review whether their governors have received enough training and guidance to carry out their roles. It is up to providers how they do this (but see *Monitor's guide for governors* for guidance).

Guidance on using the template

- Providers should choose 'confirmed' or 'not confirmed' as appropriate for the certification.
- Providers choosing 'not confirmed' should explain why in the free text box provided.

5. Useful resources

21. This guidance is necessarily high level and should be read alongside:

    a. the templates
    b. NHS provider licence (last updated February 2013)
    c. the designation framework: defining CRS and location specific services (last updated March 2013)
    d. the well-led framework for governance reviews (last updated June 2017)
    e. the NHS foundation trust code of governance (July 2014)
    f. Single Oversight Framework (last updated November 2017).

22. If you have any questions not addressed in this guidance or any of the additional documents referred to, please contact your regional lead.

6. Deadlines

Boards must sign off on self-certification not later than:

- Condition G6: 31 May – must be published no later than by 30 June.
- Condition CoS7: 31 May
- Condition FT4: 30 June.

7. Audit

23. Please do not return the completed self-certifications or templates to NHS Improvement unless requested to do so.

24. NHS Improvement will retain the option each year of contacting a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording sign-off.

Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
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@NHSImprovement

This publication can be made available in a number of other formats on request.

 Publication code: CG 36/19

Agenda Item	6.6	**Meeting**	Trust Board	**Meeting Date**	12.05.22
Title	Declarations of Interest Fit and Proper Persons 2021/22				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebeca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report is considered annually by the Trust Board				

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

Key Recommendations to be considered:

The Trust Board receives an annual report on any issues raised by the latest Declarations of Interests by Board members, as well as any issues relating to a Board member's suitability as a Fit and Proper Person, in respect of CQC requirements.

A full review has been undertaken for all Trust Board members. There are no issues of concern or non-compliance to report to the Board.

The Trust Board to review and confirm there is assurance that:

- that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons
- that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances

Hull University Teaching Hospitals NHS Trust

Trust Board

Declarations of Interest and Fit and Proper Persons Declarations

1. Purpose

To provide assurance that all Board members and Trust Directors have completed declarations of interest and meet the requirements of Care Quality Commission (CQC) Regulation 5:Fit and Proper Persons.

2. Background

In November 2014, the CQC introduced Regulation 5: Fit and Proper Persons Test. CQC Regulation 5 places a duty on the Trust not to appoint anyone to a post with Board level responsibilities who does not meet their Fit and Proper Persons Test. The Trust applies this test to all new Board appointments and to Trust Directors; the process is carried out by the Trust for Chief/Directors and is started by NHS Improvement (and documented by the Trust) for Non-Executive Directors.

The Trust Board confirm compliance annually for all Board members and Trust Directors. In addition, arrangements are in place through the Disclosure and Barring Service to ensure that the Trust is informed of any subsequent issues that may be a cause of concern in relation to Board members.

3. Procedure

At the end of every financial year all Board members and Trust Directors are asked to complete a declaration of interest form which includes the Fit and Proper Person declaration. Any material issues included on the declarations are reviewed by the Chairman and/or Head of Corporate Affairs to determine if it is relevant to the individual remaining a Fit and Proper Person.

Any changes in, or conflicts of, declared interests are entered onto the declaration register held by the Head of Corporate Affairs and reported in the Trust's Annual Report as well as to the Trust Board in-year. Board members' interests are also published on the Trust's website and kept up to date as interests change.

Appendix A details the most recent completed declarations by Board members and Trust Directors, for review by the Trust Board for assurance. Appendix B details declared interests of Trust Board members. Appendix C contains the Fit and Proper Person Assessment criteria, for reference.

4. Recommendation

The Trust Board to review and confirm there is assurance that:

- that all Board members have completed declarations of interest and meet the requirements of CQC Regulation 5: Fit and Proper Persons
- that annual checks are carried out to ensure that the Trust is up to date with any changes in circumstances

Rebecca Thompson
Head of Corporate Affairs
May 2022

Appendix A

Fit and Proper Person Declarations for Board Members and Trust Directors Completed May 2022

Name	Role	Return completed	FFP Assessment (Any issues)	On Individual Insolvency Register
Mr Sean Lyons	Chair	✓	No	No
Mr Stuart Hall	Vice Chair/Non-Executive Director	✓	No	No
Mrs Tracey Christmas	Non-Executive Director	✓	No	No
Mr Tony Curry	Non-Executive Director	✓	No	No
Mr Mike Robson	Non-Executive Director	✓	No	No
Prof. Una Macleod	Non-Executive Director	✓	No	No
Ms Linda Jackson	Associate Non-Executive Director	✓	No	No
Mr Chris Long	Chief Executive Officer	✓	No	No
Mrs Beverley Geary	Chief Nurse	✓	No	No
Dr Makani Purva	Chief Medical Officer	✓	No	No
Mr Lee Bond	Chief Financial Officer	✓	No	No
Mr Simon Nearney	Director of Workforce and Organisational Development	✓	No	No
Mrs E Ryabov	Chief Operating Officer	✓	No	No
Mrs M Cady	Director of Strategy and Planning	✓	No	No
Mrs S Rostron	Director of Quality Governance	✓	No	No
Dr D Hughes	Non-Executive Director	✓	No	No
Mrs S McMahon	Joint Chief Information Officer	✓	No	No
Dr Ashok Pathak	Associate Non-Executive Director	✓	No	No
Mr David Haire	Project Director - Fundraising	✓	No	No
Mr Duncan Taylor	Director of Estates, Facilities and Development	✓	No	No
Mrs Julie Lumb	Head of Procurement	✓	No	No

Appendix B

Declarations of Board Members' Interests

Any declarations of interest made by Board members in 2021/22 and currently on the Trust's Register of Business Interests

Name	Role	Declared interest
Mr Sean Lyons	Chair	• Chair at West Nottinghamshire Further Education College, Mansfield • Daughter is a Student Nurse at Sheffield Hallam University since September 2021 • Trust Board member
Mr Stuart Hall	Vice Chair/Non-Executive Director	• Associative Non-Executive Director at Northern Lincolnshire and Goole NHS Foundation Trust • Partner Lay member of Yorkshire Clinical Senate • Member of Advisory Committee on Clinical Excellence Awards
Mrs Tracey Christmas	Non-Executive Director	• Trust Board Member
Mr Tony Curry	Non-Executive Director	• Trust Board Member
Mr Mike Robson	Non-Executive Director	• Non-Executive Director and Trustee of Hull Truck Theatre from September 2018 to present • Trust Board member
Prof. Una Macleod	Non-Executive Director	• Is a Dean at Hull York Medical School - employed by University of Hull • Holds grants from Yorkshire Cancer Research and NIHR
Ms Linda Jackson	Associate Non-Executive Director	• Vice Chair at Northern Lincolnshire and Goole Hospital
Mr Chris Long	Chief Executive Officer	Completed Nil Return
Dr Makani Purva	Chief Medical Officer	• Has ownership in SELF 2010 Success at Medical Interviews Training and Interview Practice / Counselling • Husband has a position at Trentcliffe Healthcare 2020 Secondary Care Work • Husband works for Northern Lincolnshire and Goole Hospital
Mr Lee Bond	Chief Financial Officer	In a relationship with the Interim Chief Nurse Joint Chief Financial Officer of Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust
Mr Simon Nearney	Director of Workforce and Organisational Development	• Director of Cleethorpes Town FC /LHC • Daughter Ruby Nearney is an Apprentice Nurse at HUTH • Wife Lisa Nearney is an Auxiliary Nurse at NLAG • Son Willian Nearney is an Accountant (York) • Son Jacob Nearney works in HR at Lincolnshire Partnership
Mrs E Ryabov	Chief Operating Officer	• Budget holder and/or Trust Board Member

Mrs M Cady	Director of Strategy and Planning	• In the process of being appointed as a Volunteer Chair for the Lincolnshire Serving Community Team section of the charity known as SSAFA, the Soldiers, Sailors, Airmen and Families Association. • A family member (sibling) works at HUTH • Trust Board member • Son is employed by Templar Executives, a cyber-security and consulting services company. This company provides consulting services and cyber secuirty training to the NHS.
Mrs S Rostron	Director of Quality Governance	• Daughter works at HUTH as a HCA
Dr A Pathak	Associate Non-Executive Director	• Is a budget holder and/or Trust Board Member • Is a Trustee of Cricket Beyond Boundaries
Dr D Hughes	Non-Executive Director	• Employed as a Consultant Histopathologist at Sheffield Teaching Hospitals NHS Foundation Trust • Daughter is a nurse at Sheffield Teaching Hospitals
Mrs S McMahon	Joint Chief Information Officer	• Is in cross appointment as Joint CIO for NLaG and HUTH, decisions will be made in the best interest of both Trusts, patients and staff • Trust Board Member
Mr David Haire	Project Director – Fundraising	• Chairman of VERTUAL Ltd (Trust Nominated) • Trustee of WISHH Charity (Trust Nominated), Osprey Charity and Hull and East Yorkshire Cardiac Charity • Son Damian Haire, Son Greg Haire and Daughter-in-Law Gemma Haire all work for HUTH • Is a budget holder
Mr Duncan Taylor	Director of Estates, Facilities and Development	• Director of Taywel Egineering Ltd, Hull Profile Cutting Ltd and Taywel Holdings Ltd • Taywel works across Yorkshire in Automotive General Construction, Public, Private and Domestic Services for Construction companies, some who work for the Trust. The majority of the work is ran by tendering. • Eldest son owns Taywel Engineering Ltd • Construction work is managed by Head of Capital/Project Managers who select contracting for tenders • Youngest son Mike Taylor is a Mechanical Craftsman at HUTH
Mrs Julie Lumb	Head of Procurement	• Brother is a Partner at KPMG • Brother is a Director at Capita • Son in a Lawyer at Carpmaels & Ransford

Appendix C

Fit and Proper Persons Declarations

Detail of what declarations must be made

Disclosure	Y/N
Have you been convicted of a criminal offence in the UK or elsewhere?	
Do you consent to the Trust obtaining an automatic annual notification under the DBS?	
Are you on the Safeguarding (children and adults) barred list?	
Have you been prohibited from holding office under the Companies Act or the Charities Act?	
Do you have undischarged creditors?	
Do you have a debt relief order?	
Are you an undischarged bankrupt?	
Do you have a bankruptcy restriction order?	
Are there any reasons related to health that mean that you are unable to fulfil your role?	
Have you ever been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals?	
Do you have an outstanding referral to your professional body for an issue relating to a CQC regulated activity?	
Are there any other factors that you consider your employer should be aware of that could impact on the Fit and proper persons Test?	

Agenda Item	6.7	**Meeting**	Trust Board	**Meeting Date**	12.05.22
Title	Eliminating Mixed Sex Accommodation				
Lead Director	Jo Ledger, Acting Chief Nurse				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The Trust Board received this report annually				

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 receives an annual statement on the Trust's position on mixed-sex accommodation.

The situation remains the same as previous years:

- The Trust has maintained single-sex accommodation for sleeping, toilet and bathing facilities in line with national requirements
- There have been no complaints or PALS issues raised by patients this year regarding sharing accommodation with someone of the opposite sex

The Trust Board is asked to review and accept the attached statement, and approve it for signature and publication on the Trust's website and in the annual report

ELIMINATING MIXED-SEX ACCOMMODATION (EMSA)

DECLARATION OF COMPLIANCE 2021/22

Hull University Teaching Hospitals NHS Trust is able to confirm that mixed sex accommodation has been virtually eliminated in all of its hospitals.

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Hull University Teaching Hospitals NHS Trust is committed to providing every patient with same gender accommodation to help safeguard their privacy and dignity when they are often at their most vulnerable.

The Trust is able to confirm that mixed gender accommodation has been virtually eliminated in the Trust. Apart from a few exceptions for clinically justifiable reasons, patients who are admitted to any of our hospitals will only share the room where they sleep with people of the same gender. In addition, same gender toilets and bathing facilities will be as close to their bed area as possible.

Wards within the Trust are grouped according to their clinical specialties. This allows patients with similar conditions to be cared for in one area with staff that are experienced in this type of care. This means that men and women may be on the same ward but will not share sleeping, bathing or toilet facilities.

There are some exceptions to this. Sharing with people of the opposite gender will happen sometimes. This will only happen by exception and will be based on clinical need in areas such as intensive/critical care units, emergency care areas and some high observation bays. In these instances, every effort will be made to rectify the situation as soon as is reasonably practicable and staff will take extra care to ensure that the privacy and dignity of patients and service users is maintained.

How well are we doing in meeting these standards?
The Trust has made physical changes to many inpatient accommodation areas to provide privacy screening/partitioning and additional toilet and bathing facilities. Toilet and bathroom signage has also been improved and this work continues. New ward accommodation that has been built in the last 12 months has maintained single-sex standards.

The Trust is required to report any breaches of the Eliminating Mixed Sex Accommodation (EMSA) standards to its commissioners. The Trust can be subject to a financial penalty of £250 for each of these breaches. In 2021/22, there were no breaches of these standards.

The Trust has not received any contacts through its Patient Advice and Liaison Service (PALS) or any formal complaints relating to mixed sex accommodation concerns during 2021/22.

INFORMATION FOR PATIENTS AND SERVICE USERS

'Same gender-accommodation' means:

- The **room where your bed is** will only have patients of the same gender as you, and;
- Your **toilet and bathroom** will be just for your gender, and will be close to your bed area

It is possible that there will be both male and female patients on the ward but, apart from a few exceptions for clinically-justifiable reasons such as in intensive care or high dependency areas, they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through sleeping areas that are designated for people of the opposite gender to you.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital (e.g. on your way to X-ray or the operating theatre).

Also, it is most likely that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting one other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed space/area.

If you need help to use the toilet or take a bath that requires special equipment to help secure your care and safety (e.g. you need a hoist or special bath), then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time as you.

The NHS and Hull University Teaching Hospitals NHS Trust will not turn patients away just because a "right-gender" bed is not immediately available for them. The patient's clinical need(s) will always take precedence.

What do I do if I think I am in mixed sex accommodation?
If you think you are in mixed accommodation and shouldn't be then please speak with the nurse in charge of the ward or area. This will be taken extremely seriously by staff and action will be taken to explain the reasons behind this and assurance will be provided that you will be moved to a same gender area/bay as soon as is reasonably practicable.

The Trust also wants to know about your experiences. Please contact the Patient Advice and Liaison Service (PALS) on telephone **01482 623065** or via email at: hyp-tr.pals.mailbox@nhs.net if you have any comments or concerns about single gender accommodation. Thank you.

Signed:

Sean Lyons
Chairman

Chris Long
Chief Executive

May 2022

Agenda Item	7	**Meeting**	Trust Board	**Meeting Date**	10 May 2022
Title	Draft Trust Operational Plan 2022/23				
Lead Director	Michelle Cady, Director of Strategy and Planning				
Author	Jackie Railton, Deputy Director, Strategy and Planning				
Report previously considered by (date)	The Trust has submitted a series of operational templates to the ICS in relation to activity, performance, workforce and finance/capital. These have been considered at CRAC, PAF and EMC and the submissions have been the subject of confirm and challenge by the ICS and NHSE/I regional and national colleagues. The attached document seeks to provide a narrative summary of those submissions.				

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 consider the contents and approve the Trust's Operational Plan 2022/23.

Hull University Teaching Hospitals NHS Trust

Operational Plan 2022/23

1. Introduction

Hull University Teaching Hospitals NHS Trust (HUTH Trust) is situated in the geographical area of Kingston upon Hull and the East Riding of Yorkshire. The Trust employs 8,195 WTE staff (March 2022), has an annual turnover of £792m (2021/22) and operates from two main sites - Hull Royal Infirmary and Castle Hill Hospital – whilst delivering a number of outpatient services from locations across the local health economy area.

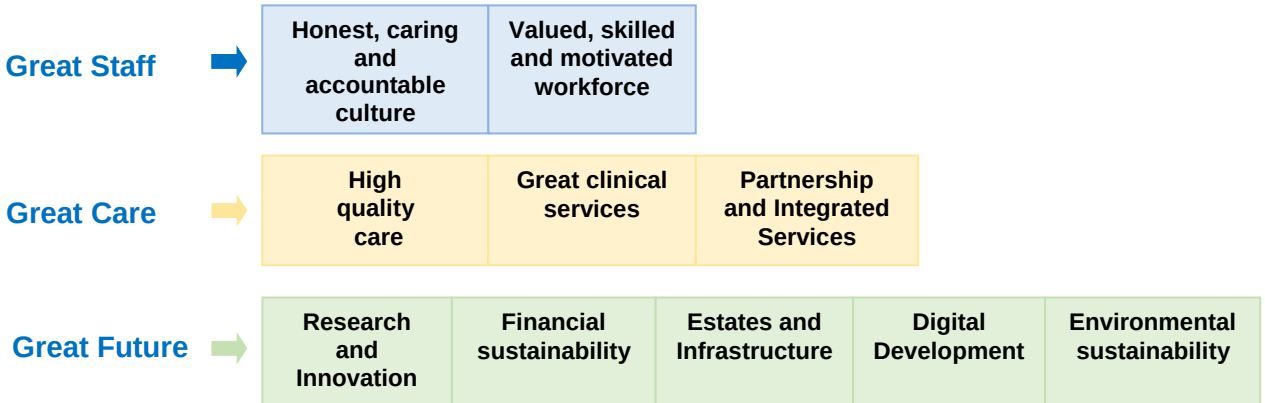
The Trust's secondary care service portfolio is comprehensive, covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The Trust provides specialist and tertiary services to a catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services.

2. Vision, Values and Goals

Our vision is *'Great Staff, Great Care, Great Future'*, as we believe that by developing an innovative, skilled and caring workforce, we can deliver great care to our patients and a great future for our employees, our Trust and our community.

We have developed a set of organisational values - *'Care, Honesty, Accountability'* - in conjunction with our staff and these form the basis of a Staff Charter which sets out the behaviours which staff expect from each other and what staff can expect from the Trust in return. The values are reflected in our organisational goals for 2022-2025



On 1st March 2019 the Trust formally changed its name to Hull University Teaching Hospitals NHS Trust in order to strengthen links with Hull University, particularly in respect of teaching and academic opportunities, and to bring about positive benefits in respect of recruitment, especially in relation to clinical posts across medical, nursing and professions allied to health. Research and innovation features as one of our organisational goals as it reflects the Trust's aspiration to be a research centre of excellence, engendering an innovation culture.

3. National Operational Planning Requirements 2022-23

3.1 Humber and North Yorkshire Health and Care Partnership (HNY HCP)

In February 2021 the Health and Social Care secretary, with the support of NHS England, set out new proposals to bring health and care services closer together to build back better from the impact of the Covid-19 pandemic by improving care and tackling health inequalities. The measures set out in the Government's White Paper: 'Integration and Innovation: Working together to improve health and social care for all' seek to modernise the legal framework to make the health and care system fit for the future and put in place targeted improvements for the delivery of public health and social care. It will support local health and care systems to deliver higher quality care to their communities, in a way that is less legally bureaucratic, more accountable and more joined up, by bringing together the NHS, local government and partners to tackle the needs of their communities as a whole. The proposals build on the NHS' recommendations for legislative
change in the NHS Long Term Plan.

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

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

The Humber and North Yorkshire Health and Care Partnership (HNY HCP) covers the geographical areas of North Yorkshire and York; Hull and the East Riding of Yorkshire; North East Lincolnshire and North Lincolnshire. Its Long Term Plan 2019-2024 sets out the Partnership's ambition to 'Start Well, Live Well and Age Well'. This means shifting the focus of our work from picking people up when they fall to helping to prevent them from becoming unwell in the first place and supporting more people to manage their health and wellbeing at home so they can get on with living happy and fulfilling lives.

The Trust's role in delivering this plan is to work openly and collaboratively with partners to support the development of new models of care and the closer integration of health and social care services. Examples of this include the development of Humber-wide secondary care services in association with Northern Lincolnshire and Goole Hospitals NHS Trust through delivery of the Interim Clinical Plan and the Humber Acute Services Review. Both aim to deliver robust and sustainable clinical services for the local population in the short, medium and longer term.

3.2 Operational Planning 2022-23

The NHS Priorities and Operational Planning Guidance 2022/23 was published in late December 2021 and identified that the goal for 2022/23 was to significantly increase the number of people we are able to treat and care for in a timely way. The priorities for the NHS for the coming year were identified as:

A. Invest in the workforce
B. Respond to COVID-19 ever more effectively
C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity
E. Improve timely access to primary

F. Improve mental health services and services for people with a learning disability and/or autistic people
G. Continue to develop our approach to population health management, prevent ill health and address health inequalities
H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes
I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.
J. Establish Integrated Care Boards and collaborative system working.

The specific operational requirements were:

- 10% more elective activity than before the Pandemic (2019/20 baseline)
- 20% more diagnostic activity against 2019/20 baseline
- 52+ week waits eliminated by March 2025.
- Eliminate 104 week waits by July 2022
- Eliminate waits of over 78 weeks by April 2023, and of over 65 weeks by March 2024.
- Long-waiting patients will be offered further choice about their care
- 95% of patients needing a diagnostic test receive it within six weeks by March 2025.
- By March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Local systems to return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023.
- Reduce outpatient waiting times by transforming the model of care and making greater use of technology.

4. Activity Planning and Service Developments

4.1 Capacity and Demand

The Trust has developed its workload forecasts and service delivery plans for 2022/23 using recognised capacity and demand models.

The Trust is planning to deliver 98% of the 2019/20 baseline value from within operational core capacity. A further 0.8% has been identified from the additional day surgery capacity which will come on line from Q4 2022/23, internal premium capacity (eg WLIs) 0.6% and the provision of Independent Sector capacity (insourcing and outsourcing) 2.7%. Work is underway to identify further measures such as mutual aid to close the remaining 1.9% gap.

Overall the cost estimates for delivering 104%, which is bridging from the 98% from core capacity are as follows:

- £5.3M IS Provider
- £1.6M Diagnostic capacity
- £1.5M Extra day case capacity from 4 theatres from Q4
- £1.7M Internal premium pay initiatives – WLI/locum
- £3.7M Required to close the gap to get to 104%

£13.8M

Changes to Infection Prevention and Control guidance may afford some opportunities in-year to increase productivity, however no activity assumptions have been included in the plans at this stage.

4.2 Activity Plan

The tables below provide a summary of the Trust's activity forecasts for 2022/23 as a percentage of the 2019/20 baseline. During April 2022 the Trust will be making a change to

the coding of Same Day Emergency Care (SDEC) activity from an outpatient attendance to a zero length of stay elective spell. This coding change is reflected in the tables.

Domain: Outpatients	Baseline 2019/20	Plan 2022/23	As % of 2019/20 baseline
All attendances	807455	801869	99%
All face to face	781226	634026	81%
Non face to face	26229	167843	640%
Face to Face: New attends	255342	200754	79%
Face to Face: Follow ups	525884	433272	82%
Non F2F: New attends	1788	50125	2803%
Non F2F: Follow ups	24441	117718	482%
Patient initiated follow ups		21338	
1st outpt spec acute	227418	199525	88%
1st outpt with procedures	38309	47227	123%
Follow up spec acute	426894	424279	99%
Follow up spec acute with procedures	74395	116678	157%

Domain	Baseline 2019/20	Plan 2022/23	As % of 2019/20 baseline
Elective Spells	90058	95309	106%
day cases (adults)	74420	79815	107%
ordinary spells	15638	15494	99%
day cases (under 18 years)	2774	2692	97%
ordinary spells (under 18 years)	655	626	96%
Referrals			
Total (GP and non GP)	171639	171642	100%
GP referrals	117920	117922	100%
Non GP referrals	53719	53720	100%
A&E attendances	137450	137450	100%
Non-Elective Spells	57144	64183	112%
LOS of zero days	12491	23258	186%
LOS of 1 day or more	44653	40925	92%
Covid LOS of 1 or more days	39	1460	3744%
Non Covid LOS of 1 or more days	44614	39465	88%

Other coding changes since 2019/20 have included:

- The transfer of Northern Lincolnshire and Goole NHS Foundation Trust's Neurology activity to HUTH during 2021/22.
- Transfer of 250 Haematology patients from NLaG to HUTH at the end of March 2022.
- Conversion of Ophthalmology inpatient ward to day cases has resulted in all activity now being recorded as day cases.

It is anticipated that further transfers of activity will take place during 2022/23 as a result of the creation of Humber-wide acute services as part of the Interim Clinical Plan between HUTH and NLaG. Any such changes will be the subject of a contract variation.

The Trust will not achieve the required 110% of elective activity outlined in the national planning guidance. Elective capacity has been significantly impacted by:

- Infection Prevention and Control measures as a result of Covid-19. This is particularly the case in Vascular Surgery and Gynaecology (elective inpatients).

- The high level of 'No Criteria to Reside' (NCTR) patients in the Trust (c.140-160 at any one time) has necessitated the utilisation of wards C9/C9A (35 beds) and C16 (28 bed plus 2 HOB) to house these patients pending discharge. This has resulted in no core capacity for elective orthopaedics at Castle Hill Hospital and has severely impacted on the core capacity for breast surgery, gynaecology and plastic surgery. An assumption has been made that Suite 20 (social care ward) will become available from May 2022 onwards (21 beds) which will release ward C16 for elective inpatients.

- The Trust has three medical wards assigned to Covid-19 patients and this is currently reducing the availability of non-elective medical capacity at HRI. This has resulted in some medical patients being cared for on surgical wards and this has had a major impact on elective surgical capacity.

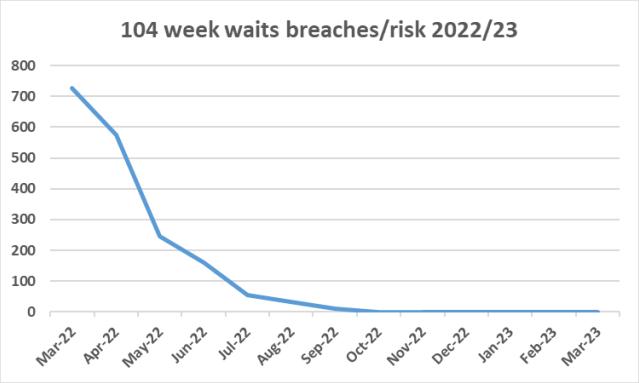
The lack of elective capacity is reflected in the Trust's trajectory in terms of its RTT pathway performance (see below).

Domain	Baseline 2019/20	Plan 2022/23	As % of 2019/20 baseline	Comment
RTT				
52 weeks and over		5312		as at end of March 2023
78 weeks and over		0		at March 2023
104 weeks and over		0		at October 2022
Number of incomplete pathways		63453		at March 2023
Completed Admitted Pathways	44536	44030	99%	
Completed Non Admitted	170290	176250	103%	
Number of new RTT pathways	211509	224193	106%	
Diagnostics				
MRI	26577	30786	116%	
CT	54050	61181	113%	
Non obstetric ultrasound	58636	48363	82%	
Colonoscopy	3931	4409	112%	
Flexi sigmoidoscopy	2051	2574	125%	
Gastroscopy	5784	5750	99%	
Echocardiography	5276	6079	115%	

In addition, diagnostic capacity is not expected to achieve the 120% (when compared to 2019/20 baseline) in all key areas. In non-obstetric ultrasound there has been a significant reduction in referrals over the last two years and this is not expected to recover in 2022/23.

Increased endoscopy capacity following the opening of the Allam Digestive Diseases development at Castle Hill Hospital has been factored into the forecasts.

The Trust has been the focus of intense scrutiny from NHSE/I and the system in relation to its performance against the 104 weeks wait trajectory. The Trust is forecasting that it will not meet the required Zero 104 week waits by the target date of 30 June 2022. The Trust and commissioners have agreed a revised trajectory of zero 104 week waits by October 2022.



The Trust is seeking to create additional capacity to address the longest waits through mutual aid, waiting list initiatives and use of the Independent Sector (insourcing and outsourcing). Advantage will also be taken of the additional day case capacity expected in Q4 2022/23 when Phase 1 of the new Day Surgery development at CHH is completed (circa 1,662 cases).

Risks to delivery of the elective recovery programme include:

- Continuing high levels of NCTR patients due to the lack of social care services and placements in the community, resulting in a lack of elective bed availability
- Lack of theatre and ICU capacity
- Insufficient independent sector capacity to meet needs (including insufficient funding to meet costs of IS)
- Insufficient mutual aid capacity
- Insufficient staff to meet needs eg recruitment, redeployment, sickness absence.

As at 20 March 2022, the total number of people on the waiting list with suspected cancer was 1,585, of which 315 people (19.9%) had been waiting in excess of 62 days. There are specific capacity challenges in relation to Computed Tomography (CT) and CT Colonography (CTC) capacity, pathology turnaround times and access to elective beds. The Trust continues to ensure that patients on cancer pathways are always prioritised, and has a recovery plan in place to reduce the number of people waiting more than 6 days back down to pre-pandemic levels by March 2023 (130 people as at February 2020). Key actions include:

- Consultant-led triage
- Administration process review in Radiology department (CTC)
- CTC demand and capacity analysis: slot utilisation
- Additional tracking resource to reduce the numbers on the PTL
- Review of guidelines for tracking staff to remove patients from the PTL following test results (clinically agreed)
- Review of Pathology turnaround times
- Cancer Transformation Programme including Colorectal, Upper GI, Lung, Head and Neck and Prostate.
- Standards of Care are being developed with the HNY Cancer Alliance.

4.3 Reducing Health Inequalities

The Trust has in place BI reports set up to identify and monitor health inequalities metrics including those patients on waiting lists. These reports are refreshed daily and reported on monthly. Tracking of patients on waiting list processes are in place, which includes proactive engagement with patients who are identified as having health inequalities.

The Trust has undertaken a review of its RTT waiting times by level of deprivation and by ethnicity. The RTT Wait is disproportionately split at Treatment Function level with Occupational Therapy having a Median Wait of 21 weeks whereas the other quintiles see a range from 2 to 5 weeks (January 2022 position).

Quintile Median	Deprivation Quintile				
Treatment Function	Q1	Q2	Q3	Q4	Q5
140 - Oral surgery	18	20	15	19	
141 - Restorative dentistry	12	34	22	13	
143 - Orthodontics	38	38	41	42	
172 - Cardiac surgery	32	28	30	25	
310 - Audiological medicine	50	28		28	
314 - Rehabilitation	6	20	5	3	
651 - Occupational therapy	21	2	2	5	
840 - Audiology	52	67	47	56	

In the Ethnicity modelling, a number of specialties have a disproportionate split; with a specific highlight against Orthodontics.

Ethnicity Median	Ethnicity Category				
Treatment Function	Asian	Black	Mixed	Other	Wh
101 - Urology	12	22	14	16	
103 - Breast surgery	11	2	2	2	
104 - Colorectal surgery	9	10	23	20	
140 - Oral surgery	13	29	17	17	
143 - Orthodontics	50	100	37	24	
219 - Paediatric plastic surgery		49	10		
410 - Rheumatology	18	0	3	13	
650 - Physiotherapy		12	34		

Specific areas of focus in 2022/23 by which the Trust will seek to reduce health inequalities include:

- Participation in prevention programmes include Lung Health Check, Bowel Screening, AAA Screening, Breast Screening. For example: The HUTH Bowel Screening Hub is working with GP practices, agencies, mental health, prisons, learning disabilities, including the homeless, to increase opportunities for these groups to participate within the Bowel Cancer Screening Programme.
- Digital Inclusion - clinically appropriate patients will be offered either telephone or virtual appointments using Attend Anywhere. However, if this is not suitable for the patient, the appointment will be converted to face to face. It is recognised that not all patients are digitally mature, and that not all have access to digital communication devices due to the high levels of social deprivation. The provision of digital devices is being considered as part of the development of new services which rely on digital monitoring to support patient treatment (eg cardiology tele-monitoring to support virtual ward)
- Core20Plus5 – The Trust is working with system partners in relation to Maternity Services.
- Development of the Respiratory Exacerbation Service providing specialist respiratory care and treatment to patients who have been admitted to hospital and can be discharged and supported to manage their exacerbation at home (Early Supported Discharge - ESD) and to prevent those who are exacerbating from being admitted to hospital.

4.4 Service Developments and Transformational Change

The Trust recognises that changes are needed to the way in which clinical services are configured, delivered and resourced. In 2018/19 the Trust was successful in its bid for Wave

4 capital investment to improve the urgent and emergency care pathways within the Hull Royal Infirmary through the reconfiguration of accommodation and the procurement of additional diagnostic equipment, including MRI and CT. As these works near completion in 2022/23, the Trust will continue to focus on measures to improve patient safety and flow between the Emergency Department and other acute services within the hospital.

Across all departments operational arrangements are being systematically reviewed and revised in order to maximise productivity and contribute to the achievement of cash releasing efficiency savings. Each Health Group has drawn up an integrated programme of service developments that will deliver significant safety, quality and financial benefits, aligned to the delivery of the Humber and North Yorkshire Long Term Plan. These service developments include:

- **Surgical Services**
  - Continued development of surgical Same Day Emergency Care
  - Further development as a Major Trauma Centre, including review of patient pathways, theatre and bed capacity.
  - Development of Endoscopy Services, including optimising the benefits of the new Digestive Diseases Unit
  - Partnership working with NLAG and York FTs on the further development of Urology Services across the Humber and North Yorkshire HCP.
  - Partnership working with York FT on the development of the HNY Vascular Service Development Network, including collaboration on plans for new hybrid theatres at HUTH and York
  - Continued review and improvements to the productivity of Trust theatres.

- **Medical Services**
  - Support the development of sustainable regional services for cardiology, neurology and stroke.
  - Further development of the hyper acute stroke service to ensure compliance with best practice standards
  - Respiratory Exacerbation Service – including Virtual Ward
  - Increased Spirometry and lung function diagnostics capacity through the use of the Clinicabin
  - Development of the Heart Failure pathway with CHCP

- **Emergency Medicine**
  - Deliver the benefits of the investment in the reconfiguration of the Ground Floor of the Hull Royal Infirmary to facilitate the flow of urgent and emergency care admissions from the Emergency Department to the acute assessment areas, including revised patient pathways and expansion of SDEC
  - Further development of the Urgent Treatment Centre stream in the ED.

- **Family and Women's Services**
  - Continued participation in the HNY Local Maternity System (LMS) and delivery of the ambitions within Better Births (2016) and the recommendations of the Ockendon Report.
  - Reconfiguration of the Neonatal Unit to better meet the recommendations of the Y&H ODN Neonatal Critical Care Review
  - Reconfiguration of facilities to deliver sufficient physical outpatient/ambulatory space for Children's Services, Gynaecological Services and Maternity Services.
  - Plastic Surgery - Creation of a Regional Hand Unit to address both trauma and elective hand surgery

- **Clinical Support Services**
  - Increase the Queen's centre bed base by opening ward 29 in preparation for the transfer of activity from the South Bank.
  - Develop plans to increase the hours of the Day Treatment Unit within the Queen's Centre

- Extend the opening hours of the Queen's Centre Acute Assessment Unit and increase capacity in line with development of new facilities.
- Relocation of radio-pharmacy from HRI to CHH.
- Development of Psychological Services
- Effective procurement and commissioning of replacement Radiology and Radiotherapy equipment.
- Work in collaboration with partners within the ICS to form an imaging network, in line with 'Transforming Imaging Services in England: A National Strategy for Imaging Networks'. This will include the developing strategy around Rapid Diagnostic Centres and community diagnostic hubs.

4.5 Winter Plan

As in previous years, the Trust will seek to continually strengthen both its internal arrangements for the management of Winter Pressures and to work with local providers and commissioners across health and social care to ensure a robust and comprehensive system response. This will be undertaken in the context of the 'Living with Covid' guidance.

4.6 Continuing Response to Covid

The Trust has a response plan which sets out all of the key arrangements and policies that are guiding our response to Covid-19. The plan seeks to ensure:

- The spread of Covid-19 is minimised
- That essential emergency and urgent core activities are maintained
- The creation of pathways and capacity to effectively care for large volumes of Covid 19 patients requiring general hospital and critical care
- To minimise morbidity and mortality from Covid-19 among patients and staff
- To optimise deployment of staff, planning for the impact of self-isolation and Covid-19
- To provide staff with training and support to undertake their duties
- To provide the best possible environment and equipment for staff to undertake their duties
- To ensure staff have access to appropriate personal protective equipment
- Effective management of the incident through the Covid-19 Command Structure
- Providing timely, authoritative and up-to-date information (that complements wider national messages) to service users, staff and partner agencies
- Return to normal working after a Covid-19 wave as rapidly and effectively as possible.

5. Workforce Plan 2022/23

The Trust's Workforce Plan for 2022/23 sees an increase in the total staffing establishment of 132.61 wte by March 2023 from a baseline of 8,195.5 wte. This includes increases across all staff groups, including Nursing & Midwifery (+39.13 wte), Scientific and Technical (+19.6 wte), Support to Clinical Staff (51.64 wte), (Medical staff (+22.24 wte).

	Establishment	Establishment	Variance
	Year End (31-Mar-22)	Year End (31-Mar-23)	
Workforce (WTE)	**Total WTE**	**Total WTE**	**Total WTE**
Total Workforce (WTE)	**8195.5**	**8328.11**	**132.61**
Registered nursing, midwifery and health visiting staff (substantive total)	2386.58	2425.71	**39.13**
Registered scientific, therapeutic and technical staff	1012.63	1032.23	**19.6**
Registered ambulance service staff	0	0	**0**
Support to clinical staff	1591.5	1643.14	**51.64**
Total NHS infrastructure support	1977.02	1977.02	**0**
Medical and dental	1227.17	1249.41	**22.24**
Any other staff	0.6	0.6	**0**
Substantive WTE	8195.5	8328.11	**132.61**
Registered nursing, midwifery and health visiting staff (substantive total)	2386.58	2425.71	**39.13**
Registered scientific, therapeutic and technical staff (substantive total)	1012.63	1032.23	**19.6**
Registered ambulance service staff (substantive total)	0	0	**0**
Support to clinical staff (substantive total)	1591.5	1643.14	**51.64**
Total NHS infrastructure support (substantive total)	1977.02	1977.02	**0**
Medical and dental (substantive total)	1227.17	1249.41	**22.24**
Any other staff (substantive total)	0.6	0.6	**0**

The increases reflect recruitment to support service developments and increased capacity requirements (eg the new Cardiology ward, new Day Surgery Unit and social care ward). They also reflect requirements to increase staffing to achieve compliance with clinical standards such as 'Facing the Future' in Paediatrics and Ockenden in maternity services.

The supply, recruitment and retention of staff is a key priority for the Trust. HUTH will continue with apprenticeship programmes, clinical and non-clinical, including apprentice nurse degree, apprentice nurse associate, ODP apprentices and apprentice health care support worker. Registered Nursing within Theatres are up skilled to complete the Anaesthetic training module to be dual-skilled Peri-operative Practitioners. The Trust is offering enhanced recruitment packages for Consultant posts in Anaesthetics and Intensive Care, and utilising the MTI scheme and in-house CESR Fellowships to support succession planning for medical roles.

The Trust will continue with international recruitment for registered staff, particularly nurses, and other recruitment campaigns nationally for registered staff. We will also continue with national and international recruitment of medical staff and partnerships with the College of Physicians and Surgeons in Pakistan and Sri Ramachandra University, India.

The Trust supports the retention of international recruits through the "Stay and Thrive" programme which promotes Hull and supports the staff member in moving up in their career.

The Trust is strengthening its Advanced Practice workforce including Advanced Clinical Practitioner (ACPs) and Physician Associate (PAs) over the next 12 months. We are converting vacancies to ACPs and PAs in Acute, Elderly and Cardiology Medicine and have a well-established ACCP team in Critical Care. There is an Anaesthesia Associate Team, which has converted further vacant Anaesthesia posts to Trainee Anaesthesia Associate roles for expansion.

After two years of the Covid-19 pandemic staff are feeling exhausted and disengaged from being redeployed / looking after other patient groups, so their ability to innovate and be more efficient / productive may be affected. The Trust has a comprehensive Health and Wellbeing support programme in place, where staff have access to a 24hr 7 day a week advice helpline, counselling services, occupational health services, pastoral and spiritual care, organisational development interventions for individuals, teams including Schwartz rounds,

psychology support and more intensive support from our mental health provider (Resilience Hub).

The Trust is also holding Executive Forum meetings for staff feedback to improve our services and working environments.

The Trust will be reviewing our organisational values and holding manager briefing sessions in the summer to reinforce Trust expectations to deliver safe and quality care, delivering activity and performance within our financial cost envelope and ensuring our people are supported, developed and well led.

The Trust will be reviewing its People Strategy later this year and will continue to deliver the 4 workforce themes from the National People Plan.

5.1 Workforce Planning

The workforce planning framework and methodology used by the Trust is the Calderdale Framework and the Six Steps methodology. This provides a systematic, objective method of reviewing skill, role and service design and is used to examine past trends, understand current and future challenges, and forecast future workforce needs. The Framework incorporates a clinical risk assessment.

The Trust's workforce planning is also informed by the ongoing review of clinical services, local population demographic change, commissioner intentions, capacity and demand modelling, strategic partnerships, the intelligence received from the Yorkshire and Humber workforce planning network, national policy and education and training establishments.

Health Groups and Divisions receive workforce intelligence packs, which include intelligence from the Electronic Staff Record (ESR), e-Job Planning and e-Rostering systems. Through the production of workforce plans and use of the intelligence data, opportunities for new roles will continue to be identified, including Apprenticeships, Nurse Associates, Advanced Clinical Practitioners and Physicians' Associates.

Activity, finance and workforce plans are developed at a service, divisional and Health Group level and are formally signed off by their respective management teams. The plans are validated by the corporate finance, planning and workforce teams to ensure that they are robust, aligned to the Trust's clinical and organisational strategies and comply with operational planning guidance. They are subject to a 'Confirm and Challenge' process with Executive Directors and support service leads before being signed off by the Executive Management Committee. Performance monitoring is undertaken at each level of the organisation via the monthly performance management framework.

6. Financial Plan

As established in previous planning processes, systems will continue to be the key unit for financial planning purposes to ensure greater collaboration and a collective responsibility for the financial position. All Systems have a breakeven requirement.

The COVID-19 pandemic necessitated the introduction of an interim allocations approach to ensure that systems had sufficient resource to respond to the pandemic. From 2022/23 however, the allocations methodology has been reset to move systems back towards a fair share distribution of resource.

The basis of the allocations for 2022/23 is a build up from the payment received in the second half of 2021/22- annualised for a full year. This is then adjusted to reflect the following:

- **Inflation**
  Inflationary uplift 2.8%
  Efficiency factor -1.1%
  Net Uplift 1.7%

- Covid income reduction of 57% of the H2 methodology
- General growth at 2.3%
- Convergence reduction of 0.5% to reflect the move to a fair shares basis
- Specific allocations for the impact of the Ockenden Review
- Elective Recovery allocations to deliver 104% of the 2019/20 elective activity value.

The Trust has developed a financial plan for 2022/23, however on the basis of the assumptions above, the Trust is not able to deliver a balanced plan at this stage and is currently reporting a £19.1m deficit plan, as shown below:

Statement of comprehensive income (SOCI)	Plan 2022-23 £'000
Operating income from patient care activities	**666,843**
Other operating income	**72,700**
Employee expenses	**(431,916)**
Operating expenses excluding employee expenses	**(303,045)**
OPERATING SURPLUS/(DEFICIT)	**4,582**
FINANCE COSTS	
Finance income	**17**
Finance expense	**(6,184)**
PDC dividends payable/refundable	**(8,195)**
NET FINANCE COSTS	**(14,362)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(9,780)**
Remove capital donations/grants/peppercorn lease I&E impact	(9,320)
Adjusted financial performance surplus/(deficit)	**(19,100)**

The main drivers for the deficit are inflation, including £11.7m energy cost increases plus £2.5m for other non-pay inflation cost issues, totalling £14.2m. The Trust also sees an increase in depreciation costs of £2m in 2022/23 due to the growth in the capital programme last year.

The planned level of investments now stand at £4.8m as per table below.

Investment Requirements	22nd April 22 £m
Cardiology Ward	1.5
Other Activity Growth	1.5
Cancer Assessment Unit/Ward 29	0.2
Ockenden	0.8
Allam Endoscopy	0.2
Oncology Workforce	0.3
Phlebotomy	0.1
Paediatric Radiology	0.1
Therapy/nursing Hybrid	0.2
Gross Investments	**4.8**

6.1 Elective Recovery Assumptions

The plan assumes that the Trust can return to 2019/20 elective activity levels by quarter 2 of 2022/23. The revised assumed costs are as per below:

	12th April 22		22nd April 22	
	% 19/20 Baseline	£m	% 19/20 Baseline	£m
Core Capacity	98.0%	-	99.5%	-
Day Surgery Capacity	0.8%	1.5	0.8%	1.5
Internal Premium Capacity	0.6%	1.7	0.6%	1.7
Insourced	2.7%	5.3	2.2%	4.2
Subcontracted	1.9%	3.6	1.0%	1.9
Diagnostic Capacity		1.6		1.6
Social Care Beds		0.0		2.8
C-Section		0.0		0.1
Income from NLAG		0.0		-0.9
Total	**104.0%**	**13.7**	**104.0%**	**12.8**
Unallocated in initial Plan				
Total	**104.0%**	**13.7**	**104.0%**	**12.8**

The initial plan to support the NCTR patients was to open 88 beds to accommodate these patients. The latest plan now assumes that CHCP will put services in place to enable the flow of these patients back home as quickly as possible once ready for discharge. The Trust will retain 40 beds (21 on Ward 20 and 19 on Ward 9) at CHH. This cost of £2.8m is within the plan and expected to be funded from the Elective Recovery Fund, as this will allow the surgical specialties to secure their bed base for delivering additional elective activity, hence this is excluded from the table of investments above.

The plan assumes the Trust will also recharge NLAG for its consultant surgeons and anaesthetists working at Goole for which NLAG will record the activity. NLAG have built the corresponding cost into their plan.

6.2 Efficiency

The Trust has developed a CRES plan in line with NHSEI guidance that combines a mixture of cash releasing savings and improved productivity (that release income to support the position) to a value of £29.7m (4%).

The target is broken down into the following areas:

2021/22 1.1% National Target	£6.1m
2022/23 1.1% National Target	£6.2m
Energy Efficiency	£5.1m
Covid19 spend reduction	£1.5m
Productivity	£4.6m
Central Efficiencies	£8.0m
Less Delivered Recurrently in 2021/22	(£1.8m)
Total	**£29.7m**

The target is broken down by Health Group/Corporate as shown in the following table, which also shows value of schemes identified to date, gross and risk adjusted.

	£000	Schemes Identified £000	Risk Adjusted Schemes Identified £000
Surgery	2,137	1,452	1,452
Medicine	1,762	831	531
Emergency	328	151	151
Family & Women's Health	1,526	413	267
Clinical Support Services	1,987	826	544
Estates, Facilities & Development	716	21	21
Corporate	1,514	570	570
Other	330	192	192
Sub-total	**10,300**	**4,455**	**3,727**
Energy	5,176	5,176	5,176
HEALTH GROUP/CORPORATE TARGET	**15,476**	**9,631**	**8,903**
Productivity / ERF Income	4,600	4,600	4,600
TOTAL INTERNALLY REPORTED EFFICIENCY PROGRAMME	**20,076**	**14,231**	**13,503**
Covid Spend Reduction	1,500	1,500	1,500
Technical Savings	8,000	8,000	8,000
TOTAL EXTERNALLY REPORTED EFFICIENCY PROGRAMME	**29,576**	**23,731**	**23,003**
		80%	**78%**

6.3 Funding outside of envelope - Covid

As in 2021/22, the funding streams for Covid testing and the Covid vaccination programme remains outside of the mainstream allocations and continue to be funded separately, with claims made each month on the basis of reasonable net incremental costs.

6.4 Agency Use

The NHS Long Term Plan outlines the national strategy to continue improving on workforce productivity and reduce the reliance on agency workers. Trusts are therefore expected to take action to reduce agency staff bills, encourage workers back into substantive and bank roles, and move back towards compliance with agency controls. NHS England and NHS Improvement will monitor progress to reinstate controls, including price cap compliance during 2022/23.

6.5 Contracting 2022/23

Unlike the last two years, there is a requirement for contractual documentation to be prepared and signed off at commissioner level for 2022-23. This requirement was relaxed previously due to the pressures of the pandemic.

The updated NHS Standard Contract sets out the national terms and conditions applicable for the 2022/23 financial year and includes schedules covering quality, information and reporting requirements as well as the finance and activity schedules.

Financial envelopes have been agreed with commissioners on the basis of the allocation methodology referenced earlier and that the Trust delivers 104% of the elective baseline value for 2019/20.

It is expected that the contracts will be signed early May with the agreed activity x price schedules that tie back to the financial values at commissioner level.

As a result of the new Health and Care Bill, CCGs will cease to exist and ICBs will come into being on 1 July 2022. Contracts are therefore negotiated and signed, formally, by CCGs, with signed contracts transferring from CCGs to ICBs under the nationally arranged Transfer Schemes provided for in the Bill. There continues to be a separate contract with NHSE/I as the Specialised Commissioner.

7. Capital Plan 2022/23

7.1 Capital Funding

Publication of the ICS envelopes was made during February and this notification confirmed a provider capital allocation for the Humber and North Yorkshire ICS of circa £72.6m. The financial planning guidance for 2022/23 makes it clear that there will be no additional national emergency capital allocation outside of ICS CDEL envelopes. As a consequence, all essential/emergency capital investments will need to be incorporated into organisational capital plans and contained within the ICS CDEL envelope. ICS partners therefore need to achieve system-wide agreement regarding the prioritisation of capital expenditure to ensure that all emergency/essential investments can be progressed.

The notified envelope for the HNY ICS is summarised below, with the corresponding allocations at organisation level, using the national formula.

Capital Expenditure	Humber FT £000	HUTH £000	NLaG £000	York £000	Harrogate £000	Total £000
Funding Formula Allocation (at provider level)	6,140	20,701	13,332	23,335	9,114	72,622

Following successful negotiation, the Trust has received a capital allocation of £20.7m for 2022/23. In addition, the Trust is hoping to secure PDC funding to support the next phase of the Day Surgery build at CHH (£13m in 2023/24 & £15m in 2024/25). The Trust is also expecting a capital allocation against the Technology Funding. This is yet to be allocated; the total Technology Fund for the ICS in 2022/2023 is £7m. The technology fund and any PDC allocations are therefore not included in the initial Trust Capital Programme.

7.2 HUTH Updated Capital Programme

The Trust's current full capital programme is higher than the ICS limit due to the fact that the ICS levels exclude donations, grants, as well as some technical PFI adjustments.

The reconciliation from the above to our full programme is shown below:

	£000
HUTH Capital Programme	33,852
Internal adjustments:	
Donations	-300
Grants	-10160
PFI Capital	-2691
Total HUTH Capital Allocation as per table above	**20,701**
National CDEL Adjustments:	
PFI Residual Interest	1395
TOTAL HUTH CDEL	**22,096**

The full capital programme, along with initial estimates for future years can be seen at Appendix 1. The initial programme for 2022/23 is an assessment based on a “do minimum” basis and makes provision for base allocations for Medical Equipment (£1.6m); IM&T (£2.5m) and Backlog Maintenance (£2m). These allocations have taken into account capital schemes that were brought forward into 21/22 and have been adjusted accordingly.

In addition, provision has been made for the capital schemes that have been carried forward from 21/22 and will continue into 22/23, namely Digestive Suite, CHH (£3.5m); completing phase 1 of the theatres upgrade at HRI (£4m) and completing phase 1 of the Day Surgery scheme (£3m). In addition, the approved business case from 20/21 for developing the Neonatal Intensive Care department was deferred this year and is included in the first draft programme for 22/23. However, the original costings would need to be updated in partnership with the PFI partner given the delays to date.

As part of the Capital Planning process, the Trust has to allocate capital to support the reduction in backlog maintenance (BLM). The BLM Target is set at £5.3m and the schemes highlighted against this target can be seen within Appendix 1.

The capital programme includes an allocation of £10m relating to external grants associated with Energy and Decarbonisation. This is a provisional sum at present and has not been confirmed. The Trust is hoping to secure bids against this in the coming year.

After accounting for the above, there is a residual balance in the capital programme of approximately £2.7m, shown within reserves. The current list of potential investments to be funded by this balance can be seen at Appendix 2. The list of priority schemes in Appendix 2 were identified by the Health Groups and from ambitions documented within the Trust’s refreshed strategy.

Initial discussions at the CRAC committee have highlighted the need for the investment for the restaurant at HRI to be worked up given that we no longer have an outsourced provider for this service.

In addition it was suggested that the feasibility budget was increased given the need for more detailed planning and cost estimates for future schemes to ensure the Trust is ready with reasonable plans should future funding become available (for example Bi Plane equipment/enabling scheme).

As referenced earlier, there is an expectation of PDC in year for specific digital schemes as part of the levelling up allocations and funding to progress phase 2 of the Day Surgery Unit, subject to business case approval.

7.3 Capital Risks

The Capital Programme focusses generally on backlog maintenance and replacement. The ability to address the issues identified from the Health Groups and ambitions within the Trust's Strategy is limited due to the amount of capital available to the Trust. Each area of the plan will require detailed management and there is a real challenge in terms of overall coordination to ensure that we are able to deliver this without unduly impacting on our ability to deliver clinical services – especially with the increased waiting lists and priority of elective recovery.

There are a number of risks emerging in terms of schemes that are not currently accommodated within the capital programme. These include IRT4, the Vascular Hybrid Theatre; addressing ward isolation facilities, car parking and risks associated with aged equipment and potential additional IT hardware requirements associated with some of the planned capital developments. In addition, inflationary pressures remain a risk as do the global supply chain issues. These risks will need to be managed from within the existing programme.

Appendix 1 – Capital Programme 2022/2023

CATEGORY	2022/23 Internal £000	2022/23 External £000	2022/23 Total £000
Sources of Funding			
Depreciation	20,200		**20,200**
Grants & Donations - Charitable Funds (General)		300	**300**
Grants & Donations - Salix Grant (TBC if any in 22/23)		10,000	**10,000**
Grants & Donations - NPIC Grant		160	**160**
internal cash	6,265		**6,265**
Internal Cash - ICS slippage (to repay)	(1,100)		**(1,100)**
Interenal Cash - NLAG Slippage	1,000		**1,000**
Sub -Total Funding	**26,365**	**10,460**	**36,825**
Less Capital Loan Repayments	(1,260)		**(1,260)**
Less Capital Element of Finance Lease	(56)		**(56)**
Less Capital Element of IFRIC/PFI - Finance lease Repayment	(1,657)		**(1,657)**
Less Capital Element of IFRIC/PFI - Lifecycle	(2,691)		**(2,691)**
Sub -Total Liabilities	**(5,664)**	**0**	**(5,664)**
TOTAL CAPITAL FUNDING AVAILABLE	**20,701**	**10,460**	**31,161**
Corporate Developments:			
Salix Grant (TBC if any in 22/23)		10,000	**10,000**
NPIC Grant		160	**160**
Theatres Redevelopment CIR	4,000		**4,000**
Matched Funding: Digestive Suite (c/f from 21/22)	3,500		**3,500**
Targeted Investment Fund - Day Surgery (c/f from 21/22)	3,000		**3,000**
FWH - NICU	251		**251**
	10,751	**10,160**	**20,911**
Buildings Maintenance and Compliance:			
Buildings Maintenance and Compliance	2,000		**2,000**
	2,000	**0**	**2,000**
IM&T:			
IT Network Servers/System Replacement	2,500		**2,500**
	2,500	**0**	**2,500**
Medical and Scientific Equipment:			
Planned Equipment Replacements	1,550		**1,550**
	1,550	**0**	**1,550**
Other Allocations:			
Feasibility Work	50		**50**
Spend to Save	300		**300**
Reserves - Other	2,650		**2,650**
Non Medical Equipment	300		**300**
Rev/Cap Transfers	600		**600**
Charitable Funds (General)		300	**300**
PFI Lifecycle	2,691		**2,691**
	6,591	**300**	**6,891**
TOTAL	**23,392**	**10,460**	**33,852**
Less IFRS Impact of PFI/IFRIC 12 Schemes	**(2,691)**	**0**	**(2,691)**
REVISED TOTAL	**20,701**	**10,460**	**31,161**
UNDER (-) OR OVER (+) COMMITMENT	**0**	**0**	**0**

Backlog Maintenance Above	6,000
Backlog Maintenance Target	5,246

Appendix 2 – Capital Programme – Unfunded Potential Investments

CATEGORY	2022/23 External £000	2023/24 External £000	2024/25 External £000
Potential New Schemes - TBC			
Catering HRI	1,000		
Vascular Hybrid Theatre/IRT	3,000		
Post Mortem CT	1,000		
Phase V Redevelopment		500	
Conversion of clinical space to offices	1,200	1,200	2,400
Electrical Generation	1,000	3,500	1,000
Social Care Ward 54 beds	5,000		
Mattress Decontamination		2,500	
Zero Carobn	10,000	10,000	10,000
IRT4	2,575		
Rehab expansion of beds		800	
Car Parking	1,600	1,600	
Fountain Street Decked car park		4,000	
Therapies accommodation	1,000	1,500	
Right sizing bed base/coming out of tower block/more isolation facilities	3,000	3,000	3,000
General Xray room replacement (3 CHH)	1,050		
CTS Xray room			350
HRI T&O Xray room		350	
Fluoroscopy room 5 HRI		800	
Fluoroscopy room 1 CHH			800
	31,425	**29,750**	**17,550**
Buildings Maintenance and Compliance:			
	0	**0**	**0**
IM&T:			
	0	**0**	**0**
Medical and Scientific Equipment:			
Other general equipment replacements	1,000		
Linear Accelerator & Enabling (No 6)			1,700
Gamma Camera 3		1,700	
MRI Optima - CHH replacement		1,750	
ADDITIONAL CT incl enabling			1,500
ADDITIONAL MRI incl enabling			2,000
	1,000	**3,450**	**5,200**
TOTAL	**32,425**	**33,200**	**22,750**

Agenda Item	7.1	**Meeting**	Trust Board	**Meeting Date**	10.05.22
Title	Board Assurance Framework				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The Board Assurance Framework is received quarterly at the Board Committees and the Trust Board				

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

Key Recommendations to be considered:

The Board is asked to:

- Approve the year-end risk rating and close the BAF for 21/22
- Approve in principle the risks for 22/23
- Decide if sufficient assurance has been provided

Hull University Teaching Hospitals NHS Trust

Trust Board

Board Assurance Framework Q4 2021/22

1. Purpose of the Report

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

2. Background

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

3. Current Status of the Board Assurance Framework

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

Year-end risk rating proposals 2021/22

The table below shows all risks and risk ratings and whether the target risks have been met for year-end. Section 5 in this report gives a brief overview of how the targets have been met and gives reasons why they have not.

Table 1

Risk	Inherent Risk (L x I)	Current Risk (L x I)	Target Risk (L x I)
BAF 1 - The Trust does not make progress towards further improving a positive working culture this year	4x4=16	4x4=16	3x3=9
BAF 2 - The Trust does not effectively manage its risks around staffing levels	5x5=25	4x3=12	3x3=9
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
BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm.	5x5=25	3x3=9	3x3=9
BAF 4 - There is a risk to access to Trust services due to the impact of Covid-19	5x5=25	5x4=20	4x4=16
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
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
BAF 7.1 - There is a risk that the Trust does not achieve its financial plan for 2021/22	4x4=16	2x4=8	2x4=8
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
BAF 7.3 - There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability	4x4=16	4x2=8	4x2=8

4. Actions Update

A number of actions have been taken in Quarter 4 and these are shown at Appendix 2 along with the proposed year-end positions.

5. Risk ratings

The Board is asked to consider if the actions taken in quarter 4 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.

There are currently 10 risks on the Board Assurance Framework, 5 (50%) of these risks achieved the target risk rating in 2021/22. One risk (BAF1) saw an increase in rating throughout the year and the remaining 4 were static. A summary of each risk rating throughout the year is provided in Table 2. It should be recognised that it is usual for strategic risks to have minimal movement in the first 2 quarters of the financial year. The Board, however, should be aiming for a higher proportion of risks to achieve the target risk ratings and this should be taken into consideration when agreeing plans for 2022/23.

Table 2

BAF Risk	Inherent Risk	Q1 Position	Q2 Position	Q3 Position	Year-End Position	Target Risk Achieved
1	4x4=16	4x3=12	4x3=12	4x3=12	4x4=16	No – Increased
2	5x5=25	4x5=12	4x3=12	4x3=12	4x3=12	No – remained the same
3.1	4x4=16	3x4=12	3x4=12	3x4=12	3x4=12	No – remained the same
3.2	5x5=25	4x4=16	4x4=16	4x4=16	3x3=9	Yes
4	5x5=25	5x4=20	5x4=20	5x4=20	5x4=20	No – remained the same
5	3x3=9	2x3=6	2x3=6	2x3=6	2x3=6	Yes
6	4x4=16	3x4=12	3x4=12	3x4=12	3x4=12	Yes
7.1	4x4=16	3x4=12	3x4=12	3x4=12	2x4=8	Yes
7.2	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	No
7.3	4x4=16	4x3=12	4x3=12	4x3=12	4x2=8	Yes

The risks that did not achieve the target risk rating (50%) have been impacted by extreme clinical pressures, staff morale, staff absence, social care and mental health staffing capacity.

Following discussions at each of the Committees and with the Executive leads the following year-end risk ratings are proposed:

BAF 1 – Honest, caring and accountable culture

The proposal is that the risk is increased to 16. Due to the staff survey results and what staff are reporting, redeployment and high sickness levels, the opinion is that the risk has not been mitigated enough to reach its target. However, there are a number of support services available for staff to help with a wide range of mental and physical challenges faced whilst at work.

The risk rating was challenged at the Workforce, Education and Culture Committee and it was suggested that the risk should be higher than the current risk as the Trust was in a worse position at year end.

The risk will be carried over to 2022/23 and the risk rating reviewed.

BAF 2 – Valued, skilled and sufficient staff
The Workforce, Education and Culture Committee discussed the risk and highlighted the Trust's vacancy rate against how staff actually felt. A number of new wards had been opened and there was concern around staffing these wards. Also the Ockenden Report and the shortage of Midwives and Obstetricians was a concern. Recruitment and retention remains a key priority. The Committee was uncomfortable agreeing that this risk target had been met.

There are still a number of vacancies in hard to recruit areas such as Acute, Oncology, Hematology and Radiology.

The risk will be re-scoped for 2022/23.

BAF 3.1 – High Quality Care
The proposed target risk rating has not been met although there has been Quality Improvement work that has taken place such as: assurance visits, undertaking a Well-Led review, continuous quality improvement training (QSIR) and framework and improved governance arrangements following a review of the quality committee structure. Quality Improvement work in 2022/23 will include collaborative work with strategic partners and alignment with the Nursing strategy and the Quality Accounts.

The risk will be re-scoped for 2022/23 to align it with the Quality Strategy objectives.

BAF 3.2 – Harm Free Care
This risk has met its target risk rating due to the low number of Serious Incidents recorded relating to avoidable patient harm caused by delays in accessing services. The Trust is still under enhanced surveillance in relation to quality risks due to performance against the elective recovery plan. However, it is expected that there will be agreement to bring this to an end in June 2022 and move quality assurance and improvement to business as usual within the ICS structure.

Currently the incidents causing harm remain within control limits but there are concerns that additional delays will be caused due to the current wave of the pandemic

The risk will be re-scoped for 2022/23 and mental health care and patients with no criteria to reside will be included.

BAF 4 – Great Clinical Services
The Performance and Finance Committee discussed performance and the measures in place to mitigate this risk. It was felt that despite the amount of actions in place, issues outside of the Trust's control would prevent the risk from achieving its target in Q4. These issues include system wide capacity, patients with not criteria to reside and Covid pathways. Two Deputy Chief Operating Officers have been appointed to oversee the Elective Recovery and Unplanned Care. The risk to be carried over to 2022/23.

BAF 5 – Partnerships
The Humber Acute Services Review and ICS work is moving at pace and the Trust is fully engaged with the process. The Committees in Common and Development Board have been established and are overseeing the work programmes. The Director of Strategy and Planning is now overseeing Programme 1 and Programmes 2 and 3 are underway. It is proposed that this risk has met its target rating and will be re-scoped in 2022/23 to incorporate the developing ICS and collaborative working.

BAF 6 – Research and Innovation
It is proposed that this risk has met its target risk rating due to the Trust being the 4th highest recruiting institution in Yorkshire and Humber, having high commercial activity and having the 3rd highest number of open studies. The risk to be re-scoped for

2022/23 to include the support service capacity to deliver research operationally and the investment required to manage this.

BAF 7.1 – Finance
The risk has been mitigated and the target risk rating achieved. The H2 position has been achieved in line with the plan. The Trust's liquidity position remains healthy and the cash balance will be £60m at the end of the year. The same risk regarding the financial target will be added to the 2022/23 BAF.

BAF 7.2 – Underlying Financial Position
It is proposed that the risk rating remains the same as the risk has not achieved its target rating. The Health Group risk is a continuation of the issues experienced throughout the year plus the current shortfall on CRES schemes. The risk will be carried over into 2022/23 and will be re-scoped to include the ICS and system wide financial objectives but will focus on the Trust's underlying financial position.

BAF 7.3 – Capital and Infrastructure
The risk has been mitigated and the target risk rating achieved for 2021/22. The main areas of expenditure related to the Salix Energy Efficient scheme, theatre upgrade, backlog maintenance, and urgent and emergency care. The risk will be re-scoped for 2022/23 and will included digital and sustainability risks in line with the updated Strategic Objectives.

6. Risks 2022/23

The Board Development session in April 2022 included the Board Assurance Framework workshops where each of the Executives and Non-Executives were put into groups relating to their areas of work and the Committees they attending. For example the Chief Operating Officer reviewed the performance and finance risks along with the NEDs attending the Performance and Finance Committee. Following the session the below table shows the outcome of the discussions to be worked up into the 2022/23 Board Assurance Framework.

Table 3

BAF Risk	Inherent (L x I)	Current (L x I)	Target (L x I)	Risk Appetite
1 – Culture The Trust does not make progress towards further improving a positive working culture this year.	5x4=20	4x4=16	3x4=12	Low
2 – Staffing 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	4x5=20	4x4=16	3x4=12	Low
3.1 - Quality 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
3.2 – Patient Harm There is a risk that patients suffer unintended or avoidable harm.	5x5=25	4x4=16	3x3=9	Low
4 - Performance There is a risk to access Trust Services following the pandemic	5x5=25	5x4=20	4x4=16	Low

and during the recovery of elective services				
5 - Partnerships That the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System due to recovery, primary care and social care constraints	3x4=12	3x4=12	2x3=6	High*
6 – Research and Innovation – There is a risk that Research and Innovation support service is not delivered operationally due to lack of investment	4x4=16	3x4=12	2x4=8	High*
7.1 – Finance There is a risk that the Trust does not achieve its financial plan for 2022/23	5x4=20	5x4=20	3x4=12	Moderate
7.2 – Underlying Financial Position 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
7.3 – Capital Programme There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability	4x4=16	3x4=12	2x4=8	Moderate

*The relevant Assurance committee will be challenging the risk appetite and/or target risk ratings for these 2 risks as they do not correlate. A 'high' risk appetite does not generally aim to reduce a risk rating as its target.

7. Internal Audit Report

During Q4 the BAF has had a process audit by the Trust's internal auditors RSM. The Trust has received substantial assurance. The only action was to include quarterly risk movement on the risk table presented to the Board. This has been addressed in Table 2 of this paper.

8. Timetable

The Board Development session to discuss the new Board Assurance Framework was held on 12 April 2022. Following this the 2022/23 Board Assurance Framework will be developed and presented at the July 2022 Board meeting.

9. Recommendations

The Board is asked to:

- Approve the year-end risk rating and close the BAF for 21/22
- Approve in principle the risks for 22/23
- Decide if sufficient assurance has been provided

Rebecca Thompson
Head of Corporate Affairs
May 2022

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

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

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

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

Inherent risk			**Year-end risk as at 31.03.22 (Q4)**			**Planned target risk position by 31/3/2022**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	4	4	16	3	3	9

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

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

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

Inherent risk			**Year-end risk position as at 31.03.22 (Q4)**			**Planned target risk position by 31/3/2022**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	4	3	12	3	3	9

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

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

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

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

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

Inherent risk			**Year-end risk position as at 31/3/22**			**Planned target risk position by 31/3/2022**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

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

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

Assurance Committee: Quality Committee

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

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: Taken from the Trust's strategy: *The Trust is the only local provider of secondary emergency and elective healthcare services for a population of 600,000. These people rely on us to provide timely, accessible, appropriate care and look after them and their families at times of great vulnerability and stress.* **Condition:** There is a risk that patients suffer unintended or avoidable harm. **Cause:** Delayed access to services due to the increased waiting lists as part of the pandemic, patient flow, human error, clinical guidance not adhered to, poor compliance with fundamental standards. **Consequence:** Deterioration of conditions for patients, poor quality of life, loss of sight. Patient experience, clinical outcomes, timely access to treatment and regulatory action.	• Clinical harm review process • Prioritisation of P1 patients • Fundamental Standards programme • The Trust's Elective Recovery Group is responsible for the co-ordinated oversight of the agreed elective recovery plans in line with the Trust's and system level recovery objectives. This work is underpinned by 14 Task and Finish Groups which will focus on different aspects of recovery 1. Independent Sector 2. Evidence Based Interventions 3. Day Case Capacity Development 4. Productivity, Benchmarking and Demand and Capacity 5. Outpatient Transformation 6. Data Quality and Validation 7. Theatre Capacity Hull University Teaching Hospitals NHS Trust 24 Assurance Framework Responsive 8. Diagnostics Capacity 9. Therapies Capacity 10. Critical Care Capacity for Elective Post-op care 11. Pre-operative Assessment Capacity 12. Outpatient Capacity 13. Partial Booking 14. Job Planning for Recovery. The trajectory for the Elective Recovery Plan continues to be 95%. Performance against this has improved in a number areas with 13 out of 22 indicators achieving above 95% Clinical harm reviews continue to be undertaken	Reduction of beds in Medicine Radiology capacity issues There were 268 breaches of the 2ww standard with the majority in Breast at 223, then Skin at 22. 2ww suspected cancer referrals are now back to pre-Covid levels of demand. The Trust is in the median quartile nationally for 2week wait performance at 82nd out of 124. 26% of the 52 ww breaches are in ENT (2,857) – of which 81% are on a non-admitted pathway Ophthalmology experiencing a delay in meeting outpatient appointments 7 extreme risks being monitored via the Quality Risk Profile: • Core Patient Safety 14 - Discharges and Patient Flow with impact on quality and safety • Core Patient Safety 52 - Significant waiting list Issues including access to screening and follow-up programmes. • Core Patient Safety 74 - Significant Reputational Risk Issues • Acute Patient Safety 6 - Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E. • Acute Patient	**Management assurance:** • Reports to Quality Committee • Clinical harm data and reports • 52 week reports • Humber Acute Strategic Development Committee joint review of P1/P2 patients • 1.2% improvement in RTT performance in April Ophthalmology validation of follow ups is undertaken weekly to ensure capacity is utilised appropriately Funding in place to source 2 additional Glaucoma Consultants and 2 additional MR consultants MRI Issue: 59 MRI procedures behind plan due to unexpected equipment issues at the end of Q3 and into the start of Q1. This led to reduced capacity and the loss of approximately 27 slots. The H1 plan at Point of Delivery was achieved in May above the Elective Recovery Fund trajectory of 80% of 19/20 baseline Overall treatments for cancer were above the enhanced bounce-back trajectory. Reduction of the 52 week waits are performing well, there continues to be a significant reduction since March 2021, achieving the trajectories month on month	**Gaps:** Diagnostic waiting times GP Capacity and increased referrals Assurance Glaucoma virtual review sessions in place The Cardiology service continues to work with the Independent Sector (IS) for Heart Failure and Intervention backlogs which remain challenged. IS also supporting with Echo delivery which will further help reduce the O/D Follow Up backlog. Two serious incidents in the Gynaecology service were identified during clinical harm reviews; the patients did not receive timely follow-ups/dates for surgery and subsequently received cancer diagnoses CS completed 7 Clinical Harm reviews in July 21 F&Ws completed 15 Clinical Harm reviews in July 21 Surgery completed 14 Clinical Harm reviews in July 21 The RTT trajectory of 55,803 was not achieved for September. Achieved 58,795 The September 2021, the total WLV baseline was 58,795; the October 2021 position is higher at 62,439, there are 2 main factors for the increase. Firstly, the Neurology service was transferred from NLAG to HUTH on 1st October 2021 as part of the Humber Acute	Improvement meetings with Family and Women's Health Group to target specific specialities Diagnostics: • Currently looking at 'delays' from D1S to ordering CTs and x-rays. These aren't high in number but do show significant wait times when they occur • Radiographers start to approve to review and sign-off of the more common, simple CT requests – at present this is only the Radiologists who are multi-tasking with reporting scans and reviewing ordered ones • Reviews have shown few delays once ordered – with the exception of laboratory system or testing machine breakdowns • Approval and funding has been given for the replacement of the RIS – expected complete late Q2/early Q3 21/22 Incomplete list size trajectory to be achieved – aim to reduce to 55,803 by end of September 2021 The Elective Recovery Group/In-hospital Delivery Group are monitoring the delivery of the improvement plan. These have representation from all Health Groups. ED quality issues and performance, all Health Groups are contributing to the improvement plans. There is a weekly meeting with the Chief Operating Officer to monitor both the delivery of actions and outcomes of this.	Q1 Review of bed base due to activity levels H1 plan in place which covers the first 6 months of the year Increase Elective Capacity Framework – independent sector providers included Updates received at the Performance and Finance Committee regarding waiting list initiatives for Breast surgery, cardiology, dermatology, ENT, Gynaecology, Interventional Radiology,Ophthalmology, Oral Surgery and Plastic Surgery St Hughs was still being used for Trauma and Orthopaedics activity Urology working with external provider in Q1 Q2 Replacement of the Radiology Information System Breast - Under 40s and over 40s clinics to be introduced (under 40s do not require mammograms) Health Group recovery actions detailed in Appendix 2. Q3 H2 Plan Q4 The Trust submitted the final H2 operational plan on 8 th November 2021. This plan identified activity to be delivered each month in the second half of 2021/22 (H2). The Elective Recovery Fund (ERF) requirement has changed in H2 and is now based upon RTT monthly clock stops comparing those achieved in 2019/20 against the monthly

			Safety 7 -Quality issues identified due to handover delays. • Acute Patient Safety 13 - > 52 week waiters Acute Patient Safety 16 - All cancers – maximum 62-day wait for first treatment from an urgent GP referral for suspected cancer. NHS cancer screening referral The Trust is still experiencing too many cancer patients waiting over 63 days, this is working progress 3 The P2 actual performance was 55.4% against a target of 70% for September 2021 Outpatients remains below the trajectory of 25%, achieving 20.4% Slight increase in the number of Incidents, PALS and Complaints received in response to delays in treatment The ED targets and the ambulance handover times were not achieved		Services Programme 1, which increased the WLV by circa 500 patients. Secondly, a counting change to include the patients awaiting referral triage (Referral Assessment Service – RAS) was implemented from 1 October 2021, this increased the WLV by a further circa 2,400 patients.	Key elements of the ED and patient flow programme are to be implemented at the beginning of July. Work is currently underway to engage with all relevant staff to maximise the benefit of this. The Executive Team include monitoring of all of these risks and the monthly Health Group performance and accountability review meetings (chaired by the CEO) Incomplete list size trajectory to be achieved – aim to reduce to 55,803 by end of September 2021	delivery in 2021/22. The ERF threshold trajectory of expected monthly clock stops has been set at a minimum of 89% of 19/20 baseline. For clock stops delivered between 89-94% the Trust will receive 100% of tariff; for delivery over 94% the Trust will achieve 120% of tariff. The value is based on the H1 SUS submissions at Treatment Function level and split between admitted and non-admitted clock stops. The regional team is providing an indicative ERF Ready Reckoner for Trust to be able to forecast potential ERF income. The ERF funding will continue to be earned on a system basis to encourage systems to continue to use their capacity and resources as flexibly as possible across organisations to maximise recovery activity
	Risks from Risk Register: 2675 - Insufficient capacity within Radiology to accommodate increasing demand			**Metrics** Patient Safety incidents Waiting list numbers **Independent / semi-independent:** CQC inspections Internal audits – Waiting lists, recovery included in schedule	**Outcomes:** 2 SI's declared in relation to clinical harm reviews. Increase in Ophthalmology Sis. 12 hour DTA Sis (harm not demonstrated) RTT list size for April was under the trajectory at 60,422 RTT list size for July was under the trajectory at 57,560 RTT list size for October was over trajectory at 62,439		

Inherent risk			**Year-end risk position as at 30.09.21 (Q3)**			**Target risk position by 31/3/2022**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	3	3	9	3	3	9

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

Executive Lead: Ellen Ryabov – Chief Operating Officer

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

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

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

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

Inherent risk			**Year-end risk position as at 31.03.22 (Q4)**			**Planned 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 Theme: Strategy
Risk Appetite: Cautious (2)
Risk: Contribute to ICS Services

Strategic Objective: Partnerships and Integrated Services
Assurance Committee: Trust Board
Executive Lead: Michelle Kemp
CQC Domain: Well Led/Effective/Safe
Enabling Plan: Trust Strategy

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: **Partnerships and Integrated Services** **Condition:** **That the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System due to recovery constraints** **Cause:** The recovery programme slows down the progress to become an Integrated Care System **Consequence:** **Reputational damage** **Relationships with other care providers are not forged**	The Trust has key leadership roles in the current ICS governance structure HUTH leading on continued partnership work and driving momentum on acute service reviews HUTH driving the wider Acute Provider Collaborative programme Humber Acute Services Development Committee has been established and has met in June and August 2021. The Humber Acute Services Programme is now moving at pace across all elements of the Programme. • Programme 1: Interim Clinical Plan • Programme 2: Core Service Change • Programme 3: Strategic Capital Investment Each of the core elements of the Programme are underpinned by a comprehensive workplan which is supported by a resource plan, an engagement plan and a comprehensive risks and issues log. ICS Chair has been appointed	Uncertainty with the national policy approach around the Independent sector programme Uncertainty around allocation of recovery funding HUTH Workforce recovery following Covid is at an early stage Limited feasibility around delivery of the mutual aid model in the context of possible reliance on the wider system to deliver Alignment of HASR programme service resilience into performance recovery is at an early stage ICS Chair recruitment is underway with Gatenby Sanderson Cardiology Humber-wide – single governance process to be considered HASR workforce plan to be developed – focussed session to be arranged	**Management assurance:** Programme 1 will be governed through the Joint Development Board. Staff briefing sessions are on-going to capture all staff groups (evenings and weekends included to cover shifts) with sessions planned around all aspects of HASR programme • Staff survey results are under review • Overarching slides describing HASR are under review following feedback to ensure they are more descriptive • Joint P1 & P2 report being taken to OSC Sept/Oct to update on progress/current position/challenges • Joint working with Planned care programme within HASR for specialities which are across both P1 and P2	**Gaps:** Urgent and Emergency Care: The requirement to improve and implement out of hospital models of care to divert activity from the hospital front door The potential for changes to service provision The potential for the displacement of activity to DRI and HUTH depending upon any potential future option implemented Neonatal: The impact of the neo natal review The impact of low births rates on the South Bank on emerging options Planned Care: The critical links to the implementation of community diagnostics	Humber Acute Services Programme - The 10 specialties included in the Interim Clinical Plan are: Haematology, Oncology, Neurology and Dermatology, Cardiology, ENT and Ophthalmology, Gastroenterology, Urology and Respiratory The review of the specialties is happening in three stages during 2021/22: – Phase 1 – haematology, oncology, neurology and dermatology (Q2) – Phase 2 – cardiology, ENT and ophthalmology (Q3) – Phase 3 – respiratory, gastroenterology and urology (Q4) Expression of Interest relating to HASR has been submitted - £720m capital projects HASR Board Development session held in October 2021	Q1 – Phase 1,2 and 3 of the HASR programme initiated Q2 - Phase 1 – haematology, oncology, neurology and dermatology (Q3) – Phase 3 – respiratory, gastroenterology and urology (Q4) Engagement and communications plan underway for P2 and P3 Capital Bid submitted for the hospital refurbishments
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			Year-end risk position as at 31.03.22 (Q4)			Planned 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 Theme: Quality Risk Appetite: High Risk: Research and Innovation development

Strategic Objective: Research and Innovation | **Assurance Committee: Quality Committee**

Executive Lead: Dr M Purva | **CQC Domain: Safe** | **Enabling Plan: Research and Innovation Strategy**

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: Research and Innovation **Condition:** That the Trust does not make progress in developing its research capability, capacity and partnerships and that the Trust does not deliver the Non-Covid research during the recovery phase due to capacity issues. **Cause:** Additional activity due to the recovery phase could mean less capacity for Research and Innovation **Consequence:** Impact on R&I Investment Impact on R&I capacity	Strengthened partnership with the University of Hull Infection Research Group established ICS Research Strategy	The impact of Covid-19 in the short and long term. The impact of Covid-19 with key partners. Reduction in support services due to activity delivery Loss of commercial research income as well as other income as non-Covid activity was paused Additional research due to Covid without additional investment in staff Social distancing impacting on research projects 20% of consultants should have 20% protected R&I time. The inability to secure dedicated resource to deliver an ambitious R&I Communications and Engagement Strategy. • The inevitable reduction of support services capacity (i.e. imaging, labs, pharmacy) dealing with clinical service delivery backlogs which may limit the ability to take on some new research activity as well as slowing down existing activities. • Legacy of COVID activity and follow-ups – the success of our COVID research activity means we will have the burden of additional workload into early 2022-23. Without additional investment in delivery staff, this will impact upon research specialties in the delivery of their existing and planned activities. • Reconfigurations and the implementation of social distancing have led to several research areas experiencing	**Management assurance:** Successful portfolio of Covid studies managed in 2020 Recruitment above target 2316 patients involved in clinical research as at August 2021 464 ongoing projects Continuing working with HYMS and the ICS	**Gaps:** Scale of ambition vs deliverability Current research capacity hampered due to the recovery plan External funding availability Collaboration, starting with Acute Trusts and moving to all providers and commissioners within the ICS footprint, will allow a unified research strategy picking up perhaps two or three mutually beneficial themes to be explored with a view that joining of resources and expertise can greater serve the needs of our geographic areas. It is anticipated (but not assumed) that a focus on mental health, community services and social care will provide a backbone to these initial scoping of themes.	(1) A Research Aware Organisation (2) Positive, Proactive Partnerships (3) Reputation through Research HUTH will continue to provide equitable access for patients and staff to both Urgent Public Health Research and non-COVID-19 research where it is possible and safe to do so. Build Research and Innovation capacity into consultants protected time. Fund dedicated research time into job roles, especially difficult to recruit areas. Launch R&D Branding, website, newsletter and social media	Q1 – Update HUTH has successfully managed an intensive portfolio of COVID-19 research as well as ensuring studies that provide access to potentially life preserving or life-extending treatment not otherwise available to the patient can continue with appropriate safeguards. This achievement has been formally recognised by the Clinical Director of the Yorkshire and Humber CRN as well as the CEO of the NIHR. HUTH has made a significant contribution to the development of a COVID-19 vaccine. This experience and momentum must be galvanised and used as a catalyst to grow vaccine and other infectious diseases research portfolios The development of the IRG is allowing the creation of capability and capacity to offer an increase in both COVID and non-COVID-19 research opportunities. Its development is being considered in tandem with routine service delivery so that it becomes a truly integrated service. Initially, this work will be underpinned by COVID-19 vaccine work and associated DHSC funding with plans to integrate into OPAT and other Infectious Diseases services. Institutional support will be required longer-term.
Risks from Risk Register: No risks highlighted			**Metrics** Recovery Activity R&I Capacity **Independent / semi-independent:** NHS E/I HASR CQC ICS	**Outcomes:** HUTH response to the COVID-19 pandemic has demonstrated our capabilities to deliver clinical research at pace and scale and we have now enrolled over 2,500 participants across 27 COVID-19 studies since April 2020 (with approximately 2,900 COVID-19 admissions since 17/03/20).		

			accommodation issues				

Inherent risk			Year-end risk position as at 31.03.22 (Q4)			Planned target risk position by 31/3/2022		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	3	4	12

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

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

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: Financial Sustainability **Condition:** Expenditure incurred exceeds income by greater than agreed control total **Cause:** Health Groups and Corporate Departments do not deliver services within agreed budgets and do not achieve Cash Releasing Efficiency Savings Capped and block contract arrangements limit scope for payment Additional activity delivered may not result in increased income; due to levels of activity or coding issues **Consequence:** Impact on investment in quality Inability to meet regulatory requirements Reputational damage Impact upon recruitment	Health Group Budgets in place 2021/22 Financial Performance Review meetings in place with Health Groups Monthly scrutiny of the Balance Sheet by the Performance and Finance Committee Realistic and achievable plan in place developed with staff input and sustainability funds identified	Ongoing development of accountability of Health Groups – further improvements required Block contractual arrangements remain in place for Q1 Cost reduction and expenditure controls in place but with lack of consistent application within Heath Groups and corporate functions Gap in identified CRES schemes and required level Delivery of the additional Emergency Recovery Fund - The Trust activity plan has been modelled by NHSEI through its 'ready reckoner' and indications are that the Trust will receive £1.6m of ERF based on the plans. Health Groups are being asked to deliver 2/3rds of the increased efficiency target The main areas of expenditure growth are in Surgery, Family & Women's and Clinical Support and are mainly in areas of pay. This will reflect the increased profile spend, for example, increment movements from 1st October. The new nursing starters from university recruitment will now be included in the numbers with nursing numbers (registered and unregistered) higher in month 7 by 74 wtes	**Management assurance:** Performance Committee and Boards Finance Performance Reviews with Health Groups Additional income can be earned by delivering income above baseline national targets to access the Elective Recovery Fund. This requires delivery across the ICS and is not just dependent upon Trust performance. Plans across the ICS assume that baselines will be exceeded and additional income received. **Metrics** 1. Run rate 2. I&E position 3. CRES position 4. Activity performance against plan 5. Cash flow **Independent / semi-independent:** 1. NHSE/I 2. CQC 3. Internal Audit 4. External Audit 5. Local Counter Fraud Specialist	**Gaps:** Divisional awareness of spend within new structures as budget centres have shifted Clarity of ownership of schemes Pace of delivery The struggle to identify efficiency schemes. **Outcomes:** 1. Achieve Board approved financial plan 2. Achieve financial control total at Trust and system level	The NHSEI indicative plan position for the period for HUTH was a deficit of £1.1m within an overall Humber Coast & Vale ICS (HC&V) target of break-even. Following discussions across all organisations within the ICS, based on forecast income and expenditure plans across the patch, the Trust has set a target plan of a deficit of £1.7m. The overall ICS position remains at break-even.	Q1 – Update NHSEI has issued official planning guidance that sets out the details of the finance and contracting arrangements for the six-month period from 1st April 2021 to 30th September 2021 (H1). The year to date surplus of £0.2m in line with plan. The H1 forecast deficit of £1.7m in line with plan. Q3 - NHSEI have indicated that they will provide further guidance on H2 in September 21 with plans due to be submitted in October 21. Early indications are that the block contracts from H1 will be rolled over but there may a reduction in the level of Covid19 funding available. Elective Recovery Funding is expected to continue but there will also be an increased efficiency requirement of up to 3% required from October 21. This is now being classed as 'waste reduction.' Q4 – Financial target met
Risks from Risk Register: RDC Funding not yet agreed						

Inherent risk			Year-end risk position as at 31.03.22 (Q4)			Planned target risk position by 31/3/2022		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	2	4	8	2	4	8

Strategic Objective: Financial Sustainability | **Assurance Committee:** Performance and Finance

Executive Lead: Lee Bond

CQC Domain: Effective | **Enabling Plan:** Financial Plan 2021/22

Strategic Theme: Finance
Risk Appetite: Low
Risk: Underlying Financial position

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: **Finance** **Condition:** 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. **Cause:** Lack of achievement of sufficient recurrent CRES or make efficiencies Unknown impact of Covid-19 finances and recovery planning National guidance not yet released for system financial planning during and post Covid-19 **Consequence:** The Trust does not achieve its Financial Plan or make efficiency savings	H1/H2 Operating and Financial plan Robust financial planning processes in place	Need to update longer term financial plan – planning assumptions may change as well as ability of ICS to be able to meet all financial pressures of system Ability to deliver a 2-3 year plan to tackle underlying financial position relies on system-level control and contribution Need to agree a process to ensure resources are transferred appropriately between Trusts as a result of the developing acute service reviews	**Management assurance:** Regular update reports to the Performance and Finance Committee	**Gaps:** NHS Finance sees performance being measured at a system (ICS) level All health groups are struggling to identify recurrent CRES schemes and this remains a challenge for the Trust. There is an opportunity through the elective recovery fund to support the programme if additional work can be undertaken below funding levels. Costs, against the £2.5m income assumption for ERF, have been assumed to match the income at this stage, for prudency whilst the full extent of the costs of the additional work (both internally and via outsourced contracts) is assessed. This included an expenditure accrual of £1.4m within the month 2 position.	Ongoing development of accountability of Health Groups Block contractual arrangements remain in place for Q1 Gap in identified CRES schemes and required level Specialist Commissioning income is increased in line with the inflation above plus for cost of pass through drugs as per current agreements. 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.	Q4 – System-wide planning review for 2022/23 underlying run-rate
Risks from Risk Register:			**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:**		

Inherent risk			Year-end risk position as at 31.03.22 (Q4)			Planned target risk position by 31/3/2022		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	3	5	15

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

Strategic Objective: Financial Sustainability **Executive Lead:** Lee Bond **CQC Domain:** Effective	**Assurance Committee: Performance and Finance** **Enabling Plan: Capital Plan**					
Risks to objective	**Controls**	**Gaps in controls**	**Sources of Assurance**	**Assurance outcomes / gaps**	**Action plan**	**Progress / Timescales**
Strategic risk: **Financial Sustainability – Capital Programme** **Condition:** There is a risk of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability **Cause:** Lack of sufficient capital and revenue for funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment. **Consequence:** Lack of capital funding impacting on services Lack of investment impacting on patient and staff safety	Capital programme in place and risk assessed Comprehensive maintenance programme in place Capital Resource Allocation Committee in place to allocate funds Service level business continuity plans in place The Trust is expecting capital grant income totalling £13.7m relating to the Decarbonisation schemes and NPIC (pathology). £9.6m of this is expected in the first 6 months The reported capital position at month 7 shows gross capital expenditure of £26.3m against a plan of £31.2m. The schemes which are currently below plan mainly relate to a profiling issue within the emergency PDC application schemes. The main areas of expenditure relate to the Salix Energy Efficient scheme; Backlog Maintenance & Compliance and Urgent & Emergency Care.	Supplier price increases and delays to building works to be managed Since the last Capital Resource Allocation Committee (CRAC) in April a number of risks are emerging in terms of schemes that are not currently accommodated within the capital programme. These include the need for accommodation for the OPAT service, equipment requests associated with elective recovery and risks that there will be additional IT hardware requirements associated with some of the planned capital developments. The planned capital expenditure for 2021/22 (incl PFI/IFRIC12 impact) is £80m; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Theatre/3rd floor redevelopment (£5m); Digital Aspirant (£1.5m) and Gamma Camera (£1.5m).	**Management assurance:** Monthly updates to the Performance and Finance Committee Regular updates to the Board	**Gaps:** Building works impacting on patients and staff Approval of the Urgent & Emergency care Business Case, however due to delays in approval the Trust has slipped £8m into 21/22. It is expected the PDC funding will be moved to match this. The Trust has been working with ICS colleagues to agree an overall ICS capital programme for 2021/22. It should be noted, however, that partner organisations within the ICS remain legally responsible for maintaining their estate and for setting and implementing capital investment plans at organisational level.	Capital Plan Approved at the Board last month, the planned capital expenditure for the full year 2021/22 (incl PFI/IFRIC12 impact) is £58.1m; this includes assumptions on the Trust receiving PDC allocations relating to Urgent & Emergency care Business Case (£16.4m); Theatre/3rd floor redevelopment (£5m); Digital Aspirant (£1.5m) and Gamma Camera (£1.5m). The PDC Applications for Theatres and the Gamma Camera have been submitted for approval following some initial queries.	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			**Year-end risk position as at 31.03.22 (Q4)**			**Planned target risk position by 31/3/2022**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	4	2	8	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 =16 Target Risk: 3 x 3 = 9			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
Risks approved at the Board in May 2021 BAME Network conference Disability Network established	Board Development deep dive: Equality, Diversity and Inclusion, Wellbeing of staff and the Staff Survey results Wellbeing champions to be appointed Mediation Service and support Roll out of wellbeing conversation programme via appraisal	Talent Management plan established in October 2021 Inclusion programme for senior leaders established Additional funding secured to support Equality, Diversity and Inclusion agenda BAME Network promotion continues Allyship Programme has commenced and continued in Q3 Diversity in recruitment programme established	Be Remarkable: This is a programme designed for existing leaders and leadership teams to stretch their skills and knowledge to make a difference in their workplace and ultimately patient care. There are three cohorts starting this autumn (Sept, Oct, and Nov) from Jan 2022 and then there will be cohorts every 2 months. They will complete module 1 as a cohort, they can then access units in module 2	Risk increased – target risk not achieved. Further work to do following the publication of the staff survey results.

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

	Valued, skilled and sufficient staff The Trust does not effectively manage its risks around staffing levels in both quality and quantity of staff across Trust Inherent Risk: 5 x 5 = 25 Current Risk: 4 x 3 =12 Target Risk: 3 x 3 = 9			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
Risks approved at the Board in May 2021	Board Development deep dive: Equality, Diversity and Inclusion, Wellbeing of staff and the Staff Survey results Management Briefing Sessions relating to staff recovery commenced – Approximately 100 managers reached so far over 4 sessions Personal Coaching service for home and work wellbeing challenges Great Leaders Management Clinics & Leading through Covid Bitesize Coordination of Schwartz Rounds and Team Time	The 'Lets Get Started' induction programme for the new Nurse registrants has been reformatted this year based on the feedback from the previous cohort The Healthcare Support Worker Development Programme established Health Groups to monitor annual leave and review loss of capacity. Additional sessions being offered to staff. Use of the Independent Sector continues.	Mary Seacole Programme We are currently advertising funded places to the Mary Seacole Leadership Programme run by the Leadership Academy. Hull University is also becoming an accredited delivery centre for Mary Seacole this will be from March 2022 onwards. The National Review of HR and OD report shared with the Workforce Education and Culture Committee Work will now be undertaken by the Director of Workforce	Target Risk rating not achieved – risk remained the same

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

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

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

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

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

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

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

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

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

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

	Great Clinical Services There is a risk to access to Trust services due to the impact of Covid-19 Inherent Risk: 5 x 5 = 25 Current Risk: 4 x 5 = 20 Target Risk: 4 x 4 = 16				
Q1 Actions		**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
Streaming implemented in ED which has had a significant impact MRI Van sessions increased Meetings with each of the challenged specialities will take place during April and will look to find additional means of support to address the significant backlogs within our top 10, now expanded to top 12 with the inclusion of Gastro and Interventional Radiology.		Humber Acute Strategic Committee meeting in June 2021 to review joint services and working ED Triumvirate presenting performance issues to the Performance and Finance Committee in June 2021 Waiting list recovery plans in place for all of the 12 worst performing specialities.	The Trust received a visit from the Emergency Care Intensive Support Team who undertook a "Missed Opportunities" Audit reviewing all patients who arrived in ED within a 24-hour period. The initial output of this work was shared with the Executive and Senior Team and the Humber CEOs Group. This review highlighted and confirmed many of the areas of concern, primarily volume of non-ED activity coming into the hospital that should realistically be seen in another setting. This audit was then followed up by a "Front Door" review of ED, AMU and Frailty all of which identified several	The H2 requirements in respect of RTT are to:- • Maintain the total WLV at or below the September 2021 baseline • Continue to reduce 52 week+ breaches • Achieve zero 104 week waits by end of March 2022. The H2 requirements in respect of RTT clock stops are to:- • Deliver a minimum of 89% of clock stops to the 19/20 baseline	Target risk rating not achieved. Risk remained the same.

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

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

	Partnerships and Integrated Services There is a risk that the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System due to recovery constraints Inherent Risk: 3 x 3 = 9 Current Risk: 2 x 3 = 6 Target Risk: 2 x 3 = 6			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
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	The Pre-Consultation Business Case will be produced by the end of December. Key elements of the document will then be socialised with stakeholder groups during January and February 2022 to gather additional information which may influence the options presented in the Statutory Consultation during 2022. Work continues with the CCG, Primary Care, Community, Mental Health and ODN representatives to work on the key enablers that need to be in place to ensure successful	Target risk rating met

		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.	delivery of the emerging models of care. A plan will be developed in Q4.	

	Research and Innovation **We will develop research capability, capacity and partnerships** Inherent Risk: 4 x 4 = 16 Current Risk: 3 x 4 =12 Target Risk: 3 x 4 = 12				
Q1 Actions		**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
Q1 – Update HUTH has successfully managed an intensive portfolio of COVID-19 research as well as ensuring studies that provide access to potentially life preserving or life-extending treatment not otherwise available to the patient can continue with appropriate safeguards. This achievement has been formally recognised by the Clinical Director of the Yorkshire and Humber CRN as well as the CEO of the NIHR. HUTH has made a significant contribution to the development of a COVID-19 vaccine. This experience and momentum must be galvanised and used as a catalyst to grow		The development of the IRG is allowing the creation of capability and capacity to offer an increase in both COVID and non-COVID-19 research opportunities. Its development is being considered in tandem with routine service delivery so that it becomes a truly integrated service. Initially, this work will be underpinned by COVID-19 vaccine work and associated DHSC funding with plans to integrate into OPAT and other Infectious Diseases services. Institutional support will be required longer-term.	AMS – 20% of consultants should have 20% research time • Dedicated research time for early career consultants • Attract talent to our Trust by advertising jobs with dedicated research time • Especially in difficult to recruit areas • Potentially reduce locum spends, waiting list R&D structure is aligned to clinical research network structure - not necessarily with health groups	Success in securing externally funded grant income from the NIHR Lead for multi-centre national research in the areas of Vascular Surgery, Gastroenterology (IBD and Hepatology), Renal, Orthopaedics, Respiratory, Infection and Haematology. • Expanding research capability - Continuing from the vital COVID-19 vaccine research, the Infection Research Group are in the process of applying for a Genetically Modified Organisms (GMO - Contained Use) license from the Health and Safety Executive. • The Hull Lung Health Study builds on the work of the HCV ICS Hull Lung Health checks. This data collection study will generate a	Target risk rating met

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

			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.	

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

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

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

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

	Financial Sustainability The Trust does not plan or make progress against addressing its underlying financial position over the next 3 years Inherent Risk: 4 x 5 = 20 Current Risk: 4 x 5 = 20 Target Risk: 3 x 5 = 15			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
	A 3% CRES target would be around £20m but based on historic delivery and the national agreement on deliverable targets, the maximum achievable may only be between 1 and 2% so between £7m – £14m. Planning guidance on the likely efficiency ask is expected by end of August 21.	H2 Indications are that the guidance will be issued week commencing 20th September 21 with plans due to be submitted in October 21. Early indications are that the block contracts from H1 will be rolled over but there will a 5% reduction in the level of Covid19 funding available at ICS level. There will also be reduced support to offset the loss of other income. Elective Recovery Funding will continue but it is not yet known if there will be any further changes to the threshold. There will also be an increased efficiency requirement from October 21. This will be a minimum of 1.1% (up from 0.28% in H1) for all organisations but	The Humber Coast and Vale ICS submitted a balance plan for H2 on 18th November. The ICS plan encompasses a level of risk to delivery. Specifically there remains an uncovered risk of £1.5m. Due to the size of the risk outstanding, it was felt that it would be inappropriate to submit a deficit plan at ICS level, but that actions would be developed during the period to manage the risk. This would include a review of the ICS management budget and the potential to earn additional Elective Recovery Fund (ERF)	Target risk rating not achieved. Risk remained the same.

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

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

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

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

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

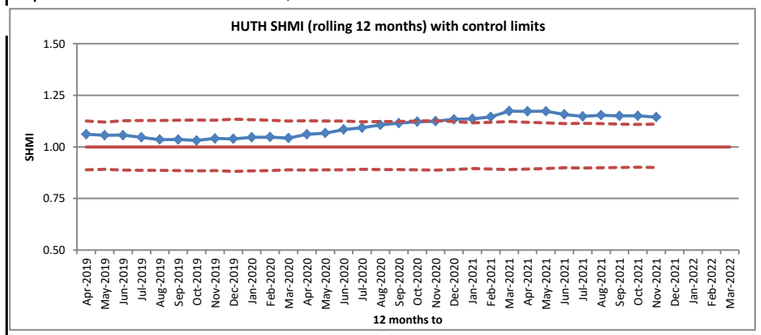
Impact Domains	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Business Objectives / Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project 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

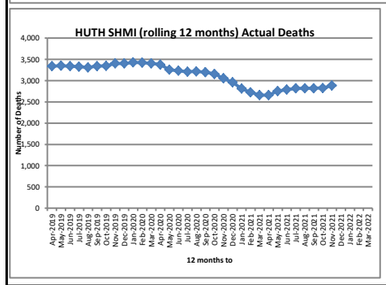
Mortality Dashboard

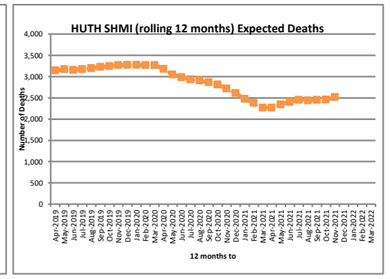
Hull University Teaching Hospitals NHS Trust

Standardised Hospital-level Mortality Indicator

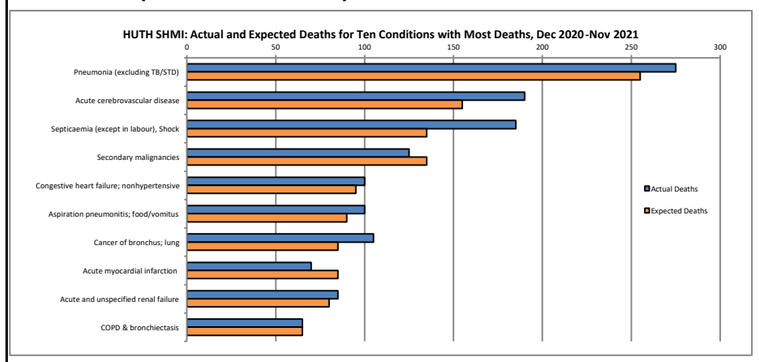
Latest	Nov-2021
SHMI	1.1449
Observed deaths	2,880
Expected deaths	2,515



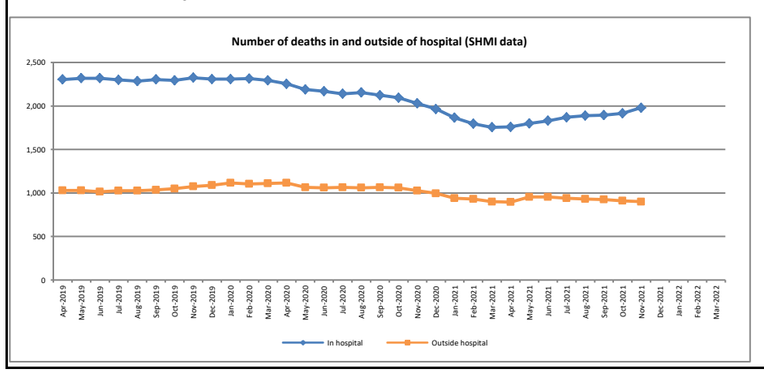




Actual and Expected Deaths for Top Ten Conditions

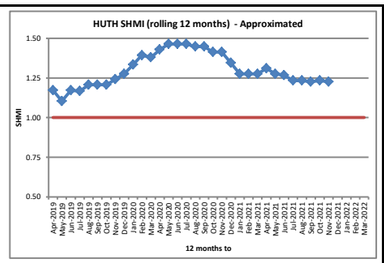


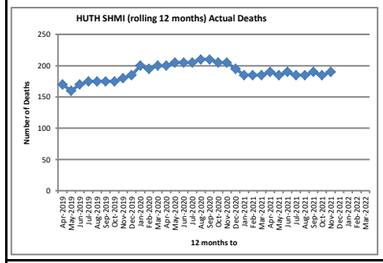
In and Out Of Hospital Deaths

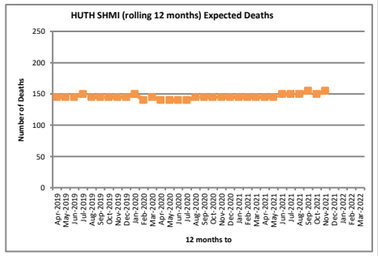


ACVD (for Stroke) Mortality

Latest	Nov-2021
SHMI (approx)	1.2258
Observed deaths	190
Expected deaths	155

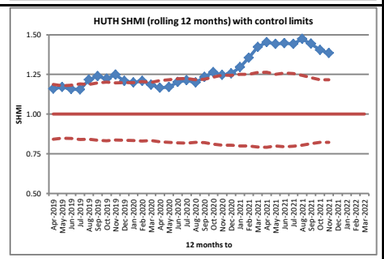


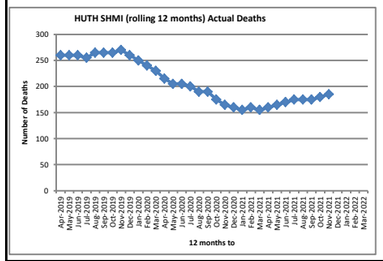


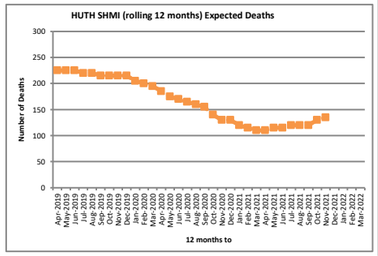


Septicaemia Mortality

Latest	Nov-2021
SHMI	1.3704
Observed deaths	185
Expected deaths	135

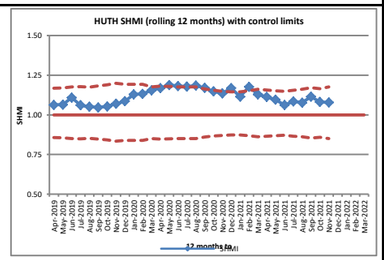


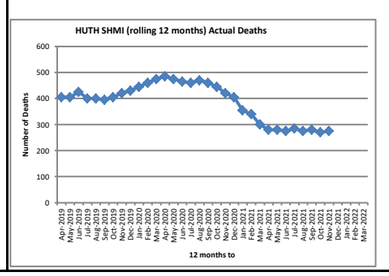


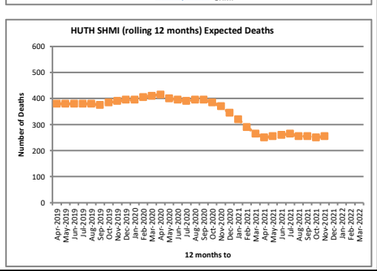


Pneumonia Mortality

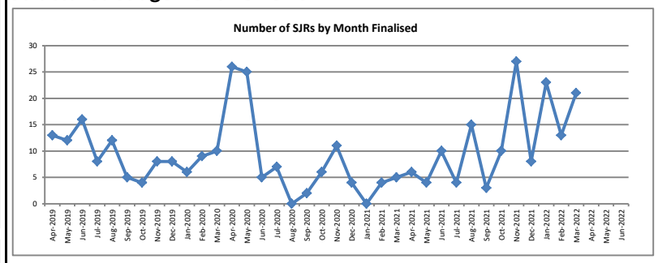
Latest	Nov-2021
SHMI	1.0784
Observed deaths	275
Expected deaths	255

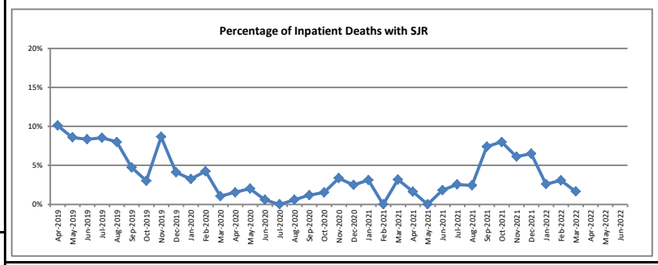




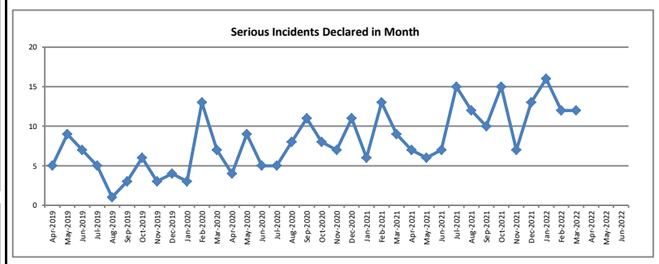


Structured Judgement Reviews

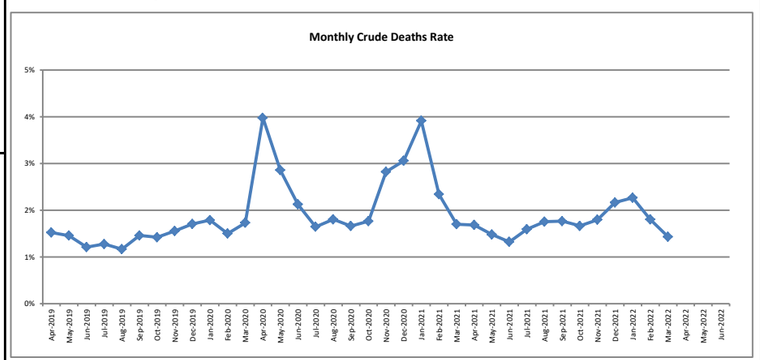




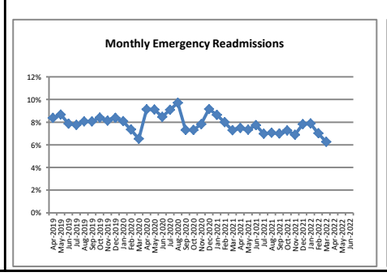
Serious Incidents

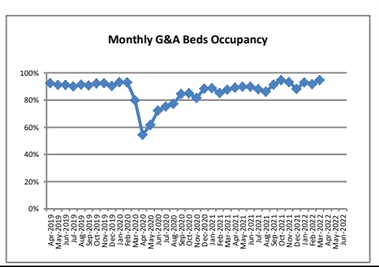


Crude Mortality



Hospital Occupancy and Emergency Readmissions





Agenda Item	8	Meeting	Trust Board	Meeting Date	10 May 2022
Title	Quality Report				
Lead Director	Jo Ledger, Interim Chief Nurse and Suzanne Rostron, Director of Quality Governance				
Author	Business Intelligence Analytics Team, Donna Pickering – Head of Patient Safety and Improvement and Leah Coneyworth – Head of Quality Compliance and Improvement				
Report previously considered by (date)	This report has not previously been considered. However, elements of it have been included in full papers to Quality Committee.				

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

Key Recommendations to be considered:

The Trust Board is recommended to:

- Delegate the approval of the Quality Accounts to the Quality Committee to enable the legal requirement of publication on the 30 June 2022 to be met
- Decide if any additional information would be useful at Board level in terms of quality indicators and information

1. Quality Accounts

The Quality Committee, Audit Committee and Patient Safety and Clinical Effectiveness Subcommittee have all received the initial draft of the Quality Accounts. A copy of this draft has been circulated to Board members to comment on.

The Quality Committee also approved the quality priorities for 22/23, which are all aligned to the Quality Strategy approved by the Board in March 2022. These priorities are:

1) COVID-19 Recovery Plans – SAFETY, EFFECTIVE AND LEARNING
2) Learning from Patient Experience – LEARNING
3) Care for older people/dementia – FOCUSED
4) Mental Health Triage in the Emergency Department – FOCUSED
5) Mortality and morbidity – EFFECTIVE AND LEARNING

The 2022/23 Quality and Safety Priorities will be aligned to the Trust's Quality Strategy priorities of Safety, Effective, Learning and Focused (SELF). The Quality Accounts, and the process that accompanies them is a key tool for delivering the Quality Strategy as well as maintaining stakeholder involvement. The Quality and Safety Priorities will be delivered using the Quality Improvement Framework and progress will be reported to the Patient Safety and Clinical Effectiveness Committee and to the Quality Committee.

The following actions will be undertaken by the Compliance Team to ensure the development and publication of the Quality Accounts is in line with the legal requirements by 30 June 2022:

Date	Action required
April to June 2022	Compliance Team to continue drafting the Quality Accounts
13th April 2022	PS&CE committee to approve the priority aims and targets for inclusion in the Quality Accounts and the Quality Improvement Plan along with any other additional requirements
25th April 2022	The Quality Committee to receive the proposed Quality and Safety priorities for 2022/23 and an update the development of the Quality Accounts
28th April 2022	The Audit Committee will receive a progress update and the first draft of the Quality Accounts
03rd May 2022	Draft Quality Account will be shared with our stakeholders for review and write their mandated statements
01st June 2022	Deadline for the stakeholder statements to be returned
June 2022	Compliance Team to review the statements and consider any suggested amendments and finalise the Quality Accounts
27th June 2022	The final version to be approved by the Quality Committee as delegated responsibility by the Trust Board
30th June 2022	Publication of the 2021/22 Quality Accounts in adherence with the revised legal requirements

The Board is recommended to delegate permissions to the Quality Committee to approve the final version prior to the publication on the 30th June, which we are on track to achieve.

2. CQC

The latest CQC Insight for Hull University Teaching Hospitals NHS Trusts report was released in March 2022. The following table provides a brief overview of the Trust position against the Insight indicators. The indicators rated as 'Much Worse' and 'Declined' continue to be HSMR, SHMI, CAS alerts and Never Events. As previously reported, the data within the CQC Insight report is often quite dated.

Much Better	Much Worse	Improved	Declined
Sick days for medical and dental staff- [set target 3.5%]	Hospital Standardised Mortality Ratio (HSMR)	Health & wellbeing	Never events (total events with rule-based risk assessment)
	CAS alerts closed late in preceding 12 months	Morale	CAS alerts closed late in preceding 12 months
	Summary Hospital-level Mortality Indicator (SHMI)	Quality of care	Hospital Standardised Mortality Ratio (HSMR)
	Hospital Standardised Mortality Ratio (Weekday)		Summary Hospital-level Mortality Indicator (SHMI)
	Hospital Standardised Mortality Ratio (Weekend)		Hospital Standardised Mortality Ratio (Weekday)
			Hospital Standardised Mortality Ratio (Weekend)
			Never events (total events with statistical comparison to bed days)

The Quality Committee has reviewed the above indicators alongside any audits where the Trust is an outlier and received an up to date position on actions being taken and/or the latest Trust data. The Patient Safety and Clinical Effectiveness Subcommittee overview of these outlier areas is provided below:

National Audit	Current Position	Assurance	Update
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.	Another report has been published in 2022; however, the data has been reported as Network Data rather than Trust data. Dr Gavin Anderson is currently reviewing the outcomes of the National Audit to compare with local Trust information to determine if improvements have been made. However, initial findings are as follows: Lung function (Aug 2021-Oct 2021)* 67 out of 77 patients had recorded lung function (FEV1) who went to have active treatment (where lung function is important role in fitness assessment, particularly	Dr Gavin Anderson presented the outcomes to the April 2022 Patient Safety and Clinical Effectiveness Committee where assurance was received regarding the improvements that have been achieved and the ongoing work; however, it was noted that due to the 2022 data bring Network only it is currently difficult to compare nationally and to determine any further outlier status.

		surgery). Of the 8 identified as no entry in Somerset; all had lung function when reviewed the case notes. *NB lung function was a time grossly curtailed in access during certain waves of the pandemic. That time interval was relatively free.	
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 updated action plan has been provided and this, along with the outcome form, was presented at the Patient Safety and Clinical Effectiveness Committee on 8 December 2021. The main concern is linked to the use of pumps. This area has not been fully addressed as yet but work is underway with the Quality Improvement Team and a process map has been completed of the whole process. The Executive Team were told at the Performance Review Meeting in May 2022 that the use of pumps is steadily increasing each week. The latest data has just been submitted to the national audit.
National Bowel Cancer Audit: • 'Insufficient data - 30-day emergency readmission' outlier; • 'Insufficient data - 90-day mortality' outlier; and • 'Insufficient data - Two-year survival' outlier.	The outcome form from the National Bowel Cancer Audit was discussed at the Clinical Effectiveness Practice and Development Committee in June 2021. 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	• 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%.	The latest data submission is for 2019/20 TNM = 97.7% complete ASA = 92.4% complete (122 out of 132 records with a completed ASA) Increase the number of patients seen by a clinical nurse specialist.

	80% of patients included in the analyses.	• 56% of patients received pre-operative radiotherapy. This is higher than the national average of 32%.	
National Joint Registry (NJR) Hip Replacements	On 21 September 2021, the Trust received a letter confirming the Castle Hill Hospital's revision rate for hip replacements lies outside the 99.8% control limits, which the National Joint Registry (NJR) regard as potential Alarm status.	Presentation from Surgery Medical Director at the performance management meetings. A great deal of work has been done in this area.	The Trust has acknowledged the potential alarm status and undertaken an in-depth review. There were 34 over a 5 year period. The review has been completed and submitted to the national team. Mr Symes has been invited to present the findings at the Patient Safety and Clinical Effectiveness Committee in June 2022.
National Neonatal Audit Programme (NNAP)	O 4 February 2022, the Trust received a letter confirming the Trust was an outlier at alarm level (negative outlier status by 3 or more standard deviations from the expected performance) for the audit measure parental consultation within 24 hours of admission	Dr Manou has reviewed the accuracy and potential reasons for the negative outlier status for this measure for babies admitted to Hull NICU in 2020	The Trust has acknowledged the potential alarm status and undertaken an in-depth review. There were 416 eligible cases. The review has been completed and submitted to the national team and an improvement plan is in place. Dr Manou has been invited to present the findings at the Patient Safety and Clinical Effectiveness Committee in June 2022. The latest data shows a much improved position.

3. Serious Incidents

A total of 21 serious incidents were reported in March and April 2022; 12 in March and 9 in April.

One of the serious incidents also met the Never Event criteria of Retained Foreign Object; this was reported within the Gynaecology Service where a surgical swab was found to have been retained.

The categories of each incident are shown below:

Treatment delay	8
Maternity/Obstetric incident	3
Slips,trips,falls	3

Medication incident	2
Sub-optimal care of the deteriorating patient	2
NEVER EVENT: Retained Foreign Object	1
VTE	1
Other (awaiting investigation findings)	1

28 serious incident investigations were completed during March and April 2022.

The initial 12hour DTA breach cluster comprising of 9 SIs was completed and the investigation found that the common causes amongst the 9 breaches included unavailability of beds for in-patients at HUTH and Mental Health Beds in partner organisations with NHS trusts experiencing increasing number of admissions.

A thematic review was undertaken for incidents reported in the Ophthalmic Service. The review found that the COVID-19 pandemic had a great impact on the operation of ophthalmology services. Themes included; a reduction in overall clinical capacity due to social distancing, additional cleaning / ventilation time for rooms has added to a system that was already running at capacity, staff shortages and sickness absence as a result of Covid isolation also contributed to delays in the system.

Two hospital acquired pressure ulcer investigations were completed which found that there are continuing themes in relation to pressure ulcers of;

- Incorrect risk assessments being undertaken
- Delays in reporting the pressure damage on Datix and escalation to the Tissue Viability Team
- Delays for a review by the Dietetics Service
- Documentation in relation to the use of a cushion to prevent pressure damage was inconsistent
- Lack of escalation to the senior nursing team where new or deteriorating pressure ulcer damage was identified
- No changes to care plans when pressure damage deteriorated

Although the Trust continues to see an in increase in the number of inpatient falls reported there has not been an increase in harm occurring.

The highest number of falls occur within the Elderly Medicine wards and an ongoing Quality Improvement Programmes (QIP) aims to develop a structured framework for the assessment and interventional care of patients who have a diagnosis of dementia within Elderly Medicine to understand the barriers that prevents the escalation of care and to improve situational awareness of safety concerns.

4. Quality Report

As previously agreed by the Trust Board, the Trust is moving towards having one integrated performance report that will cover quality, performance, finance and workforce. The joint Chief Information Officer for HUTH and NLAG will introduce the same process and format as NLAG at Hull to strengthen this reporting.

Work is currently being underaken for patient experience data, such as PALS, Complaints and friends and family responses to be included in a SPC format alongside the improvement actions being taken.

Elements of the Quality report are attached at Appendix 1. The highlights include:

- Positive patient safety incident reporting culture
- Sustained increase in the volume of serious incidents
- Plan in place to address serious incident backlog by the end of July 2022
- Continued quality improvement work streams in falls and pressure ulcers
- Increase in mortality indicators following CHKS rebase of data.

5. Recommendations

The Trust Board is recommended to review the quality data provided and decide if sufficient assurance has been received and accept the updates provided in this report.

- Delegate the approval of the Quality Accounts to the Quality Committee to enable the legal requirement of publication on the 30 June 2022 to be met

- Decide if any additional information would be useful at Board level in terms of quality indicators and information.

INTEGRATED PERFORMANCE REPORT
APRIL 2022 PERFORMANCE
Produced May 2022 for the Trust Board

Table of Contents

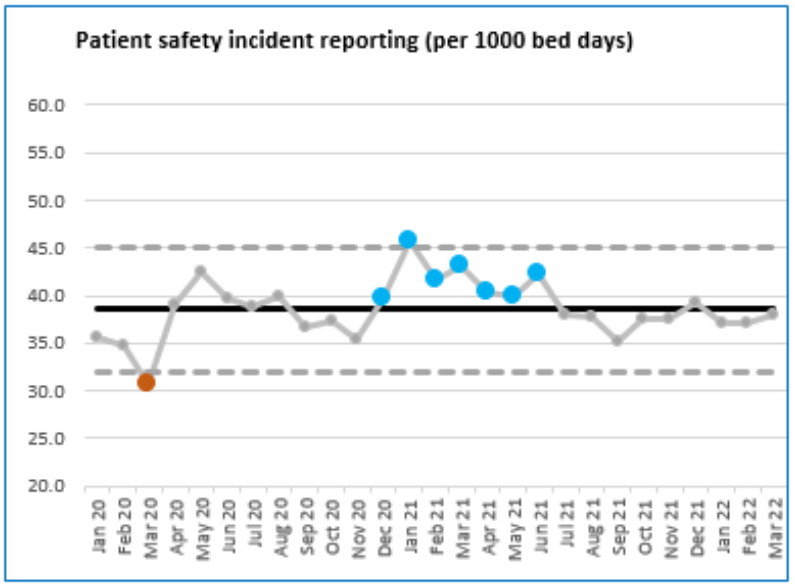
1. Executive Summary

Areas for escalation		
Domain	**Indicator**	**Update**
Safe	Patient Safety Incident Reporting	The Trust has a positive patient safety reporting culture (high volume, low harm) There has been a reduction in the incidents that are being reported. However, these have reduced proportionately with the bed occupancy per 1000 bed days as we have moved through the Coronavirus pandemic waves. Incidents causing moderate harm or above have increased but remain within control limits. The learning from incidents is shared through various avenues in the Trust to communicate key information and key learning and to share and celebrate success. Key quality improvement programmes are informed by incident data.
Safe	Serious Incidents	There been an increase in the number of serious incidents declared. There continues to be a backlog of serious incidents overdue investigation as a result of the pandemic. To aim be in a stable position within agreed tolerance limits, by July 2022 with a sustainable case load of open serious incidents
Effective	All	A number of indicators detailed in the effective domain are under review, this will be reflected in future IPR reports.
Effective	HSMR and SHMI	The Trust continues to highlight as an outlier for the HSMR and SHMI mortality indicators. The Mortality and Morbidity Task and Finish Group is undertaking a significant amount of work to really understand the reasons why the HSMR and SHMI continues to be above the England average, as part of this the Trust is also challenging CHKS on its data and the reasons for undertaking a rebasing exercise. The group is also working with the clinical teams to increase the number of staff trained to undertake Structured Judgement Reviews (SJRs), in turn increase the number of SJRs

		completed to understand the quality of care provided at end of life and where lessons can be learned to improve.
Caring	All	Indicators are under review, this will be reflected in future IPR reports.

2. Performance Review – Safe

2.1 Patient safety incident reporting and incidents causing harm



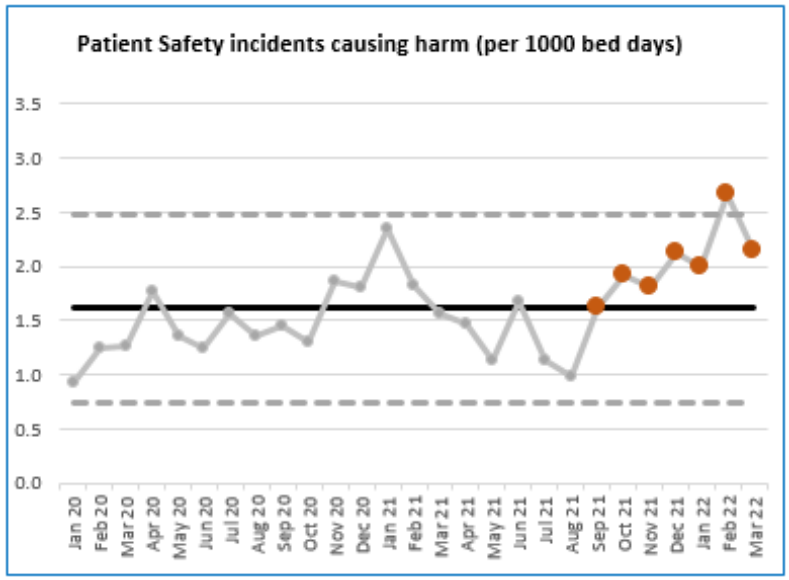
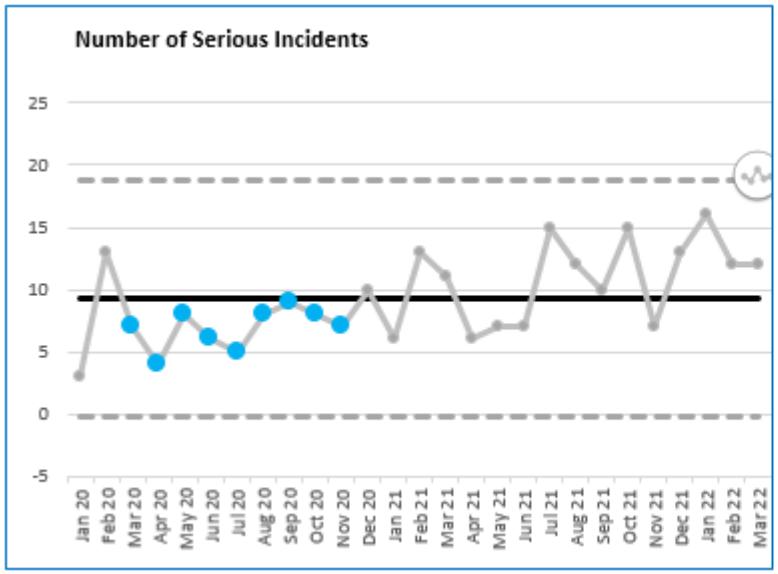


Chart Says:	• There were 39 patient safety incidents per 1000 bed days recorded in March 2022 (n=1588).; 2.14 (per 1000 bed days) incidents resulted in moderate, severe or catastrophic harm to the patient. • There has been a shift in the data for incidents causing harm to patients • The Trust has a positive patient safety reporting culture (high volume, low harm)
Issues:	• The highest proportion of incidents causing harm to patients are hospital acquired pressure ulcers (category 2 and above) and inpatient falls • The Neurosurgery department reports the highest number of pressure ulcers with the Elderly Medicine wards report the highest number of inpatient falls
Actions:	• Learning from incidents causing harm is shared throughout the Governance Structures and via the Trust Lessons Shared newsletters and Quality and Safety Bulletins, in a way to communicate key information and key learning. • To embed the Trust Quality Strategy to focus on learning from excellence in addition to incidents. • To develop and encourage a Quality Improvement approach to learning from incidents at the earliest opportunity
Mitigations:	• To continue to review patient harms at the Weekly Patient Safety Summit

2.3 Serious incidents



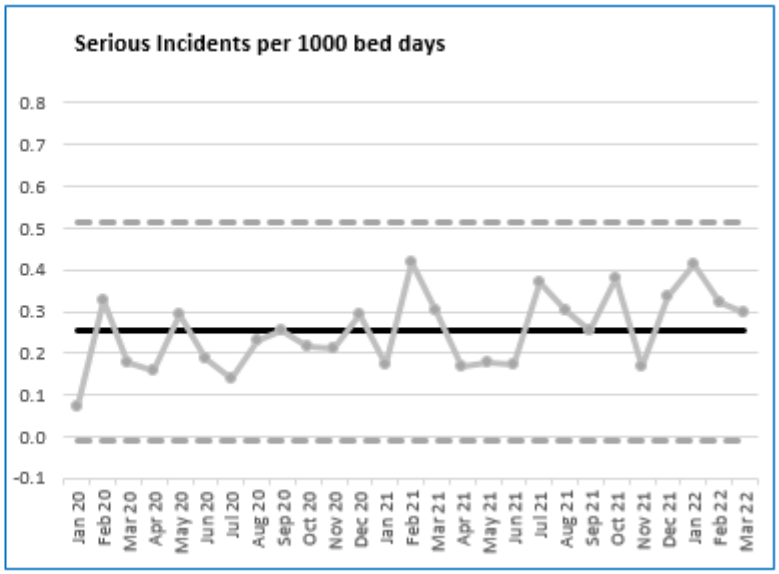
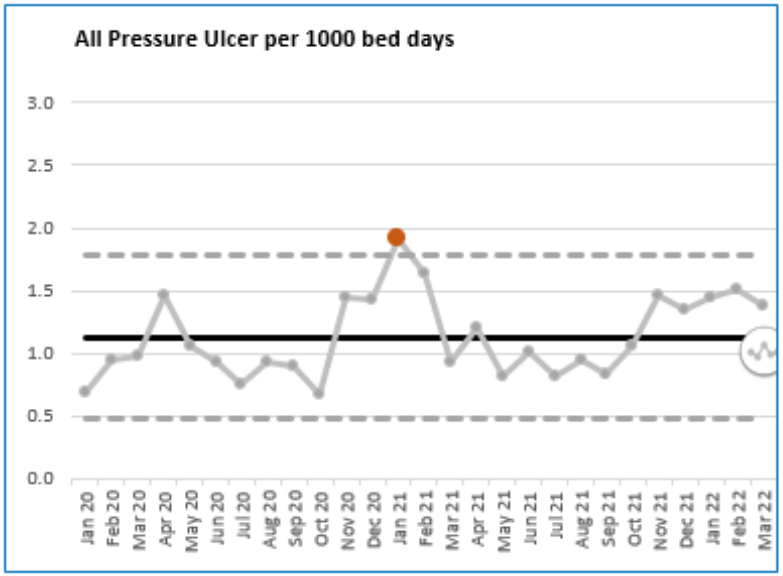


Chart Says:	• The Trust declared 12 serious incidents in March 2022 equating to 0.30 serious incidents per 1000 bed days • The graphs above show common cause variation with no cause for concern.
Issues:	• Treatment delays in the Emergency Department accounted for the highest category of serious incidents reported with delays in obtaining a Mental Health bed being a common theme • The Trust continues to declare an average of 3 serious incidents per week • Agreement with commissioners in March 2020 to stop monitoring 60 day investigation completion compliance for the duration of the pandemic • In March the Trust had 94 serious incidents under investigation with 22 that had been open for investigation for more than 100 days
Actions:	• . Aim be in a stable position, within agreed tolerance limits, by July 2022 with a sustainable case load of 35 open SIs at any time • For no serious incident investigation to take more than 100 days • Utilise the wider Governance team members to facilitate investigations
Mitigations:	• Implementation of the Patient Safety incident Response Plan (PSIRP)

2.4 Hospital Acquired Pressure Ulcers causing harm



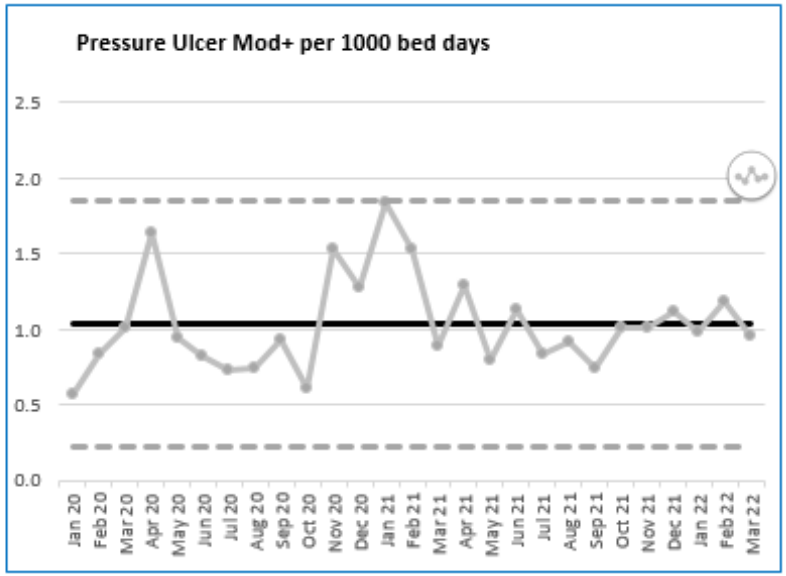
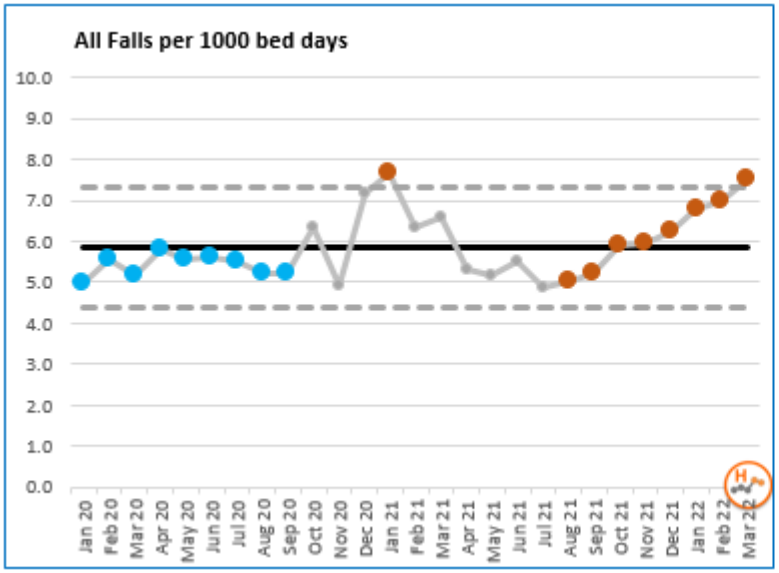


Chart Says:	• There were 1.38 hospital acquired pressure ulcers per 1000 bed days recorded in March 2022 (n=56). • 0.96 (per 1000 bed days) hospital acquired pressure ulcers resulted in moderate, severe or catastrophic harm to the patient.
Issues:	• There were 23 Category 2 pressure ulcers reported (2 as device related); 18 Deep Tissue Injuries (DTI) and 6 unstageable pressure injuries (3 device related) • There has been an increase in device related pressure ulcers (DRPU) reported in March 2022 • There are 15 RCAs outstanding at the time of report submission; not all RCAs are returned within 14 days • Incidents continue to have the incorrect level of harm reported; the Tissue Viability Team inform the incident investigators for this to be addressed. • Category 1 pressure ulcers are not routinely recorded onto DATIX
Actions:	• The Tissue Viability Team review all hospital acquired category 2 and above skin damage to support clinical areas to minimise wound deterioration • The Tissue Viability Team validate all category 2 reported pressure damage and provide training, education and support at each patient visit • The team continues to support the digital team implementation of Purpose T with an emphasis on staff awareness of individualising the skin integrity plan of care • Nerve centre photography continues to be implemented to support categorisation of pressure damage and clinical support to ward staff

2.5 Inpatient falls causing harm



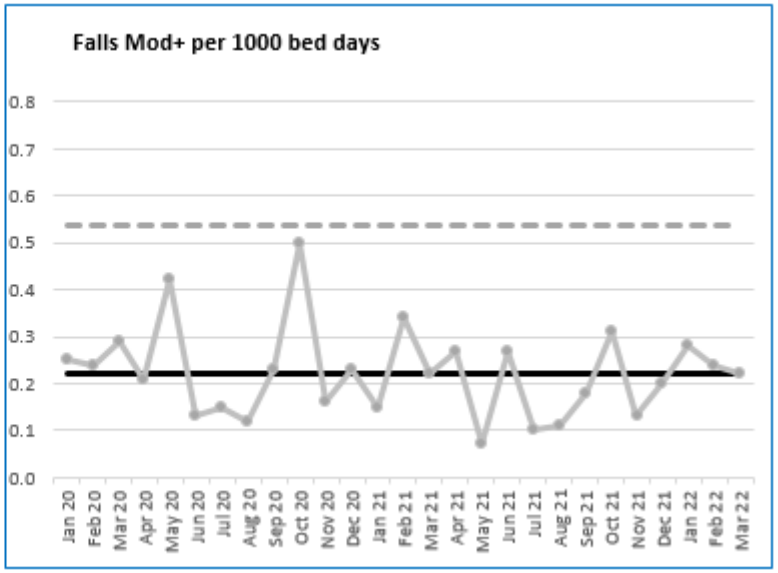
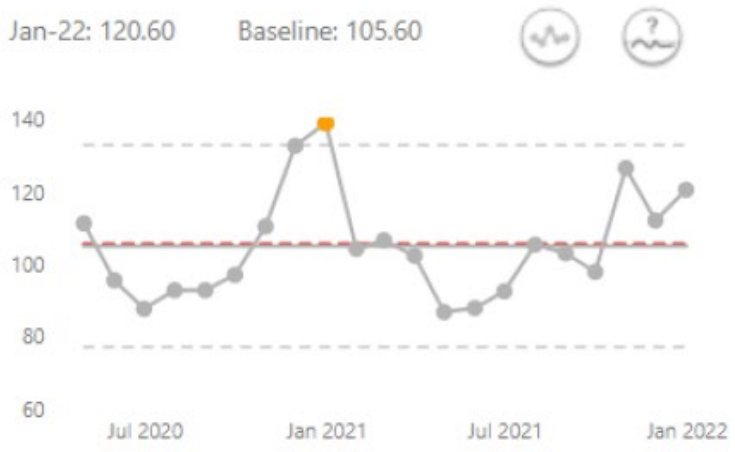


Chart Says:	• There were 7.5 inpatient falls per 1000 bed days recorded in March 2022 (n=56). • 0.22 (per 1000 bed days) inpatient falls resulted in moderate, severe or catastrophic harm to the patient. • There has been an upward trend in the number of falls being reported
Issues:	• The Trust is reporting a high number of inpatient falls however the number of falls resulting in harm remains low within control limits. • 3 of the falls met the criteria for serious incident investigation • Low staffing levels are having an impact on the number of falls occurring • The Elderly Medicine wards report the highest number of inpatient falls resulting in harm • The majority of falls reported are un-witnessed
Actions:	• Reduction of inpatient falls in patients who have a diagnosis of Dementia within the Department of Elderly Medicine continues has been introduced to develop a structured framework for the assessment and interventional care for this group patients, to understand the barriers that prevents the escalation of care for this group of patients and to improve situational awareness of safety concerns
Mitigations:	• The Trust Multi-Disciplinary Falls Committee continues to meet bi-monthly

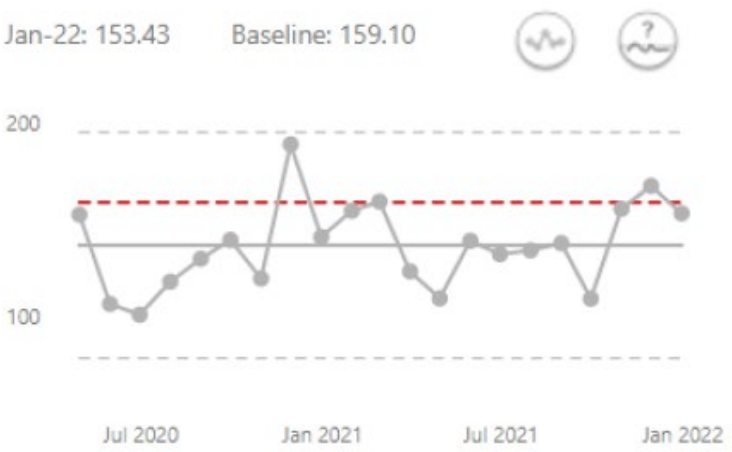
3. Performance Review – Effective

3.1 Mortality; HSMR and SHMI

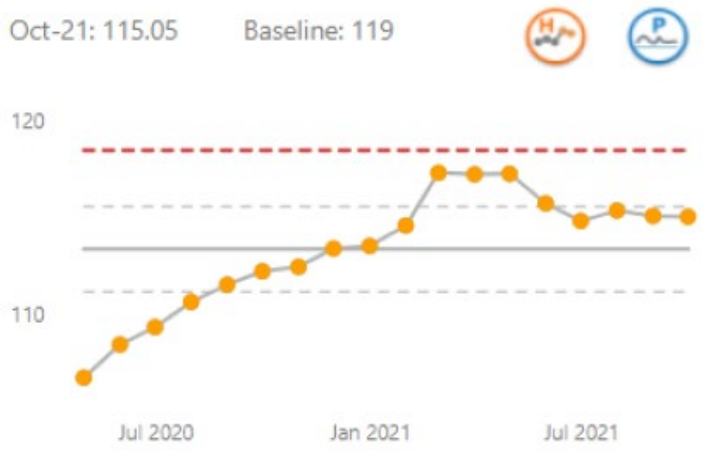
Hospital Standardised Mortality Ratio - monthly position



Hospital Standardised Mortality Ratio - Weekend



Summary Hospital Mortality Indicator (HSCIC)



Crude Mortality (non-elective admissions)

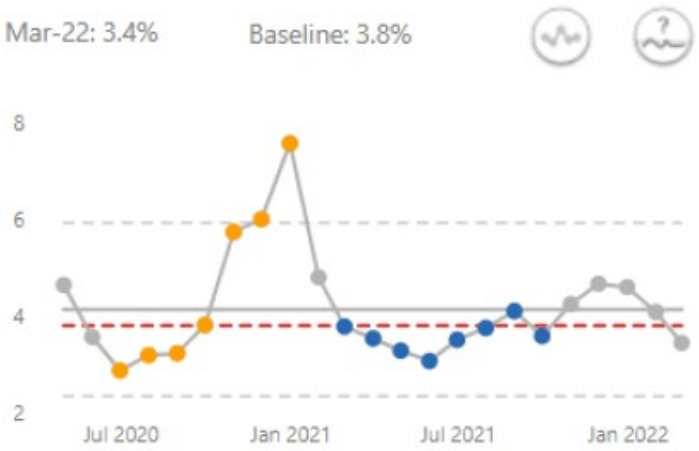


Chart Says:	Both HSMR monthly and weekend position have both increased as of January 2022, both are also above the England average of 100 and continues to highlight as an outlier. The SHMI continues to remain significantly above the England average of 100.0. This is highlighted as a high cause for concern. The Crude Mortality for Non-elective admissions had been increasing from July 2021 and was reported at is highest point of 4.6% in January 2022 compared against the England average of 3.2%. This was highlighted as a potential trigger in the NHS England SHMI report. However, the rate has since reduced to 3.4% in March, which is more in line with the England average.
Issues:	The Trust continues to be reported as an outlier in the CQC Insight Report for HSMR and SHMI. The Trust did experience an improved HSMR during 2021. The HSMR ratio returned within the Trust control limits and was below the England average of 100. However, CHKS have undertaking a rebasing exercise which has had a negative impact on the Trust's HSMR status and it is now showing back above the England average at 120.60. SHMI continues to be an outlier. Both these indicators are under investigation to understand the reasons and the Trust is also in discussion with CHKS regarding the reasons of the rebasing.
Actions:	The Mortality Task and Finish Group Led by the Chief Medical Officer continues to undertake in-depth analysis and improvement work on the high risk areas highlighted in the HSMR and SHMI data. A range of mortality indicators are monitored by the Mortality Dashboard Current areas of focus are Septicaemia, Lung Cancer, Pneumonia, Stroke, crude mortality for non-elective admissions and the CHKS rebasing of HSMR and SHMI data. The Mortality Task and Finish Group Update Report and the Q4 Learning from Deaths Report will both be presented to the July 2022 Trust Board.
Mitigations:	The group continues to meet twice-weekly to deliver the Mortality Improvement Plan following the internal HSMR review, which was also supported by external scrutiny by Dr Foster to address the Trust's Mortality Outlier status. This groups also reviews the HSMR and SHMI data in more detail to undertake improvement work in the key areas. This is being informed and supported by the development of an in-house Mortality dashboard and the completion of SJRs as well as other improvement actions as agreed by the group.

3.2 NICE

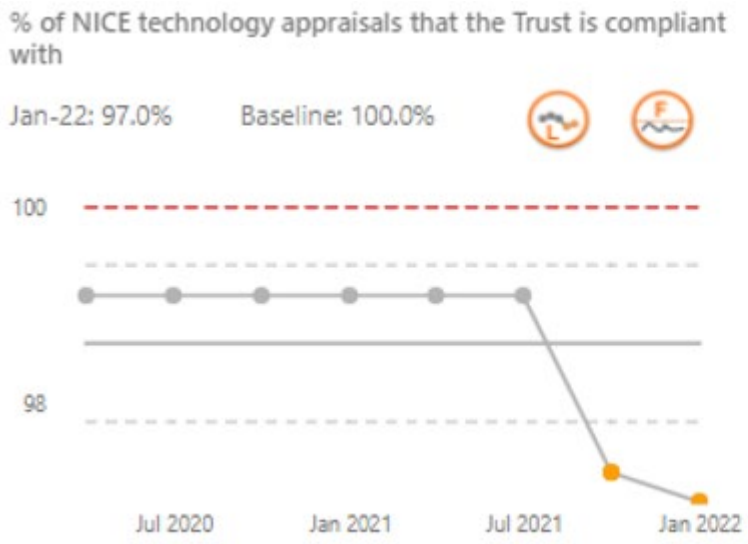


Chart Says:	The charts demonstrate a slight reduction in the number of NICE guidelines the Trust is demonstrating compliance with.
Issues:	The Trust is not reporting any non-compliance with the TAGS and IPGs. Summary is provided as follows: IPGS: The Trust has assessed and confirmed compliance with 26 IPGs and is in the progress of assessing compliance with 3 IPGs TAGs: The Trust has assessed and confirmed compliance with 63 TAGs and is in the progress of assessing compliance against 12 TAGS
Actions:	The Clinical Audit and Effectiveness Team continue to work with the Clinical Teams to finalise the assessment and determine compliance status. The outcome of these assessments will be presented to the Health Group Specialty Governance Meetings and to the Clinical Audit Effectiveness, Policies and Practice Development Committee.
Mitigations:	There are no risks associated with these assessments in progress.

a. National Audits

3.3.1 National Audit Outlier Alerts

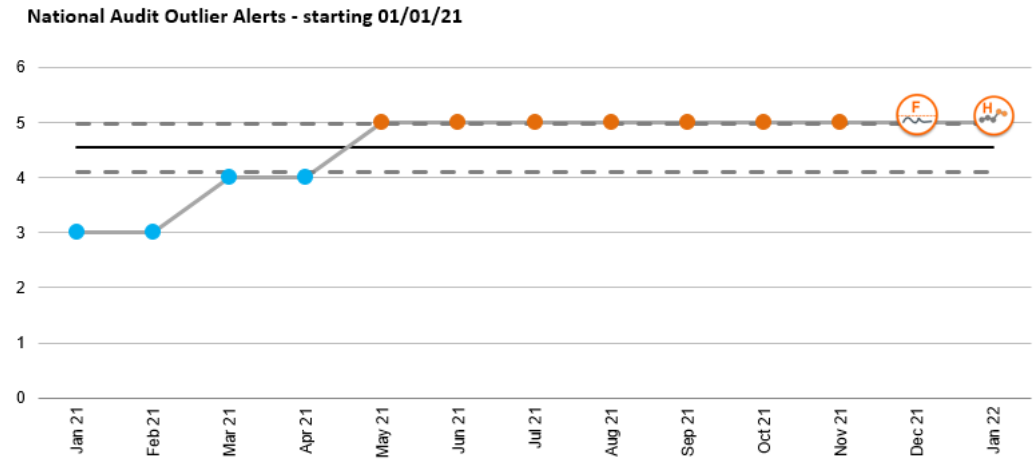


Chart Says:	The Trust continue to be an outlier against 5 National Audits, these are:
	• National Lung Cancer Audit, 2021, alarm (3sd), Pathological confirmation in patients with stage I/II and performance
	• National Paediatrics Diabetes Audit, alarm level outlier 'Case-mix adjusted mean HbA1C'
	• National Bowel Cancer Audit (2018/19 patients):
	  ○ 'Insufficient data - 30-day emergency readmission' outlier;
	  ○ 'Insufficient data - 90-day mortality' outlier; and
	  ○ 'Insufficient data - Two-year survival' outlier.
	• National Joint Registry (NJR) Hip Replacements - Castle Hill Hospital's revision rate for hip replacements lies outside the 99.8% control limits
	• National Neonatal Audit Programme (NNAP)

Issues:	The Trust's position against the number of National Audit Outliers has not reduced and the same areas are highlighting as outlier. Although some of the data detailed in the audits is out dated, the Trust is still in the process of undertaking the required improvement work; however, the impact of this improvement work will not be noted until another two/three National Audits as they are still reporting on outcomes between 2018 and 2021. In summary: • National Lung Cancer Audit - assurance was received at the April 2022 Patient Safety and Clinical Effectiveness Committee regarding the improvements that have been achieved and the ongoing work; however, it was noted that due to the 2022 data bring Network only it is currently difficult to compare nationally and to determine any further outlier status.

	• National Paediatrics Diabetes Audit - The main concern is linked to the use of pumps. This area has not been fully addressed as yet but work is underway with the Quality Improvement Team and a process map has been completed of the whole process • National Bowel Cancer Audit – Improvements have been highlighted in the 2019/2 data reviewed. The latest data submission is for 2019/20 TNM = 97.7% complete and ASA = 92.4% complete (122 out of 132 records with a completed ASA). There has also been an increase in the number of patients seeing the Clinical Nurse Specialist. • National Joint Registry (NJR) Hip Replacements – A review against the required cases over the last 5 year period was undertaken by the team. Although HUTH has been identified as an outlier, this may have been contributed to by a high complexity of cases, due to routine work being taken to the private sector, and referrals into our unit. The proportion of possibly avoidable revisions appeared to be low with no repeating concerns amongst the consultant body. • National Neonatal Audit Programme (NNAP) Parental consultation within 24 hours of admission – The team complete a review against 416 eligible cases. The outlier status identified the Trust as 90.9% complaint with consultation within 24 hours of admission. The review highlight some data quality issues and was able to complete the missing data, improving the quality of data submitted which confirmed that 93.2% received consultation within 24 hours of admission, which is an improvement and would not have triggered the alert. The review has also identified some improvement work which the service are now undertaking.
Actions:	Improvement work is underway in all outlier areas. A full update against the outlier status is required to be provided to the CQC with the request that the outlier status is reviewed locally to determine whether the outlier status can be removed in response to the work being undertaken.
Mitigations:	The latest National Audit Outlier Report was presented to the April 2022 Patient Safety and Clinical Effectiveness Committee and the Quality Committee. Presentations from the Clinical Leads was also received against the National Lung Cancer at the April 2022 Patient Safety and Clinical Effectiveness Committee. The other National Audit Outlier Clinical Leads are invited to present their improvement work to the June 2022 Patient Safety and Clinical Effectiveness Committee. Progress against all outliers will be monitored there and reported to the CQC through the Trust's routine Engagement Meeting arrangements.

3.3.2 National Audit

During 2021/22, 46 national clinical audits covered NHS services that Hull University Teaching Hospital NHS Trust provides. During that period HUTH participated in 89% of national clinical audits, which it was eligible to participate in. This will be reported on in the Quality Accounts which is due to be published by 30 June 2022. The applicable audits that the Trust did not participate in are:-

National Audit
Inflammatory Bowel Disease Programme / IBD Registry
National Outpatient Management of Pulmonary Embolism
National Smoking Cessation 2021 Audit
Cytoreductive Radical Nephrectomy Audit
Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)

b. Local Audit Plan – Audits Overdue

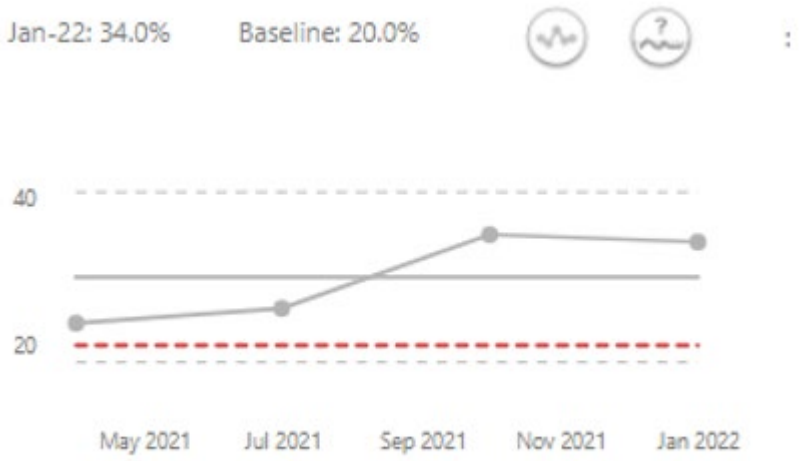


Chart Says:	In 2021/22 there were 286 audits approved and as of the end of January 2022 34% (98) of those were overdue completion.
Issues:	The COVID-19 pandemic had an impact on the number of audits being completed, with many scheduled to complete on 31 March 2022. The majority of non-essential tasks were stood down to ensure the clinical members of staff could purely focus on their clinical commitments.
Actions:	Those audits which have not been completed are continuing to be followed up to ensure completion.
Mitigations:	This does not pose a risk to the organisation, these audits are locally agreed and all priority audits will be reviewed and added to the 2022/23 Audit Plan.

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	10 May 2022
Title	Maternity self-assessment tool				
Lead Director	Joanne Ledger 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 Committee is requested to:

- **Receive the report findings**
- **Decide if any further information and/or assurance are required.**

Hull University Teaching Hospital NHS Trust
Maternity self-assessment tool

Executive Summary

The Maternity Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the Trust Board and Commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool, version 6 July 2021, has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme, the Kirkup Report (2015) and the areas CQC found to be outstanding in other maternity services across England.

Findings

Out of the 167 evidential requirements below there are 120 (72%) have been rated green with the ability to provide supporting evidence. A further 35 (21%) have been rated Amber and 12 (7%) are red. A subsequent action plan will provided to support the progression of these evidential requirements.

Recommendations

The Trust Board of is asked to note the self-assessment (Appendix 1) and to consider whether the assurance mechanism within the Trust are effective and, with the local maternity system (LMS).

Appendix 1

This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

Please use this tool to as a benchmark for your organisation in the core principles of good safety standards within Maternity services.

The tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		Triumvirate organogram
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		Organogram/ Divisional Structure
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		HoM JD under review by Chief Nurse
		Agenda for change banded at 8D or 9		HoM JD under review by Chief Nurse
		In post		HoM JD under review by Chief Nurse
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		Job Descriptions

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Clinical director to executive medical director		
		DoM to executive director of nursing		HoM JD under review by Chief Nurse
		General manager to executive chief operating officer		Ops Director reports to the COO
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockenden learning actions		Maternity reports shared at Trust Board. PMRT ATAIN ¼ - PQSAG report CNST – updates Ockenden updates
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Quarterly Report as Trust Board do not meet monthly. Monthly by the Health Group.
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Quarterly Report as Trust Board do not meet monthly Monthly by the Health Group
		There should be a minimum of three PAs allocated to clinical director to execute their role		2PA allocated to Clinical Director and 1PA allocated to Clinical Lead
	Collaborative leadership at all levels	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		Organogram/ Divisional Structure

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	in the directorate/ care group	Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate		Weekly Triumvirate meetings with HR support
		Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		Monthly meetings with midwifery sisters
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		Senior financial manager in post, present at weekly triumvirate meetings
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		Established pre-covid but needs re-launching. Establishment reviews in place as part of annual budget setting.
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		Weekly patient safety Maternity Case Reviews Monthly PMRT Speciality Governance meetings

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly		Speciality Governance Health Group Governance FWHG Board ¼ LMS wide PQSAG ¼ MVP meetings Labour ward forum Maternity Safety Learning events CNST meetings Fortnightly Ockenden Meetings Weekly Maternity Case Review Monthly PMRT meetings
		Leadership culture reflects the principles of the '7 Features of Safety'.		
	Leadership development opportunities	Trust-wide leadership and development team in place		Great Leaders Programme, rise and shine programme, Great Leaders Supervisors Plus and T2 Talks Leadership New STAND Programme External Baby Lifeline Training

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		In-house or externally supported clinical leadership development programme in place		Great Leaders Programme, rise and shine programme, Great Leaders Supervisors Plus and T2 Talks Leadership New STAND Programme External Baby Lifeline Training
		Leadership and development programme for potential future talent (talent pipeline programme)		
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		Do not have bespoke leadership development for clinicians
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		Trust Organogram
		Organisational vision and values in place and known by all staff		Trust Vision and Values
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		Trust Vision and values and HR Policies

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		HUTH maternity service has a Maternity Safety and Culture Policy under review) LMS are in the process of developing an LMS wide strategy in collaboration with MVPs. Trust needs to develop its own Maternity Strategy that aligns to LMS Strategy
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		HUTH maternity service has a Maternity Safety and Culture Policy under review) LMS are in the process of developing an LMS wide strategy in collaboration with MVPs. Trust needs to develop its own Maternity Strategy that aligns to LMS Strategy

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.		HUTH maternity service has a Maternity Safety and Culture Policy under review) LMS are in the process of developing an LMS wide strategy in collaboration with MVPs. Trust needs to develop its own Maternity Strategy that aligns to LMS Strategy
		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 [Ockenden Assurance]		Two active MVP Hull and East Riding
		Maternity strategy aligned with trust board LMNS and MVP's strategies		
		Strategy shared with wider community, LMNS and all key stakeholders		
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		Job description in place
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Safety Champion meetings minutes, papers and presentations
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)		Due to the COVID-19 Pandemic
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		Minutes of meetings
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]		Safety Champions poster and email address

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans		¼ LMS wide PQSAG ¼ MVP meetings Labour ward forum Maternity Safety Learning events CNST meetings Fortnightly Ockenden Meetings Weekly Maternity Case Review Monthly PMRT meetings Clinical Expert Group
		Record of attendance by professional group and individual		Minutes of meetings
		Recorded in every staff member's electronic learning and development record		HEY 247
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		Mandatory training programme is set to the new standards
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		TNA needs to be completed for all staff
		All staff given time to undertake mandatory and job essential training as part of working hours		During the pandemic some training has been cancelled due short term staffing sickness
		Full record of staff attendance for last three years		PQSAG report
		Record of planned staff attendance in current year		PQSAG report
		Clear policy for training needs analysis in place and in date for all staff groups		TNA needs to be completed for all staff

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Compliance monitored against training needs policy and recorded on roster system or equivalent		Recorded on eroster and Hey 247 – need to develop TNA policy for maternity
		Education and training compliance a standing agenda item of divisional governance and management meetings		Needs to be added as a standard agenda item
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		PROMPT training slides and records
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		TNA needs to be completed for all staff
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		JD
		Compliance with annual appraisal for every individual		During the pandemic some annual appraisals have been cancelled
		Professional validation of all relevant staff supported by internal system and email alerts		Internal notification system in place
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		During the pandemic some annual appraisals have been cancelled
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		Minutes of meeting/attendance
	Multiprofessional clinical forums	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups		HR policies

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Multiprofessional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		Values Base recruitment training and electronic online VBR recruitment system
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures		
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints		Developing in service (After Action Reviews) Trauma Risk management (TRiM) training
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		Provided by the clinical leaders/PMAs and governance team
		Schedule of attendance from multiprofessional group members available		Minutes of meetings/action
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.		
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		Service users have been used for recruitment at HUTH
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		MVP work plan
	Collaborative multiprofessional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility		Ockenden work plan
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		Action plan and improvements
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		
		Clear communication and engagement strategy for sharing with key staff groups		An LMS wide Strategy to be developed
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		
		Weekly/monthly scheduled multiprofessional safety incident review meetings		
	Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		Annual National Patient safety Day
		Positive and constructive feedback communication in varying forms		Moments of magic, compliment letters, MCR positive feedback letters
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		SoP needs to be developed. Happens informally at present.
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		
		Schedule of focus for behavioural standards framework across the organisation		
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		Needs to be focus each month
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		Accepted responsibility process and robust HR policies
		All policies and procedures align with the trust's board assurance framework (BAF)		
Governance infrastructure and	**System and process clearly defined and**	Governance framework in place that supports and promotes proactive risk management and good governance		Maternity Risk Management Policy

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
ward-to-board accountability	**aligned with national standards**	Staff across services can articulate the key principles (golden thread) of learning and safety		
		Staff describe a positive, supportive, safe learning culture		More improvement work (ward to Board)
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		HUTH do not currently have dedicated PA time for governance support to reflect Ockenden recommendation
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills)		Do not have min 2PA Consultant or Maternity Risk Manager
		Maternity clinical incident leads		3 senior midwives trained Baby Lifeline.
		Audit midwife		Part of Clinical Governance Midwife role.
		Practice development midwife		
		Clinical educators to include leading preceptorship programme		
		Appropriate Governance facilitator and admin support		Health Group Quality Facilitators & CD admin support. Specific maternity to be clarified.
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		ToR and JD
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales		Room for improvement post-covid.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		Maternity Safety and Culture Policy.
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		PQSAG report
		Mechanism in place for trust-wide learning to improve communications		
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		
		Governance communication boards		Not in all areas
		Publicly visible quality and safety board's outside each clinical area		Not in all areas
		Learning shared across local maternity system and regional networks		PQSAG meetings Maternity Safety Learning Events
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		Do not have a Trust wide Communication Strategy
		Multi-agency input evident in the development of the maternity specification		Do not have a Trust wide Communication Strategy
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		
		In date and reflective of local maternity system plan		
		Full compliance with all current 10 standards submitted		Achieved CNST year 3

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		Achieved CNST year 3
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		LMS delivery Board
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines		Minutes of meetings/actions/attendance
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.		
		All guidance NICE complaint where appropriate for commissioned services		
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		
		All five elements implemented in line with most updated version		
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan		
		All four key actions in place and consistently embedded		
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy		Focus on CoC for BAME and deprivation. HUTH have a BAME guideline in place
		All actions implemented, embedded and sustainable		Focus on CoC for BAME and deprivation. HUTH have a BAME guideline in place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Implementation of 7 essential learning actions from the Ockenden first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		In post on e-roster JD Training attendance records
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		Currently 0.5PA
		Plan in place for implementation and roll out of A-EQUIP		
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		Need to have a documented plan for A-EQUIP
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		HUTH have 7 practicing PMAs and 2 currently in training
		Service provision and guidance aligned to national bereavement pathway and standards		HUTH were a pilot for the bereavement care pathway
	Maternity bereavement services and support available	Bereavement midwife in post		2 in Post – one on Mat leave
		Information and support available 24/7		Currently have 28hrs in service due to maternity leave. Will have 6 days cover following maternity leave
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		Room 9 on labour suit Quiet room in ANC Fetal medicine facilities
		Quality improvement leads in place		JD

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		
		Recognised and approved quality improvement tools and frameworks widely used to support services		
		Established quality improvement hub, virtual or otherwise		
		Listening into action or similar concept implemented across the trust		
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.		
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		LMS are developing an LMS wide strategy
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)		
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		
		FTSU guardian in post, with time dedicated to the role		
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		Clinical simulation do have to human factors consultants – they presented at the patient safety conference last year. HUTH want to provide more training in this area in line with Ockenden
	Human factors training available	Human factors training part of trust essential training requirements		PROMT
		Human factors training a key component of clinical skills drills		PROMT
		Human factors a key area of focus in clinical investigations and formal complaint responses		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.		System in place for formal handovers and safety huddles. CG1 an audit undertaken
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		SoP in place
		Audit of compliance against above		CG1 and audit
		Annual schedule for Swartz rounds in place		HUTH have subscribed to Swartz round HoM has been on a Swart round as a panel member

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Trust wide Swartz rounds	Multiprofessional attendance recorded and supported as part of working time		Trust dates and evidence of attendance
		Broad range of specialties leading sessions		Trust dates and evidence of attendance
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		Trust dates and evidence of attendance
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		Annual events
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		
		In date business plan in place		
Comprehension of business/ contingency plans impact on quality. **(i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance		
		Business plan supports and drives quality improvement and safety as key priority		
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		birth rate plus report 2021
		Consultant job plans in place and meet service needs in relation to capacity and demand		Further work required on job plan compliance and ensuring appropriate PAs allocated for quality, safety & governance.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		No consultant lead for governance and EPAU
		Business plans ensures all developments and improvements meet national standards and guidance		
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		Infant Feeding Smoking cessation Screening Obesity prevention Immunisation
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		Infant Feeding Smoking cessation Screening Obesity prevention Immunisation

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18
Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Key supporting documents and reading list

1. NHS England National Maternity review: Better Births. February 2016; https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2. Royal College of Obstetricians and Gynaecologists Maternity Standards 2016; https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf

3. NHS England NHS Long Term Plan: January 2019; https://www.longtermplan.nhs.uk/

4. Report of the Investigation into Morecambe Bay March 2015; https://www.gov.uk/government/publications/morecambe-bay-investigation-report

5. Royal College of Midwives. Birth-rate plus tools; https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf

6. Royal College of Midwives State of Maternity Services 2018; https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf

7. NHS England. Spotlight on Maternity: Safer Maternity care. 2016; https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

8. Department of Health Safer Maternity care. The National Ambition. November 2017; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf

9. NHS Resolution. Maternity Incentivisation Scheme 2019/20; https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

10. NHS staff survey. (2018); https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

11. Maternity Picker Survey. 2019; https://www.picker.org/wp-content/uploads/2014/10/Maternity-4-pager-for-website-ARe-V2-18122018.pdf

12. National Maternity Perinatal Audit. (NMPA) report; https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XdUiX2pLFPY

13. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (MBRACE) report; https://www.npeu.ox.ac.uk/mbrrace-uk

14. Organisations Monthly Maternity Dashboards; https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

15. Organisational Maternity and Neonatal Cultural Score Survey; https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf

16. NHS England Saving babies lives Care bundle. V2 March 2019; https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

17. 7 Features of safety in maternity services framework; https://for-us-framework.carrd.co/

18. Ockendon Report: investigation into maternity services at Shrewsbury and |Telford NHS hospitals 2020; https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

19. Perinatal Surveillance Model; https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

20. Maternity Incentive Scheme; https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf

Agenda Item	8.1.2	**Meeting**	Quality Committee and Trust Board	**Meeting Date**	26 April and 10 May 2022
Title	**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**				
Lead Director	Joanne Ledger Chief Nurse				
Author	Lorraine Cooper Head of Midwifery				
Report previously considered by (date)	Quality Committee				

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

Key Recommendations to be considered:

The Committee is requested to:

- Receive the report findings
- Decide if any further information and/or assurance are required.

Hull University Teaching Hospital NHS Trust

Avoiding Term Admissions into Neonatal Units (ATAIN):
Learning from Term Admissions Quarter 3

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. This report will update progress from Hull University Teaching Hospital NHS Trust in regards 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"*. Furthermore this report will focus on an action plan to address local themes from Avoiding Term Admissions into Neonatal unit reviews, this will be agreed with the Maternity and Neonatal Safety Champions and Board level champion.

The Aim of the ATAIN program is designed to reduce the avoidable causes of harm that can lead to infants born at term (at or over 37 weeks' gestation) being admitted to the Neonatal Unit. Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the ATAIN work to date. The case reviews of unanticipated term admissions to the NNU to determine whether there were modifiable factors, which could be addressed, as part of an action plan has been continuing throughout the recent covid 19 pandemic.

The National target for term admissions into a NNU per 1000 birth is < 5 % with the previous target aimed to reduce the number of term admissions into a NNU per total admissions by 20% by 2020. At Hull University Teaching Hospital NHS Trust the aim to reduce the number of term admissions into the neonatal unit to meet the stretch trajectory.

In Quarter 3 the auditors for this report have focused on the primary reason for admission with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed, in order to develop the action plan.

In addition year 4 of CNST, Trusts are required to report on the number of babies admitted to the NNU that would have met current Transitional Care (TC) admission criteria, but were admitted to the NNU due to capacity or staffing issues. In addition the number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.

Hull University Teaching Hospitals - Current position

As demonstrate by table 1 they has been a decrease in the number of Term Admissions to NNU since 2016. **Table 1** highlights the number admissions to the NNU during the commencement of the ATAIN programme.

Table 2 shows the current position for the year 2021 in Quarter 1 (01/04/21- 30/06/21) 3.1 % and Quarter **2** (01/07/2021- 30/09/21) 3.0 %. Quarter **3** 2.6%.

Table 1

Year	In born term admissions	% of total NNU admissions	% of Term admissions to NNU
2016	191	39.6%	4.1%
2017	186	37.7%	3.9%
2018	154	35.2%	3.3%
2019	175	35.5%	3.1%
2020	159	33.3%	3.2%
2021	187	39.9%	2.6%

Table 2

Duration	In born admissions	% of total NNU	% of term admissions
Quarter 1 2021	1250	33.4%	3.1%
Quarter 2 2021	1450	35.6%	3.0%
Quarter 3 2021	1282	45.2%	2.6%

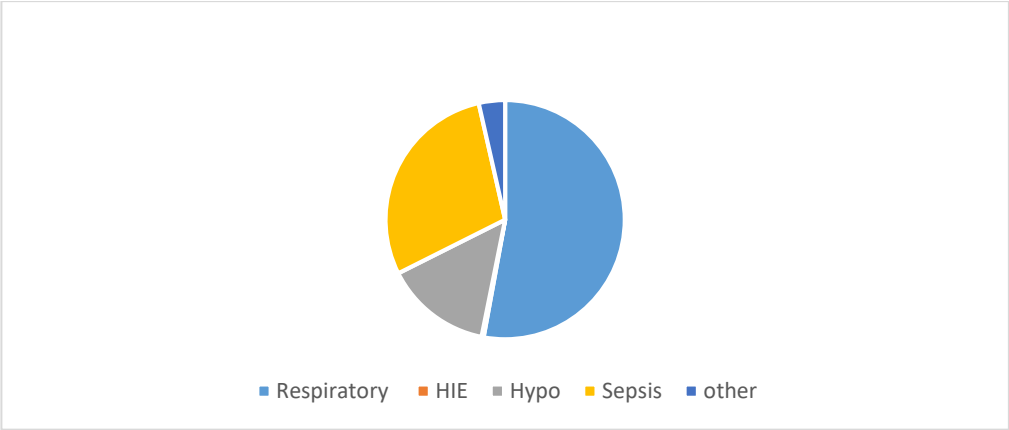
All unexpected term admissions to NNU are reported through the DATIX system and investigated through the weekly Maternity Case Review multi-disciplinary meeting. The CNST approved template ATAIN proforma is completed for data collection purposes. The themes, trends and learning points are shared amongst all clinical staff from both Maternity and Neonatal services. In addition an online training package is available on the Trust HEY 24/7 educational platform which is required learning for all midwives which covers these learning points.

A high-level review was completed of the primary reasons for all admissions, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. Firstly the focus was on gestation as demonstrated below 38% of the cohort of babies are 37+0 – 37+6 weeks gestation. A deep dive was then completed to identify the primary reasons for admission from this cohort of babies as recommended in the technical guidance for CNST year 4. The review then focused on area of admission.

Gestation

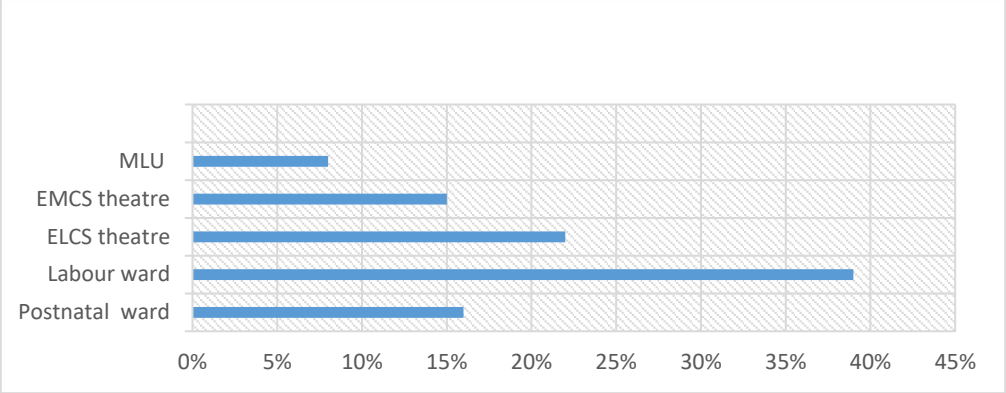
In quarter three 48 Unexpected Term Admissions to NICU cases have been reviewed through Maternity case review compared to 89 cases in quarter two. Themes identified are presented below. The average gestation at admission to NICU was 37+0 - 37+6 weeks

The primary reason for admission at gestation 37 +0 – 37 + 6 to NNU was for respiratory support requiring Continuous positive airway pressure (CPAP)**.**



Admission Location

Babies were most commonly admitted to NICU from the labour ward and theatre. Within the action plan the Neonatal team have identified through this review that that this cohort of babies are admitted to NNU for a short period and are soon returned back to the mothers. The Neonatal team will be trialling a new quality improvement initiative starting in February 2022, which involves using the lifestyle platform at the bedside on labour ward which in turn should reduce the number of babies admitted to NICU on CPAP.



Preventable admission – Perinatal management
It has been identified that changes in the perinatal management may have prevented admission to NICU. Most common mode of delivery for admission to NNU was Emergency Caesarean Sections. As babies born by this mode can struggle with adaptation and in view of National recommendation a baby should be placed skin to skin at least until after the first feed and for as long as the mother wishes. This is currently not standard practice with this mode of delivery within a theatre situation therefore this has been added as a quality improvement within the action plan.

Birth Weight
The most common birth weight range at admission to NICU was 3.0 – 4.4kg.

Length of NICU stay
The length of stay on NICU was most commonly between 1 -3 days.

Category of care
The most common category of care at admission to NICU was Intensive Care Level 3.

Suitability for transitional care
The number of babies admitted to the NNU that would have met current Transitional Care admission criteria but were admitted to the NNU is 8 compared to 11 in quarter 2 and the number of babies that were admitted to, remained on NNU because of their need for nasogastric tube feeding is 0. It has been identified the bed capacity on the transitional care is the reason in all 8 cases.

The themes as identified above were reviewed and the following action plan agreed through multidisciplinary discussion. Compliance with the below action plan will be monitored regularly through the weekly Maternity Case Review meeting. A copy of this report will be shared through the Obstetric Governance meeting and, the Family, and Women's Health Group Governance meeting. It will also be shared with the Executive Maternity Safety Champion and the Neonatal Safety Champion. An update of progress on this action plan will be reported via the Health Group Governance process

Jayne Gregory - Clinical Governance Midwife
Dr Helen Yates - Neonatal Consultant (ATAIN program lead)
February 2022

Action	Lead	Status
Review of 'Respiratory management of the infant' guideline to ensure high standard of practice standardised	Consultant Neonatologist	Completed
Consideration for development of a criteria for admission to NICU to avoid unnecessary admissions	Consultant Neonatologist	Completed
Development of a Robust system in order to collect data on all Avoidable Term admissions to NNU	Neonatal consultant and Clinical Governance Midwife Local Maternity System	Completed
Respiratory management platform to be trialled for respiratory support (CPAP) at the bed side on labour ward	Neonatal consultant	April 2022
Traffic light system	Clinical Governance Midwife	May 2022
To embed practice of skin to skin at EMCS/ELCS	Labour ward coordinators Infant feeding co coordinators	April 2022

Agenda Item	8.1.3	**Meeting**	Quality Committee and Trust Board	**Meeting Date**	26 April and 10 May 2022
Title	**Perinatal Quality Surveillance Report Q4**				
Lead Director	Joanne Ledger Chief Nurse				
Author	Lorraine Cooper Head of Midwifery				
Report previously considered by (date)	Quality Committee				

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

Key Recommendations to be considered:

The Committee is requested to:

- Receive the report findings
- Decide if any further information and/or assurance are required.

PERINATAL QUALITY SURVEILLANCE TOOL
April 2022

1.0 INTRODUCTION

The following document provides a monthly update on key measurements, as detailed in the NHSI/E report on the revised requirements for perinatal quality surveillance tool.

2.0 CQC MATERNITY RATINGS

	Safe	Effective	Caring	Responsive	Well Led	Overall
Maternity	Good	Good	Good	Good	Good	Good

In June 2018, the CQC undertook a full inspection of both the Castle Hill Hospital & Hull Royal Infirmary sites and achieved an overall rating of 'Requires Improvement'. Within this inspection, Maternity Services received an award of 'Good' against the five domains – safe, effective, caring, responsive and well led.

In March 2020, the CQC returned to repeat their inspection however due to the COVID-19 pandemic this inspection was suspended to relieve pressure on the healthcare systems. Maternity Services had not been inspected by this point, and therefore the rating of 'Good' remains in place. With an overall trust rating of 'Requires Improvement'.

3.0 REVIEW OF PERINATAL DEATHS

The following provides numbers of perinatal deaths using the real time data-monitoring tool.

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
2	3	0									

In January to March 2022 we reported:
79329 37+5 Stillbirth
79668 28+6 Neonatal Death
79978 25+0 Neonatal Death
79996 34+3 Stillbirth (Twin pregnancy – 1 x stillbirth, 1 x livebirth)
80160 37+3 Stillbirth

PMRT meeting update March 2022:

MBRRACE ID	Stillbirth/ Neonatal Death	Grading	Actions / Good practice
77473	NND		Joint review with York- delayed due to requirement for joint review
78076	NND 23 weeks		Complete - pre-published
79153	NND 26 weeks		Returned from Lincoln - to complete
79668	NND 28 weeks		In progress
79978	NND 25 weeks		Commenced
MBRRACE ID	***Stillbirth/ Neonatal Death***	***Grading***	***Actions / Good practice***
79329	37+5 week stillbirth		To agree
79996	Twin SB and LB 34 weeks		To commence
80160	37 week stillbirth		to commence

4.0 HSIB REFERRALS

The following provides numbers of HSIB referrals made:

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
0	0	0									

There are two completed reports from Q4.
MI 004482 - Safety recommendations: The Trust to ensure staff are encouraged and supported to utilise the emergency buzzer system when a fetal bradycardia occurs

MI 004025 - Safety recommendations : The Trust to ensure that staff are supported to perform a category 1 caesarean birth as soon as possible, and in most situations within 30 minutes of making the decision (NICE, 2011, amended 2021). 2. The Trust to ensure placentas are sent for pathological examination including histology in line with national guidance (RCPath, 2019)

5.0 INCIDENTS

The following provides the number of incidents reported:

Severity	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
Moderate	0	0	1									
Major	0	0	0									
Catastrophic	0	0	0									

W255219 - Safeguarding – Baby noted to have unexplained bruising. Safeguarding referral completed but no immediate escalation of baby.

Themes & Actions

There are no overriding themes from the moderate incidents reported.
There was one Serious Incident declared in March

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
0	0	1									

6.0 TRAINING COMPLIANCE

Obstetric Emergencies (PROMPT)

Area	No of Staff	In date	% Perf
Obstetric Cons, Ass Spec	15		
	15	12	80%
Obstetric Registrar	12		
Obstetric SHO	12		
	24	14	58%

Anaesthetic Consultant	7		
	7	5	71%
Anaesthetists*	16		
	16	11	69%

Labour & Del. MW	39	30	
Community	42	29	
Specialist Senior Midwives	19	17	
Maple & Rowan Ward Core Midwives	30	23	
MLU Midwives	42	31	
Bank Midwives	4	6	
ANC - W&C Midwives	36	33	
	212	169	80%

Labour & Del. MW Assist	8	7	
Community MW Assistants	4	3	
Maple & Rowan Ward Midwifery Assistant	29	20	
MLU MW Assistant	14	8	
Bank Midwife Assistant	2	1	
ANC - W&C Midwives Assistant	7	10	
	64	49	77%

ODA-Ps	28	23	
Gynae Theatre Nurses	15	11	
	43	34	79%

Total No. Staff	381	294	74%

CTG Training

Staff have to complete K2 competency assessments in Fetal Physiology, Intrapartum CTG & Intrapartum Intermittent Auscultation with a pass mark of >85%. Compliance is as below for completion of the competency assessment.

A number of staff have fallen outside of their 1-year repeat requirement. All out-of-date staff have been emailed with a reminder to complete by the end of September 2021. Anyone remaining non-compliant will be escalated for performance management by the Manager.

ACTUAL PERFORMANCE TO DATE				
Area	**No of Staff**	**In date**	**% Perf**	
Obstetric Cons, Ass Spec	14			
	14	10	71%	
Obstetric Registrar	11	9	82%	
Obstetric SHO	12	6	50%	
	23	15	65%	
Labour & Del. MW	41	35	85%	
MLU Midwives	40	35	87%	
Community	36	28	77%	
Specialist Snr Midwives	16	12	75%	
Maple & Rowan Midwives	28	15	53%	
Bank Midwives	6	2	33%	
ANC Midwives	37	29	78%	
	204	156	76%	

Neonatal Resuscitation

It is a mandatory requirement for all Midwifery staff to complete the Newborn Life Support (NLS) Course at least once and to undertake a neonatal resuscitation update annually (delivered by an NLS trained instructor).

ACTUAL PERFORMANCE TO DATE			
Area	No of Staff	In date	% Perf
Neonatal Consultant	10	4	
	10	4	40%
Neonatal Registrar ANNP	12	9	
Neonatal SHO	5	4	
	17	13	76%
Specialist Snr NICU Nurses	8	4	
NICU Nurses	94	65	
NICU Bank Nurses	0	0	
	102	69	68%
Labour & Del. MW	38	25	
MLU Midwives	35	24	
Community	44	34	
Specialist Snr Midwives	24	14	
Maple & Rowan Midwives	25	13	
Bank Midwives	6	4	
ANC Midwives	39	32	
	211	146	69%

7.0 MINIMUM SAFE STAFFING LEVELS

HUTH in line with national guidance has undertaken a Birthrate plus assessment using three months casemix data for the months of April to June 2021. The Birthrate plus Workforce Planning system provides Hull University Teaching Hospitals NHS Trust Board and Committee with a detailed breakdown of the number of midwives required for each area of service in both hospital and community. It also provides each service with its own individual ratios of hospital births per whole time equivalent midwife and the number of cases and home births per wte community midwife.

This allows each service to apply its own allowances for holiday, sickness and study leave and for time spent in travel by community staff. A 21.6% uplift was applied to cover annual, sickness and study leave has been included in the staffing calculations, and 12.5% travel allowance.

The report identified the percentage of women in Categories IV and V has increased from the 2018 data, and most noticeably in Category V (High category). The Delivery Suite casemix has 74.3% in the 2 highest categories whereas in 2018, it was 66.5% of which 35.8% was in IV and 30.7% in V, an increase of 7.8%. The higher the casemix, the more clinical staffing is required to ensure women receive 1 to 1 care in labour and delivery as a minimum but also to provide additional support as necessary.

	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2021 DS % Casemix	7.9	14.3	3.5	35.4	38.9
	25.7%			74.3%	
2018 DS % Casemix	33.5%			66.5%	
2021 Generic % Casemix	11.8	21.3	3.0	30.5	33.4
(Includes Birth Centre)	36.1%			63.9%	
2018 Generic % Casemix	42.0%			58.0%	

Casemix Table 1

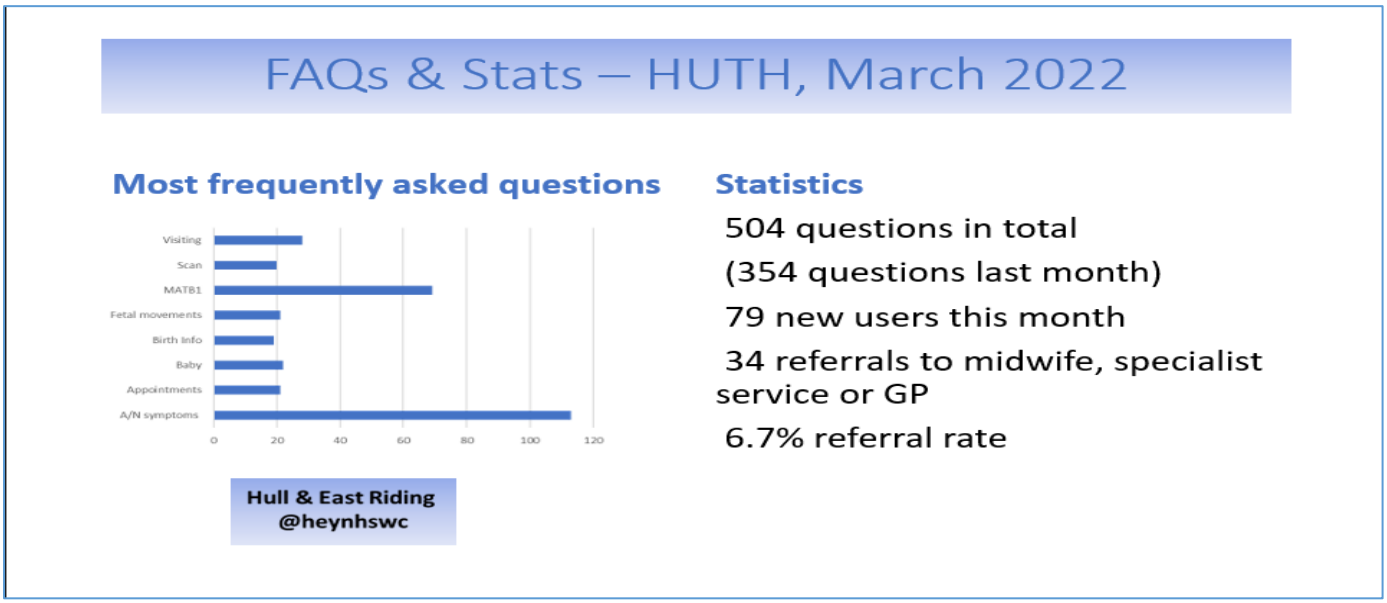
The 2021 Birthrate Plus Report identified Annual Activity based on the FY 2020/2021 total births has fallen to 4814 total birth rate, however women have been identified has having more complex health needs falling into category IV and V and thus requiring an increase in midwifery hours.

Birth Rate Plus Red Flags
Maple Ward – 0 red flags were reported from Jan – March 2022
Rowan Ward – 0 red flags were reported from Jan – March 2022
Fatima Allen Birth Centre – 0 red flags were reported from Jan – March 2022
Labour ward – 8 red flags reported from Jan – March 2022:

- 5 of these were missed / delayed care
- 1 delay between admission and triage
- 1 delay in pain relief
- 1 Labour ward Co-Ordinator not supernummary

8.0 SERVICE USER VOICE FEEDBACK

Information from the 'Ask a Midwife' service at HUTH for March 2022.



Safer Sleep week is coming! 14th-20st March

- The theme this year is: the digital world. The aim is to remind parents and carers about simple and easy to follow safer sleep advice rather than following hints, tips and hacks on social media sites which may be the wrong advice.
- Ask a Midwife will support the local campaigns by sharing the information and always signpost the families to the Lullaby Trust to ensure they are using the safest and most up-to-date guidance for safe sleep.
- https://www.lullabytrust.org.uk/safer-sleep-advice/

Comments March 2022

Thank you so much for your help, I feel less worried now	..thank you so much. You've put my mind at rest!	Happy birthday! I am so thankful for all the support and kind words I have received from you.	I think the service is amazing I've been intouch for advice a couple of times and been more than happy with the response. Thank you	Fantastic, thank you so much for your reply and the clarity
Thanks so much. You've been such a help throughout, it's very much appreciated. Hope you have a lovely weekend ahead	...it's been lovely just to go through things with you as I feel I wake up feeling with something else everyday.	Hi so nice to see you on a weekend you've helped me so much.	Yeah that's fine , I will do Thankyou for your help I feel a lot better now!! X	Thanks so much for your help and your well wishes, hopefully all is ok x
Amazing you've made me feel so much better! Thank you for all your help	This service is such a good idea. Keeps me feeling reassured during these last 2 weeks. Thank you	Awww thank you for letting me know about that. And if I need any further advise I will certainly contact you again x	Thank u so much for your help! You've really reassured us. Xx	You provide the best possible service in this city!!!

9.0 **STAFF FEEDBACK**

A Senior Midwife's Assurance Handbook was undertaken. Part of this assurance handbook will explore staff experience in relation to culture, communication, support, incidents and learning lessons.

Action Plan:

Required Actions / Improvements				
Improvement required	**Action**	**Time Frame**	**Accountable Person**	**Completed**
Transport Incubator check reminder	Discuss with staff members	End of March	Julia Chambers	Yes
Action of out of range fridge temperatures	Education to those staff completing fridge checks	End of April	Julia Chambers	

10.0 EXTERNAL CONCERNS OR QUERIES

The Trust was issued with no Coroners Regulation 28 in relation to maternity:

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2021	Oct 2022	Nov 2022	Dec 2022
0	0	0									

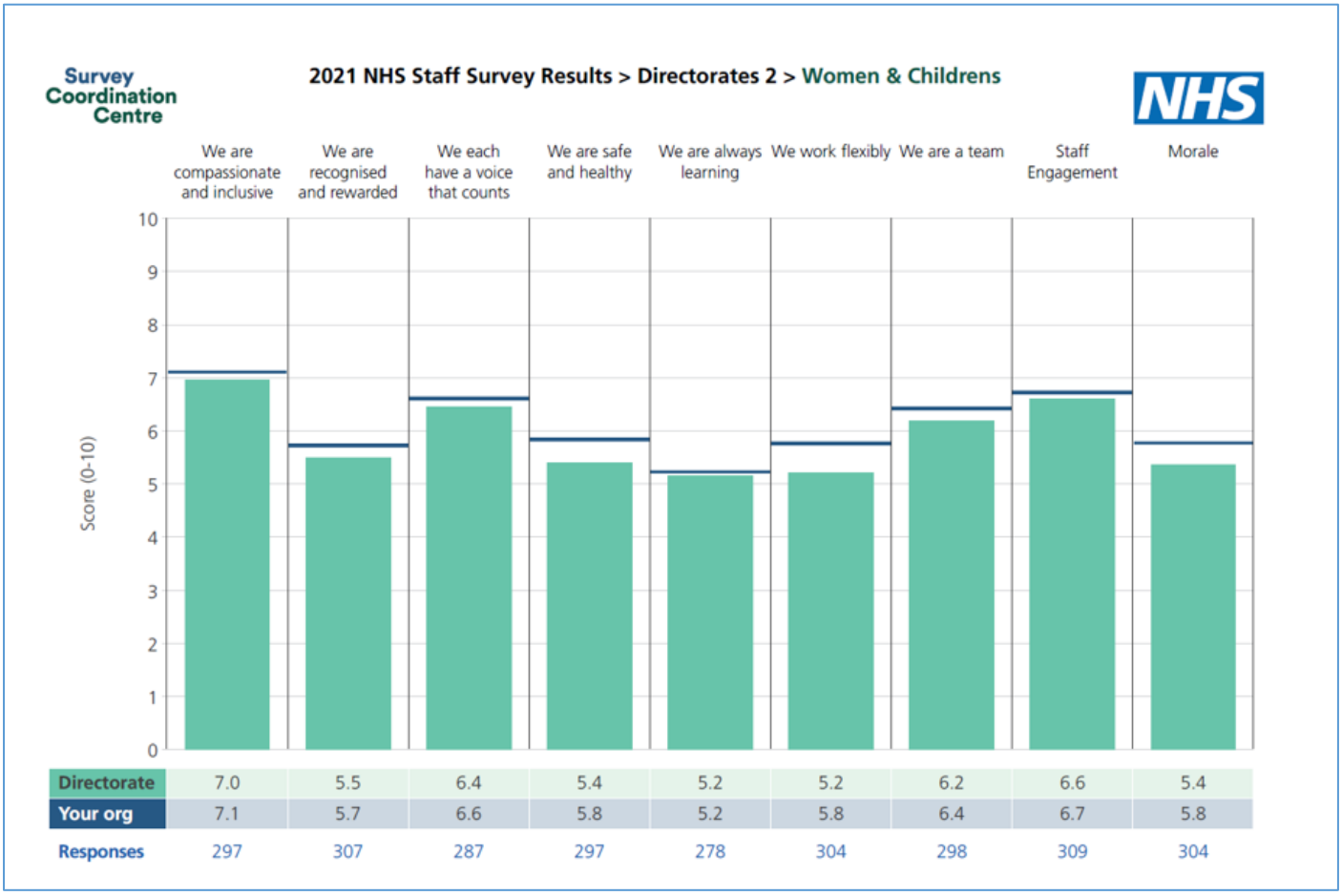
11.0 CNST

The section of the report provides details on the Trust's progress against compliance with the 10 CNST Standards. The new Maternity Incentive Scheme – Year Four Safety Actions have been released. There have been some significant changes to some of the requirements which the necessary people are looking at. A letter was received on 23rd December 2021 from NHS Resolution highlighting the decision to pause the reporting procedure for the maternity incentive scheme for a minimum of 3 months. As of the 31/03/2022 there had been no correspondence of when this will be reinstated.

There has not been a recent meeting to review the Trust progress against the Year Four Safety Actions. On the 14th February 2022 it was confirmed that the Trust had been assessed as fully compliant for MIS Year Three.

12. 0 NATIONAL SURVEY RESULTS

The national staff survey was undertaken in 2022. Overview results for the Trust are highlighted below:



Locality 4			Comparator (Organisation Overall)	Community Midwifery	H30 Cedar Ward	H31 Maple & H33 Rowan Wards	Midwifery Led Unit	Obs/Gynae Med Staff/Specialty	WCH Gynaecology OP (HRI)	Wch Labour and Delivery (HRI)	Womens and Childrens ANC/ADU HRI
Section	Q	Description	n = 3977	n = 19	n = 10	n = 28	n = 19	n = 15	n = 18	n = 24	n = 13
YOUR JOB	q2a	Often/always look forward to going to work	51.3%	33.3%	*	39.3%	38.9%	53.3%	83.3%	50.0%	53.8%
	q2b	Often/always enthusiastic about my job	67.7%	66.7%	*	60.7%	88.9%	73.3%	88.2%	79.2%	53.8%
	q2c	Time often/always passes quickly when I am working	72.9%	100.0%	*	85.7%	63.2%	60.0%	61.1%	66.7%	92.3%
	q3a	Always know what work responsibilities are	86.7%	88.9%	*	100.0%	83.3%	80.0%	82.4%	87.5%	92.3%
	q3b	Feel trusted to do my job	91.1%	100.0%	*	88.5%	94.4%	93.3%	83.3%	91.7%	84.6%
	q3c	Opportunities to show initiative frequently in my role	70.7%	50.0%	*	57.7%	66.7%	53.3%	66.7%	43.5%	61.5%
	q3d	Able to make suggestions to improve the work of my team/dept	67.2%	55.6%	*	38.5%	55.6%	60.0%	66.7%	70.8%	53.8%
	q3e	Involved in deciding changes that affect work	44.4%	38.9%	*	15.4%	38.9%	20.0%	50.0%	37.5%	15.4%
	q3f	Able to make improvements happen in my area of work	49.2%	33.3%	*	15.4%	50.0%	33.3%	66.7%	25.0%	15.4%
	q3g	Able to meet conflicting demands on my time at work	42.9%	5.6%	*	19.2%	27.8%	26.7%	70.6%	25.0%	15.4%
	q3h	Have adequate materials, supplies and equipment to do my work	58.4%	5.6%	*	34.6%	44.4%	46.7%	77.8%	33.3%	38.5%
	q3i	Enough staff at organisation to do my job properly	24.5%	11.1%	*	3.8%	0.0%	20.0%	33.3%	8.3%	7.7%
	q4a	Satisfied with recognition for good work	47.5%	16.7%	*	23.1%	27.8%	73.3%	66.7%	37.5%	30.8%
	q4b	Satisfied with extent organisation values my work	38.5%	16.7%	*	3.8%	11.1%	53.3%	44.4%	20.8%	30.8%
	q4c	Satisfied with level of pay	33.4%	33.3%	*	11.5%	16.7%	60.0%	11.1%	25.0%	30.8%
	q4d	Satisfied with opportunities for flexible working patterns	49.1%	22.2%	*	19.2%	44.4%	13.3%	44.4%	25.0%	38.5%
	q5a	Have realistic time pressures	23.4%	0.0%	*	12.0%	16.7%	6.7%	43.8%	12.5%	0.0%
	q5b	Have a choice in deciding how to do my work	50.3%	31.3%	*	36.0%	44.4%	13.3%	37.5%	33.3%	41.7%
	q5c	Relationships at work are unstrained	40.5%	18.8%	*	8.0%	11.1%	33.3%	44.4%	16.7%	0.0%
	q6a	Feel my role makes a difference to patients/service users	86.2%	94.4%	*	84.6%	94.4%	80.0%	100.0%	91.7%	91.7%
	q6b	Organisation is committed to helping balance work and home life	38.0%	5.6%	*	15.4%	5.6%	33.3%	56.3%	12.5%	16.7%
	q6c	Achieve a good balance between work and home life	49.2%	44.4%	*	38.5%	44.4%	40.0%	64.7%	20.8%	25.0%
	q6d	Can approach immediate manager to talk openly about flexible working	60.9%	33.3%	*	38.5%	66.7%	46.7%	58.8%	37.5%	41.7%

Locality 4			Comparator (Organisation Overall)	Community Midwifery	H30 Cedar Ward	H31 Maple & H33 Rowan Wards	Midwifery Led Unit	Obs/Gynae Med Staff/Specialty	WCH Gynaecology OP (HRI)	Wch Labour and Delivery (HRI)	Womens and Childrens ANC/ADU HRI
Section	Q	Description	n = 3977	n = 19	n = 10	n = 28	n = 19	n = 15	n = 18	n = 24	n = 13
YOUR TEAM	q7a	Team members have a set of shared objectives	69.5%	61.1%	*	61.5%	88.2%	66.7%	62.5%	56.5%	50.0%
	q7b	Team members often meet to discuss the team's effectiveness	48.2%	22.2%	*	19.2%	76.5%	46.7%	56.3%	39.1%	50.0%
	q7c	Receive the respect I deserve from my colleagues at work	66.3%	55.6%	*	38.5%	58.8%	66.7%	52.9%	47.8%	50.0%
	q7d	Team members understand each other's roles	70.3%	58.8%	*	53.8%	82.4%	66.7%	64.7%	60.9%	58.3%
	q7e	Enjoy working with colleagues in team	79.5%	77.8%	*	76.9%	82.4%	80.0%	68.8%	65.2%	75.0%
	q7f	Team has enough freedom in how to do its work	53.4%	17.6%	*	7.7%	35.3%	13.3%	47.1%	30.4%	33.3%
	q7g	Team deals with disagreements constructively	51.9%	38.9%	*	34.6%	64.7%	53.3%	47.1%	34.8%	41.7%
	q7h	Feel valued by my team	65.0%	64.7%	*	57.7%	76.5%	80.0%	58.8%	52.2%	25.0%
	q7i	Feel a strong personal attachment to my team	62.3%	55.6%	*	57.7%	70.6%	40.0%	75.0%	60.9%	33.3%
PEOPLE IN YOUR ORGANISATION	q8a	Teams within the organisation work well together to achieve objectives	48.2%	33.3%	*	26.9%	23.5%	46.7%	56.3%	40.9%	50.0%
	q8b	Colleagues are understanding and kind to one another	65.0%	55.6%	*	46.2%	47.1%	46.7%	62.5%	36.4%	41.7%
	q8c	Colleagues are polite and treat each other with respect	66.0%	50.0%	*	46.2%	41.2%	66.7%	58.8%	36.4%	33.3%
	q8d	Colleagues show appreciation to one another	62.0%	50.0%	*	40.0%	50.0%	53.3%	58.8%	31.8%	33.3%
YOUR MANAGERS	q9a	Immediate manager encourages me at work	65.4%	44.4%	*	80.8%	64.7%	53.3%	64.7%	68.2%	50.0%
	q9b	Immediate manager gives clear feedback on my work	57.5%	33.3%	*	61.5%	58.8%	33.3%	70.6%	59.1%	50.0%
	q9c	Immediate manager asks for my opinion before making decisions that affect my work	52.8%	27.8%	*	65.4%	35.3%	40.0%	58.8%	50.0%	41.7%
	q9d	Immediate manager takes a positive interest in my health & well-being	63.3%	33.3%	*	73.1%	70.6%	46.7%	64.7%	68.2%	63.6%
	q9e	Immediate manager values my work	66.3%	50.0%	*	69.2%	76.5%	53.3%	68.8%	68.2%	58.3%
	q9f	Immediate manager works with me to understand problems	63.4%	38.9%	*	65.4%	82.4%	66.7%	68.8%	63.6%	58.3%
	q9g	Immediate manager listens to challenges I face	65.5%	38.9%	*	61.5%	76.5%	46.7%	68.8%	63.6%	50.0%
	q9h	Immediate manager cares about my concerns	64.5%	27.8%	*	73.1%	70.6%	46.7%	64.7%	68.2%	66.7%
	q9i	Immediate manager helps me with problems I face	61.0%	27.8%	*	65.4%	52.9%	40.0%	64.7%	59.1%	50.0%

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Section	Q	Description	n = 3977	n = 19	n = 10	n = 28	n = 19	n = 15	n = 18	n = 24	n = 13
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	58.2%	44.4%	*	34.6%	23.5%	33.3%	76.5%	50.0%	33.3%
	q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	44.1%	16.7%	*	38.5%	29.4%	26.7%	58.8%	22.7%	16.7%
	q11a	Organisation takes positive action on health and well-being	51.0%	61.1%	*	15.4%	17.6%	26.7%	43.8%	40.9%	50.0%
	q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	66.9%	50.0%	*	69.2%	70.6%	40.0%	68.8%	63.6%	66.7%
	q11c	In last 12 months, have not felt unwell due to work related stress	50.3%	33.3%	*	38.5%	29.4%	53.3%	31.3%	50.0%	25.0%
	q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	45.6%	27.8%	*	26.9%	29.4%	53.3%	37.5%	63.6%	25.0%
	q11e	Not felt pressure from manager to come to work when not feeling well enough	72.0%	38.5%	*	68.4%	41.7%	*	*	*	*
	q12a	Never/rarely find work emotionally exhausting	19.7%	5.6%	*	3.8%	0.0%	6.7%	23.5%	9.1%	0.0%
	q12b	Never/rarely feel burnt out because of work	25.5%	16.7%	*	3.8%	0.0%	13.3%	35.3%	13.6%	0.0%
	q12c	Never/rarely frustrated by work	17.7%	5.6%	*	3.8%	0.0%	6.7%	41.2%	0.0%	16.7%
	q12d	Never/rarely exhausted by the thought of another day/shift at work	32.6%	23.5%	*	3.8%	5.9%	20.0%	43.8%	9.1%	8.3%
	q12e	Never/rarely worn out at the end of work	15.4%	11.1%	*	0.0%	5.9%	13.3%	23.5%	4.5%	0.0%
	q12f	Never/rarely feel every working hour is tiring	48.5%	38.9%	*	11.5%	11.8%	40.0%	75.0%	45.5%	25.0%
	q12g	Never/rarely lack energy for family and friends	31.4%	38.9%	*	15.4%	11.8%	26.7%	41.2%	31.8%	8.3%
	q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	84.2%	94.4%	*	84.6%	94.1%	100.0%	94.1%	86.4%	91.7%
	q13b	Not experienced physical violence from managers	99.4%	100.0%	*	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%
	q13c	Not experienced physical violence from other colleagues	98.7%	100.0%	*	88.5%	100.0%	100.0%	100.0%	95.5%	100.0%
	q13d	Last experience of physical violence reported	61.2%	*	*	*	*	*	*	*	*
	q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the	74.0%	64.7%	*	56.5%	82.4%	73.3%	58.8%	50.0%	66.7%
	q14b	Not experienced harassment, bullying or abuse from managers	86.2%	58.8%	*	82.6%	76.5%	66.7%	93.8%	77.3%	66.7%
	q14c	Not experienced harassment, bullying or abuse from other colleagues	79.4%	76.5%	*	56.5%	35.3%	60.0%	80.0%	54.5%	66.7%
	q14d	Last experience of harassment/bullying/abuse reported	41.8%	*	*	25.0%	54.5%	*	*	42.9%	*
	q15	Organisation acts fairly: career progression	56.8%	38.9%	*	34.6%	29.4%	33.3%	41.2%	50.0%	83.3%
	q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	94.0%	100.0%	*	96.2%	100.0%	80.0%	100.0%	100.0%	100.0%

Locality 4			Comparator (Organisation Overall)	Community Midwifery	H30 Cedar Ward	H31 Maple & H33 Rowan Wards	Midwifery Led Unit	Obs/Gynae Med Staff/Specialty	WCH Gynaecology OP (HRI)	Wch Labour and Delivery (HRI)	Womens and Childrens ANC/ADU HRI
Section	Q	Description	n = 3977	n = 19	n = 10	n = 28	n = 19	n = 15	n = 18	n = 24	n = 13
	q16b	Not experienced discrimination from manager/team leader or other colleagues	91.2%	72.2%	*	92.3%	88.2%	73.3%	100.0%	100.0%	100.0%
	q17a	Would feel secure raising concerns about unsafe clinical practice	71.9%	72.2%	*	69.2%	62.5%	66.7%	88.2%	81.8%	63.6%
	q17b	Would feel confident that organisation would address concerns about unsafe clinical practice	56.0%	33.3%	*	30.8%	31.3%	46.7%	58.8%	40.9%	54.5%
	q18	Feel organisation respects individual differences	68.3%	66.7%	*	53.8%	50.0%	66.7%	70.6%	59.1%	66.7%
YOUR PERSONAL DEVELOPMENT	q19a	Received appraisal in the past 12 months	83.7%	94.4%	*	64.0%	100.0%	91.7%	85.7%	95.5%	91.7%
	q19b	Appraisal helped me improve how I do my job	19.2%	5.9%	*	0.0%	18.8%	27.3%	18.2%	14.3%	27.3%
	q19c	Appraisal helped me agree clear objectives for my work	30.2%	11.8%	*	12.5%	25.0%	36.4%	18.2%	23.8%	54.5%
	q19d	Appraisal left me feeling organisation values my work	24.9%	5.9%	*	0.0%	18.8%	18.2%	25.0%	23.8%	18.2%
	q20a	Organisation offers me challenging work	70.2%	61.1%	*	48.0%	75.0%	64.3%	41.2%	77.3%	83.3%
	q20b	There are opportunities for me to develop my career in this organisation	52.5%	16.7%	*	20.0%	33.3%	71.4%	29.4%	40.9%	58.3%
	q20c	Have opportunities to improve my knowledge and skills	67.5%	55.6%	*	60.0%	50.0%	78.6%	52.9%	59.1%	75.0%
	q20d	Feel supported to develop my potential	50.7%	22.2%	*	25.0%	37.5%	64.3%	37.5%	40.9%	50.0%
	q20e	Able to access the right learning and development opportunities when I need to	56.8%	27.8%	*	29.2%	37.5%	57.1%	35.3%	50.0%	66.7%
YOUR ORGANISATION	q21a	Care of patients/service users is organisation's top priority	70.9%	83.3%	*	45.8%	60.0%	78.6%	81.3%	77.3%	66.7%
	q21b	Organisation acts on concerns raised by patients/service users	67.3%	72.2%	*	50.0%	66.7%	78.6%	87.5%	63.6%	58.3%
	q21c	Would recommend organisation as place to work	56.5%	22.2%	*	12.5%	13.3%	42.9%	68.8%	31.8%	41.7%
	q21d	If friend/relative needed treatment would be happy with standard of care provided by organisation	64.3%	38.9%	*	29.2%	53.3%	71.4%	87.5%	54.5%	50.0%
	q21e	Feel safe to speak up about anything that concerns me in this organisation	58.9%	61.1%	*	33.3%	60.0%	64.3%	62.5%	54.5%	50.0%
	q21f	Feel organisation would address any concerns I raised	45.6%	27.8%	*	8.3%	20.0%	50.0%	56.3%	36.4%	50.0%
	q22a	I don't often think about leaving this organisation	42.7%	11.1%	*	12.5%	13.3%	35.7%	50.0%	54.5%	25.0%
	q22b	I am unlikely to look for a job at a new organisation in the next 12 months	54.7%	38.9%	*	37.5%	33.3%	57.1%	62.5%	77.3%	45.5%
	q22c	I am not planning on leaving this organisation	59.5%	38.9%	*	41.7%	40.0%	42.9%	62.5%	77.3%	45.5%
BACKGROUND INFORMATION	q28b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	69.8%	*	*	*	*	*	*	*	*

Locality 4			Comparator (Organisation Overall)	Community Midwifery	H30 Cedar Ward	H31 Maple & H33 Rowan Wards	Obs/Gynae Med Staff/Specialty	WCH Gynaecology OP (HRI)	Wch Labour and Delivery (HRI)	Womens and Childrens ANC/ADU HRI
Section	Q	Description	n = 3977	n = 19	n = 10	n = 28	n = 15	n = 18	n = 24	n = 13
Motivation	q2a	I look forward to going to work.	6.1	5.4	*	5.4	6.3	7.6	6.3	5.8
	q2b	I am enthusiastic about my job.	7.2	6.8	*	6.4	7.0	8.4	7.5	6.9
	q2c	Time passes quickly when I am working.	7.5	8.7	*	8.1	6.8	6.8	6.9	8.5
	E_1	Motivation sub-group score	6.9	7.0	*	6.7	6.7	7.5	6.9	7.1
Involvement	q3c	There are frequent opportunities for me to show initiative in my role.	7.1	6.1	*	5.8	6.2	7.2	5.3	7.3
	q3d	I am able to make suggestions to improve the work of my team / department.	6.8	6.0	*	5.4	5.7	7.2	6.1	6.0
	q3f	I am able to make improvements happen in my area of work.	5.9	5.3	*	3.9	4.7	6.4	4.8	4.6
	E_2	Involvement sub-group score	6.6	5.8	*	5.0	5.5	6.9	5.4	6.0
Advocacy	q21a	Care of patients / service users is my organisation's top priority.	7.0	6.9	*	5.1	7.0	7.8	7.4	7.1
	q21c	I would recommend my organisation as a place to work.	6.2	4.2	*	3.4	5.7	7.5	5.3	6.0
	q21d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	6.6	5.1	*	4.6	7.0	8.0	6.3	6.3
	E_3	Advocacy sub-group score	6.6	5.4	*	4.4	6.5	7.8	6.3	6.5
Overall	E_4	Staff Engagement Score	6.7	6.0	*	5.4	6.2	7.4	6.1	6.5

The triumvirate are working closely with all the services within the Health Group to explore the staff survey results in greater detail.

Appendix 1 - Humber Coast and Vale Regional Quality Oversight Group Highlight Report

Humber and North Yorkshire
Health and Care Partnership

Perinatal Quality, Safety and Assurance Group (PQSAG) Highlight Report – January to March 2022

LMS	Humber and North Yorkshire	**Programme Lead**	Becky Case
Trust	**Hull University Teaching Hospitals NHS Trust**	**Completed by/date**	Julia Chambers, 15/04/2022

No of Serious incidents	K2 & PROMPT Compliance	ATAIN Rates	HISIB reported events	No of complaints/PALS - themes
1) abnormal pre term CTG	**Prompt Overall Compliance 74% K2 Overall Compliance 76%**	**2.6 % from quarter 3 2.8% January to march**	**MI 004025 - APH baby admitted for cooling MI 004482 RFM @ 38+5 SGA baby admitted for cooling**	**25 PALS received – theme – attitudes & behaviours around communication 8 Complaints received – no specific themes**

Top 5 Perinatal DATIX Themes (combined obstetrics and neonatology)	Top 5 PMRT Themes (combined obstetrics and neonatology)	Top 5 HSIB Themes (combined obstetrics and neonatology)
1/ PPH >1.5 mls	Learning from PMRT cases •Ensure all women receive written information with regard to fetal movements in pregnancy via a leaflet or QR code •At AN appointments if an attempt is made to auscultate the fetal heart and it is not located refer to the ADU •Ensure all women who have an unexplained loss have an HVS taken, including following an early neonatal death •Ensure all women are offered all postnatal investigation following an unexplained pregnancy loss or early neonatal death	1/ staff are supported to perform a cat 1 EMCs within the 30 mins of making the decision
2/ Growth <10th centile		2/ To ensure placentas are sent in a timely manner for histology
3/ Unexpected Admission to NICU		3/ The trust to support staff to pull the emergency buzzer when a bradycardia occurs
4/ GAP		4/
5/ Postnatal Re-admission - Maternal		5/

Appendix 2 – HUTH Maternity Dashboard

Maternity Dashboard	Threshold	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Activity													
Number of Births per month		428	395	397	391	430	449	435	458	388	389	398	444
Number of Bookings per month		506	457	461	461	458	458	444	419	422	412	394	503
Direct Access before 12+6		88%	88.0%	96.0%	89.0%	90.0%	100.0%	100.0%	88.0%	85.0%	82.0%	85.0%	100.0%
Booking over 13 weeks within 2 weeks	95.0%	98%	92.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Caesarian Section	26.2%	32.7%	33.9%	32.9%	32.2%	29.8%	37.6%	36.2%	30.9%	35.7%	34.3%	34.3%	32.2%
Elective Caesarean Section	11.1%	15.2%	14.4%	14.9%	13.4%	13.6%	20.3%	18.3%	12.9%	18.9%	14.1%	16.9%	15.5%
Emergency Caesarean Section	15.4%	17.5%	19.5%	18.0%	18.8%	16.2%	17.3%	17.9%	18.0%	16.8%	20.2%	17.4%	16.7%
Instrumental Birth	13.1%	8.1%	8.5%	6.3%	6.2%	8.6%	4.6%	7.8%	11.6%	4.1%	9.7%	4.7%	6.2%
Normal Birth	61.0%	58.0%	56.4%	55.8%	57.3%	61.2%	53.2%	55.6%	56.9%	57.3%	55.2%	60.4%	60.9%
Home Birth		1.4%	2.0%	2.0%	1.7%	0.6%	0.8%	0.4%	0.3%	1.5%	1.5%	1.3%	1.6%
MLU Births		15.4%	11.1%	12.5%	10.2%	13.2%	12.9%	12.1%	12.2%	10.8%	14.4%	13.9%	11.4%
Induction of Labour		32.0%	26.8%	36.0%	39.4%	36.8%	27.0%	31.0%	30.0%	31.0%	32.0%	30.6%	34.0%
Epidural		28%	33.0%	37.0%	35.0%	35.0%	26.0%	32.0%	33.0%	32.0%	34.0%	30.0%	34.0%
Workforce													
Weekly hours of Consultant cover on LW	98	95	95	95	95	95	95	95	95	95	95	95	95
Midwife/Birth Ratio	1:32	1:30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30	1.30
Provision of 1:1 Care in Labour	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Supernumary status of Labour Ward Coordinator	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Maternal Morbidity													
Eclampsia		1	0	0	0	0	0	0	0	0	0	0	0
ICU/HDU Admissiona in Obstetrics		1	0	1	1	0	0	1	1	3	1	1	0
Blood Transfusion (>4 units)		1	1	0	2	0	2	0	1	0	1	1	1
Post-Partum Hysterectomies		1	1	0	1	0	1	0	0	0	0	0	0
Neo-Natal Morbidity													
Number of cases of meconium aspiration		0	0	0	0	0	0	0	0	0	0	1	1
Number of cases of hypoxic encephalopathy (grades 2 & 3)		1	1	0	0	1	0	1	0	0	1	0	0
Referrals to NHSR		0	1	0	0	0	2	0	0	0	1	0	0
Total Stillbirths		0	2	2	1	1	1	2	1	1	1	1	1
Stillbirths at Term (after 37 weeks)		0	1	1	0	0	0	1	1	0	1	1	1
Risk Management													
Failed Instrumental Delivery	< 1%	0.0%	0.0%	0.2%	0.1%	0.4%	0.2%	0.3%	0.1%	0.1%	0.3%	0.1%	0.2%
Maternal Death	0	0	0	0	0	0	0	0	0	0	0	0	0
Massive PPH > 2 litres	10	8	7	7	4	10	7	8	6	20	7	5	5
Shoulder Dystocia	6	0	0	2	1	0	2	3	0	2	0	2	0
3rd/4th degree Tear	20	6	4	4	1	1	0	2	8	5	0	1	10
Complaints													
Number of Complaints		4	0	1	0	3	2	6	2	4	5	4	3

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
TOTAL BIRTHS 2021/22	**428**	**395**	**397**	**391**	**430**	**449**	**435**	**458**	**388**	**389**	**398**	**444**	5002
TOTAL BIRTHS 2020/21	**405**	**394**	**454**	**438**	**409**	**437**	**426**	**401**	**380**	**393**	**353**	**379**	2963
TOTAL BIRTHS 2019/20	**391**	**465**	**414**	**455**	**469**	**405**	**423**	**390**	**444**	**420**	**364**	**414**	5054
TOTAL BIRTHS 2018/19	**422**	**439**	**458**	**445**	**432**	**480**	**442**	**429**	**419**	**420**	**367**	**404**	5157
TOTAL BIRTHS 2017/18	**434**	**433**	**458**	**414**	**462**	**474**	**467**	**484**	**448**	**407**	**370**	**434**	5285
TOTAL BIRTHS 2016/17	**432**	**461**	**453**	**520**	**481**	**463**	**459**	**454**	**467**	**444**	**420**	**451**	5505
TOTAL BIRTHS 2015/16	**419**	**466**	**483**	**492**	**501**	**486**	**488**	**468**	**459**	**464**	**450**	**448**	5624
TOTAL BIRTHS 2014/15	**461**	**486**	**485**	**468**	**438**	**529**	**485**	**492**	**457**	**458**	**432**	**462**	5653

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Stillbirths 2021/22	**0**	**2**	**2**	**0**	**1**	**1**	**2**	**1**	**1**	**1**	**1**	**1**	**13**
Stillbirths 2020/21	1	2	2	1	1	1	**0**	**0**	**0**	**1**	**2**	**2**	14
Stillbirths 2019/20	1	4	2	1	2	0	1	2	2	1	2	2	20
Stillbirths 2018/19	0	0	2	0	3	2	2	4	1	2	0	0	16
Stillbirths 2017/18	1	1	1	3	1	1	0	0	0	3	3	3	17
Stillbirths 2016/17	2	6	4	3	1	1	2	3	1	0	1	3	27

Appendix 3 – Abbreviations

- ATAIN – Avoiding Term Admissions to Neonatal Unit
- BBA – Born Before Arrival to Hospital
- CTG – Cardiotocograph
- HSIB – Health Safety Investigation Branch
- IUD – Intra Uterine Death
- LSCS – Lower Segment Caesarean Section
- NND - Neonatal Death
- PMRT – Perinatal Mortality Review Tool
- PPH – Postpartum Haemorrhage
- PSROM – Prolonged Spontaneous Rupture of Membranes
- PROMPT – Practical Obstetric Multi-Professional Training
- SB – Stillbirth

Agenda Item	8.1.4	**Meeting**	Quality Committee and Trust Board	**Meeting Date**	26 April and 10 May 2022
Title	**Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool**				
Lead Director	Joanne Ledger Chief Nurse				
Author	Lorraine Cooper Head of Midwifery				
Report previously considered by (date)	Quality Committee				

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

Key Recommendations to be considered:
The Committee is requested to: • Receive the report findings • Decide if any further information and/or assurance are required.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY SERVICES
FAMILY AND WOMEN'S HEALTH GROUP

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 - Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool

1. Purpose of the Report

The purpose of this report is to provide assurance to the Trust Board that a multidisciplinary team is completing the national Perinatal Mortality Review Tool (PMRT) to the standard required by the Clinical Negligence Scheme for Trusts (CNST).

2. Introduction

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme, to support the delivery of safer maternity care. Trusts involved in the maternity incentive scheme will contribute an additional 10% of the CNST maternity premium creating the CNST maternity incentive fund. The scheme incentivises 10 safety actions; Trusts demonstrating they have achieved all ten of the safety actions will recover their contribution and will receive a share of any unallocated funds. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on 30 June 2022. Trust submissions will be subject to a range of external verification points including cross checking with MBRRACE-UK data (safety action 1 point a,b,c).

3. Requirements for Safety Action 1; are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard. **Appendix 1 and 2**

A)

i. Perinatal deaths eligible to be notified to MBRRACE-UK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust

B) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

C) For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents, should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors, which may have a bearing on a future pregnancy. In the absence of a bereavement lead, ensure that someone takes responsibility for maintaining contact and for taking actions as required.

D) Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

4. Perinatal Mortality Review Tool (PMRT)

The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

The PMRT has been designed with the following principles:

- A comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth
- Reviews conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes
- Review by a multidisciplinary group at a meeting where time is set aside for doing the work;
- Parental input into the process from the beginning.
- An action plan should be generated from each review, implemented and monitored;
- The review should result in a written report, which should be shared with families in a sensitive and timely manner.
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements.
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning.

5. Summary

a) i.The requirement to notify perinatal deaths was amended from 2 days to 7 days in January 2022 during the COVID pandemic. From the 1st January until the 31st March 2022, the Trust was **100%** compliant with the standard. All perinatal deaths were notified to MBRRACE-UK within 7 working days and al the surveillance details are complete.

ii. In this reporting period there have been 3 stillbirths and 3 neonatal deaths suitable for review. **100%** of all deaths of babies have been started within two months of each death in the Trust. From the 8th August 2021 to 31st March 2022, there have been 8 stillbirths and 7 neonatal deaths suitable for review, **100%** of all deaths of babies have been started within two months of each death

b) In the period from 8th August, 15 cases in the Trust are suitable for review using the PMRT. 7 cases have been completed and the report written and published. 1 cases is complete and the report is being written.7 cases are under review. Two cases were reviews have been conducted with other Trusts are outside the 4 month target period for completion. Seven of the eight cases completed are within the 4 month time frame – 87% and 100% of the reports published were within 6 months. The Trust is compliant with the CNST target of 50%

c) In 100% of all deaths of babies who were born and died in the Trust Quarter 3 reporting period, the parents have been told that a review of their baby's death will take place, and the parents' perspectives and any concerns they have about their care and that of their baby has been sought. The bereavement midwife maintains contact with the parents through the PMRT review.

d) Quarterly reports are submitted as per standard and discussed with the Trust safety champion

6. Recommendations

The Trust Board is requested to:

- Receive (the report outlining the details of the deaths reviewed and the action plans.
- Receive assurance by the team that the PMRT has been used to review eligible perinatal deaths and that all the required standards have been achieved.
- Decide if any further information and/or assurance are required

Lorraine Cooper

Head of Midwifery April 2022

APPENDIX 1 December 2021 PMRT Update

Hull University Teaching Hospitals NHS Trust Perinatal Mortality Review Tool Review update December 2021									
Outstanding and completed Neonatal cases December 2021									
	MBRRACE ID	Stillbirth/ Neonatal Death	Date of death	PMRT commenced	Target for completion	PMRT Completed	Grading	Report date target	Actions/ Good practice
1	75197	NND 24+3 week Twin	09/05/2021	11/05/2021	09/09/2021				Joint review with York- delayed due to requirement for joint review *(outside of the CNST review period)*
2	77800	NND 24 weeks	14/10/2021	25/10/2021	14/02/2022	22/12/2021	B/A/A	v	Completed- Actions published on action tracker
3	78076	NND 23 weeks	31/10/2021	23/11/2021	28/02/2021				Commenced -joint review with Mid Yorkshire
4	79153	NND 26 weeks	26/12/2021		26/04/2022				To commence joint review with Lincoln
	MBRRACE ID	*Stillbirth/ Neonatal Death*	*Date of death*	*PMRT commenced*	*Target for completion*	*PMRT Completed*	*Grading*		*Actions/ Good practice*
Outstanding and completed Maternity Cases upto December 2021									
1	76761	27+2 week SB	18/08/2021	23/08/2021	18/12/2021	19/11/2021	B/A	v	Actions are with booking unit Aneurin Bevan Health Board
2	77778	30 week SB	15/10/2021	25/10/2021	15/02/2022	21/12/2021	D/A		Escalated for an SI investigation. Writing PMRT report- Actions published on action tracker
3	77982	37 week stillbirth	25/10/2021	29/10/2021	25/02/2022	22/11/2021	B/B	v	Completed- Actions published on action tracker
4	78218	37+1 week stillbirth	05/11/2021	08/11/2021	05/03/2021				In progress- awaiting placental histology

APPENDIX 2
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
PMRT ACTION MATERNITYTRACKER DECEMBER 2021

MBRRACE ID	ACTIONS	Lead	Due date	RAG
77982	Review, amend and update staff on the guideline for smoking in pregnancy highlighting it being an 'opt out' service and families should be provided with referrals also with a box to evidence this being completed	CC	26/01/22	
	Create a sticker to highlight a referral has been made each time a Co2>4 is identified	CC	26/01/22	
	Publish a leaflet/QR code for stop smoking/Co2 monitoring	CC	26/01/22	
	Individual feedback to staff involved regarding risk management and case to be shared at Perinatal Mortality meeting	KS/ WM	17/12/21	
	Liaise with new maternal mental health service to implement pre-conceptual mental health counselling	SC	17/12/21	
77778	CTG to be reviewed by leads and discussion with involved staff if concerns highlighted	SN	17/12/21	
	Advise staff via newsletter to use continuous maternal HR monitoring when maternal/fetal tachycardia identified	AB	17/12/21	
	Set a trust standard with frequency of 'fresh eyes' on an antenatal CTG and classifying latent phase CTGs	SN	26/01/22	
	Feedback to staff in newsletter the action if a FFN result is invalid	AB	26/01/22	
	Review, amend and update staff on the guideline for smoking in pregnancy highlighting it being an 'opt out' service and families should be provided with referrals also with a box to evidence this being completed	CC	26/01/22	
	Create a sticker to highlight a referral has been made each time a Co2>4 is identified	CC	26/01/22	
	Publish a leaflet/QR code for stop smoking/Co2 monitoring	CC	26/01/22	
	Liaise with USS regarding DNA process and take to governance meeting	KS	10/01/21	
	Reminder on the monthly newsletter re documentation of observations on the partogram	AB	17/12/21	
	Reminder on the monthly newsletter re relevant investigations been offered and taken	AB	17/12/21	
77800	Review guidance and leaflet for Aspirin including when contraindicated	KS	26/01/22	
	Create a pre-term guidance counselling checklist	KS	25/02/22	
	Reminder on the monthly newsletter re relevant investigations been offered and taken	AB	17/12/21	
	Reminder on the monthly newsletter re calculating the correct gestation	AB	17/12/21	
Actions now completed (to be received at the PMRT meeting then removed from this tracker)				

RAG rating

Red – off track and overdue
Amber- off track but recoverable
Green – complete
No colour – not yet commenced

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item	8.2	**Meeting**	Trust Board	**Meeting Date**	10 May 2022
Title	Learning from Mortality and Morbidity Report – Q3 2021/22				
Lead Director	Dr Makani Purva – Chief Medical Officer				
Author	Chris Johnson – Effectiveness and Improvement Manager				
Report previously considered by (date)	Quality Committee February 2022				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		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 recommended to receive this report and:

- Decide if this report provides sufficient information regarding Mortality and Learning from Deaths
- Decide if any further information and/or actions are required
- Note that the quarter 4 2021/22 report will be considered at Quality Committee in May, and shared with Board in July.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
MORTALITY - LEARNING FROM DEATHS QUARTER 3 2021/22

1. PURPOSE OF THIS REPORT

The purpose of this report is to provide the Board with a summary of mortality statistics and learning from deaths in line with the requirements set by NHS Improvement, outlined in the national framework. The data in this report is from Quarter 3, 2021/22, unless otherwise stated (broader timeframes are used in some instances for deeper statistics.)

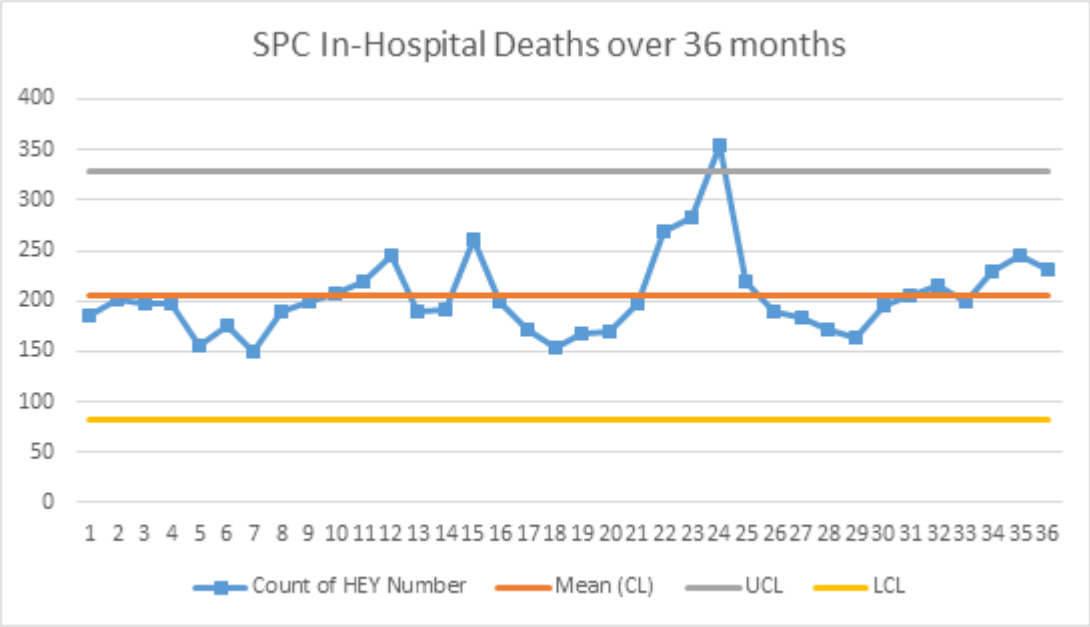
Information relating learning and actions taken are obtained from various sources including the Medical Examiner Office, Speciality M&M meetings and the Trust incident reporting system (Datix).

2. SUMMARY OF IN-HOSPITAL MORTALITY IN Q3 2021/22

The following table provides a breakdown of patient deaths that occurred within the Trust during Q3 2021/22, drawing comparison to last year:

	Year for Comparison	Total number of In-hospital deaths
Q3	2020/21	747
	2021/22	**675**

2.1 SPC of All In-Hospital Deaths occurring over the last 36 Months (Crude)



The SPC chart illustrates the large spike during January 2021 due to COVID-19. The spike that occurred within the Trust in April 2021 is also illustrated. Other than these spikes, the overall in-hospital mortality is following the expected increases during winter, and decreases during the warmer months.

2.2 Five Most Common Clinical Conditions Present at Time of Death
The three most common clinical conditions (CCS) present at time of death (excluding Covid-19) during Q3 were:

Clinical Condition	Number of Patients
Pneumonia	867 (11.7% of all deaths)
Septicaemia	522 (7.1% of all deaths)
Acute Cerebrovascular Disease	479 (6.5% of all deaths)

Additionally, there were 639 deaths attributed with COVID-19 during Q3.

2.3 Minimal Criteria for Structured Judgement Review (National LFD Framework)
The National Quality Board determined minimal criteria for undertaking mortality review via a chosen case-note review methodology. The Trust adopted the structured judgement case note review system to undertake such reviews. The criteria are illustrated below, along with the Trusts compliance against these criteria during Q3.

Criteria	Number of cases requiring SJR / other case note review	Outcomes / Update
Deaths where a concern was raised about the quality of care provision (including cases raised by ME)	16	12 of the 16 cases were reviewed, the remaining 4 cases are still outstanding and will be monitored for completion. Learning from these reviews is available further in the report. This now incorporates deaths that were unexpected and deemed to potentially have an element of learning.
Patients who had Learning Difficulties or Severe Mental Illness	6	The Safeguarding Team, in addition to other trained reviewers, regularly undertake reviews on this cohort of patients. Outcomes from SJR's can be found further on in the report.
Deaths where an alarm has been raised with the provider (mortality alert – Dr Foster)	0	NA
Number of deaths that underwent a Serious Incident Investigation and completed, within the Quarter, where it is likely that problems in care contributed to patient death.	0	NA
Further sample of deaths where the learning will inform a provider's quality improvement work	12	Fracture neck of femur cases are reviewed by the Trauma and Orthopaedic department on a regular, on-going basis.

In addition to the Structured Judgement Review, cases receive other reviews outside of the SJR methodology within the M&M setting. The Trust is also enrolled in the LEDER program and has trained reviewers who undertake reviews on patients who die both within the Trust and outside of the Trust, forming part of the wider LEDER network.

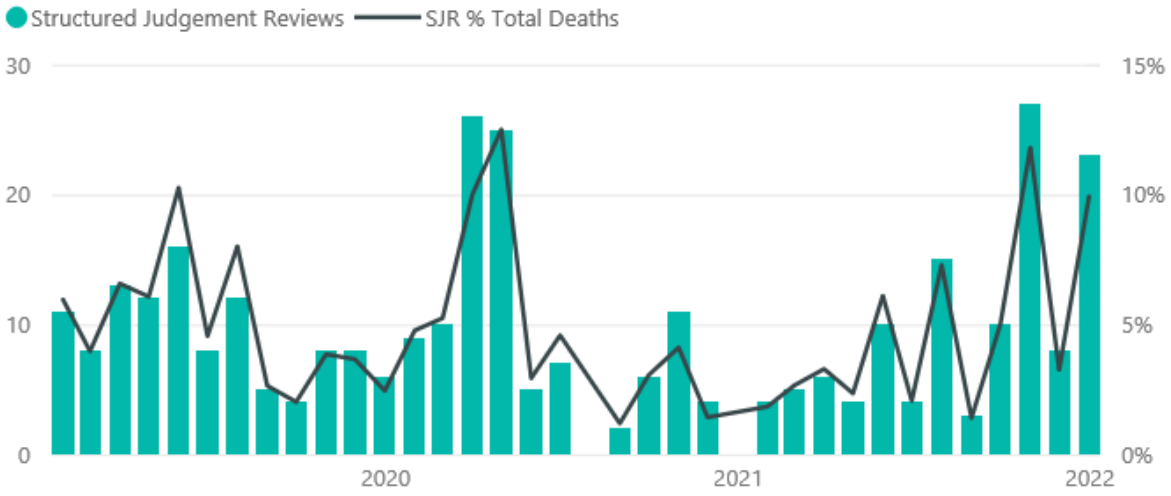
3. SUMMARY OF STRUCTURED JUDGEMENT REVIEWS

The following table illustrates the number of SJR's completed within Q3; including details on how many were escalated to Tier 2 and Triumvirate level.

	Total Number of SJR completed	Cases escalated to Tier 2 Review	Cases requiring Escalation to Speciality Discussion	SJR cases escalated and declared as a Serious Incident
Q3	53	3	1	0
% compared with number of deaths	8% of all in-hospital deaths in Q3 had an SJR			

The following graph illustrates the total number of in-hospital deaths vs. the percentage of which received an SJR.

There was an expected lull in December 2021, as SJR reviewers were taking annual leave, but overall there has been a positive uptake in the number of SJR's being completed, in certain Specialities. There now needs to be more ownership of the SJR process onto the Specialties.



3.1 Phase of Care Scores & Thematic Analysis Summary

During the Structured Judgement Review, various aspects of the patient's hospital stay are judged and given a score to represent the quality of care that they received.

The care score works on a 1 to 5 basis, with 1 being very poor and 5 being excellent. The table below provides an overall summary of Structured Judgement review care scores that were completed during the last 36 months:

Section	Avg Score	1 Poor	2	3	4	5	6 Good
1. Phase of Care							
Admission & initial care (1st 24hrs)	3.9	2	20	67	102	88	
Care during a procedure	4.2	1	2	6	46	28	
End of life care	4.1	2	12	51	111	101	
Ongoing care	3.8	3	24	74	107	69	
Overall assessment of care	3.7	1	28	74	117	57	
Perioperative care	3.9	2	4	9	39	16	
2. Avoidability of death							
Avoidability of death judgement	4.8		1	2	6	3	8
3. Themed Analysis							
Ceiling of care	3.7		4	7	1	8	
Communication with patient/family	3.7	3	6	4	8	14	
Documentation	2.9	7	11	19	11	4	
End of life care	4.1	1	3	10	17	23	
Fluid balance	2.4	4	6	5	2	1	
Interventions	3.5		5	5	2	6	
Management plans	3.4	1	7	9	3	8	
Medication \ Prescribing	2.1	3	6	4			
Multi-disciplinary care	3.7	1	4	4	3	8	
Other	3.2	2	16	16	12	9	
Senior clinical involvement	3.3		5	9	8	2	
Sepsis management	2.8	1	5	3	2	1	

Overall, the average care scores represent a high quality of care delivered to patients who received an SJR.

The details of findings from those reviews that highlighted issues in relation to the amber/red points in the table above are covered further on in this report under the “Learning & Improvement” section.

4 LEARNING FROM DEATHS

This section of the report provides details on key learning that has been identified as a result of on-going Structured Judgement Reviews (including those escalated to the Triumvirate), Mortality and Morbidity Speciality meetings, LEDER reviews and any commissioned reviews that were undertaken collaboratively with the Clinical Commissioners. These lessons are not solely limited to the Speciality undertaking the review, and where possible can be replicated throughout the Trust.

4.1 Mortality and Morbidity Review in the Emergency Department

The Emergency Department regularly hold M&M meetings that have proven to be a valuable source of sharing learning and improvement.

The following learning has been taken from the M&M meetings that took place during the reporting period, Q3 2021/22.

The following case was presented by Chris Srinivasan at the departmental M&M meeting. The key points are as follows:

- Young woman 7 weeks since last menstrual period.
- Minimal vaginal bleeding and severe abdominal pain
- Had a 'vasovagal' in the ambulance

She had an ectopic pregnancy with massive internal haemorrhage that would have caused her death if she hadn't been successfully resuscitated and promptly operated on.

Learning points identified at the M&M meeting were as follows:

1) The recognition of shock.
The nurse in Initial Assessment set off a chain of events that resulted in the woman's life being saved because the nurse recognised that the patient looked unwell. The care was escalated to the Emergency Medicine consultant immediately. The EM consultant recognised that there were signs of shock including:

a. Air hunger
b. Pale
c. Clammy
d. Venous collapse
e. Hypotension
f. Altered mentation
g. Tachycardia.

2) Vasovagal events are something that happen in euvolaemic patients and, in this case, syncope was due to shock NOT vasovagal.

3) Repeated drills in the management of major haemorrhage, including a drill performed within 2 hours of the patient's arrival, are really useful in anticipating and planning such events.

4) One of the key learning points is that the haemoglobin was normal. If the patient had been risk stratified in terms of her haemoglobin, blood pressure and pulse, it would not have been apparent that she was close to death.

5) Management according to the Major Haemorrhage Protocol was excellent. Blood products were given in a 1:1:1 ratio. Calcium and Tranexamic acid were also given. The patient was actively warmed to avoid hypothermia. Bedside ultrasound confirmed the presence of intraperitoneal blood.

6) The responsiveness of the ITU registrar and outreach nurse was excellent.

7) The Gynaecology consultant was called directly and prepared the theatre to receive the patient. They understood from the relayed information how sick the patient was. This effective communication and cooperative attitude saved the patient's life.

The main message that the Emergency Department would want to disseminate is as follows:

"Do not be falsely reassured by a normal haemoglobin in haemorrhagic shock". Haemodilution must occur before the haemoglobin level drops.

It was discussed at the ED M&M meeting that many clinicians are falsely reassured by normal Haemoglobin and are not cognisant of the signs of acute haemorrhagic shock. This case of excellent practice clearly emphasises this point.

4.2 Mortality and Morbidity Review in the Paediatric Emergency Department
The following points of good practice, in addition to improvement requirements were discussed during the Paediatric ED M&M meetings during the reporting period.

Good practices include:

- Appropriate and well-timed Senior involvement
- Timely recognition of sick children
- Good adherence to various pathways.

Areas for improvements include:

- Lengthy triage times
- Documentation of triage times
- Communication between Registrars and Consultants at night

The following plan of action was formulated to help address some of the issues identified:

Action Taken	Delivery Date
Reminder regarding documentation Emails sent to the whole team, information given at induction and a note added to daily safety brief to aim to improve the standard of documentation.	Jan 22 Completed
Work on triage times Guidance provided (written) for triage nurses on information to cover and tasks to achieve during the triage process. Due to move to Nerve Centre based triage system.	Jan 22 Completed
Advice for registrars regarding calling Consultants Discussion held at ED Consultant meeting to ensure the agreement amongst Consultants in regards to the on-call criteria. This was then disseminated to the Registrar team via email, and included in the induction for new starters.	Jan 22 Completed

4.3 Mortality and Morbidity Review in the Department of Medical Elderly
Highlighted cases are discussed within the DME M&M meeting, as well as any pertinent cases that have been escalated via the Trust Medical Examiner Office.
The main area for discussion highlighted for this report relates to end of life care, in particular the ReSPECT form.

The learning identified in relation to the use of the ReSPECT form mimics the observations made during the ReSPECT form review that was undertaken in 2021. It includes:

- Weak ReSPECT plans– where the ReSPECT plan only contains a minimal amount of data, such as “ward level care only”. ReSPECT plans should be reviewed and strengthened when necessary, to demonstrate good practice and compassionate care.

- ReSPECT plans should be discussed with frailty in mind, ReSPECT = limited mobility

- Drug cards must be reviewed regularly, especially at times of deterioration.

- If invasive testing is ordered, this should be discussed with the family/Next of Kin, especially in severe frailty.

- Assess if starting coagulation is the right thing to do when investigating bleeding of an elderly patient. Ensure good documentation of risks vs. benefits.

- Opportunities to begin end of life care need to be acted upon as soon as possible, where appropriate.

Actions Taken
The DME department have taken actions to help improve the quality of care delivered, including:

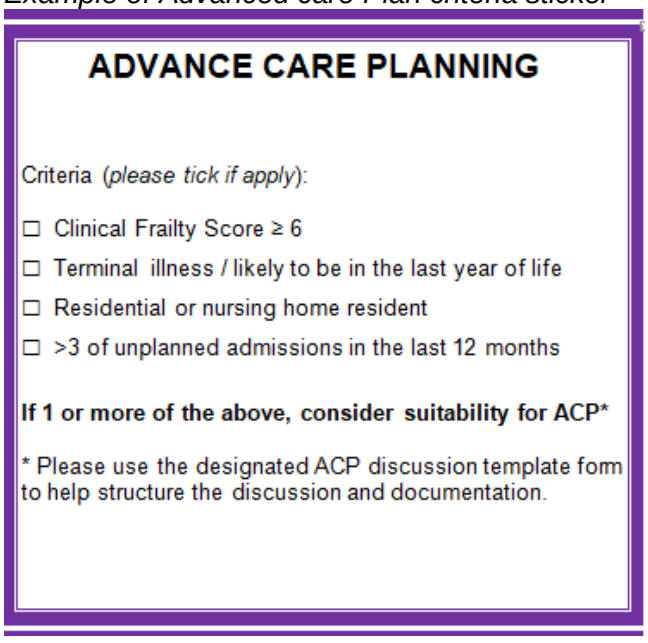
- A plan to generate a pack/leaflet for patients/relatives with details of what to except and what terms like DNCPR etc mean. To include info on advance care planning, falls, frailty, dementia, delirium etc. This could be available on all wards jointly.

- The formation of a working group to aid imporvmeent work in relation to ReSPECT planning, potentially led by Registrars, charge nurses and sisters.

ReSPECT Plan – Quality Improvement Idea
Dr Uzma Tazeen has led on a quality improvement plan within the department of Medical Elderly. The project serves as a proof of concept and demonstrates a strong idea that could potentially be developed into a larger network, with the proper refinement and backing.

After it was noted that the quality and extent of ReSPECT documentation had not been very clear on the form, with the quality and detail of the discussion is not always outlined. It is good practice for junior doctors to engage in advanced care planning and there is a need for improvement in this area. An advanced care plan criteria sticker was developed to act as a visual prompt to engage properly with ReSPECT planning and to have the required discussions to consider ReSPECT initiation.

Example of Advanced care Plan criteria sticker



Using the advance care form with relevant questions not only gave extensive and detailed discussion it has also improved the quality of our discussion and has helped asking the family/NoK relevant questions. The team have managed to standardise their discussions and also record it on the ReSPECT paper form, with a plan to upload it on to Lorenzo.

Noticeably, if the information is recorded on Lorenzo it prints on the IDL and acts as valuable information for the community team to look at. The team have noticed that in their M&M meetings they have found the information useful and also as a record of valuable discussion with the family/NoK and it appears to have helped reduce complaints as well.

If this proof of concept is to be taken forward and developed, it will require a full multi-agency agreement with input from providers such as YAS, Dove House Hospice, CHCP, CCG and the Trust, in addition to other providers who will potentially benefit.

5. M&M IMPROVEMENT WORK

The Mortality and Morbidity Task and Finish Group continued to meet every two weeks in Q3 to continue with the improvement work to fully understand the Trust's mortality outlier status including HSMR and SHMI and undertaking improvement in areas that continually flag as experiencing higher deaths than expected.

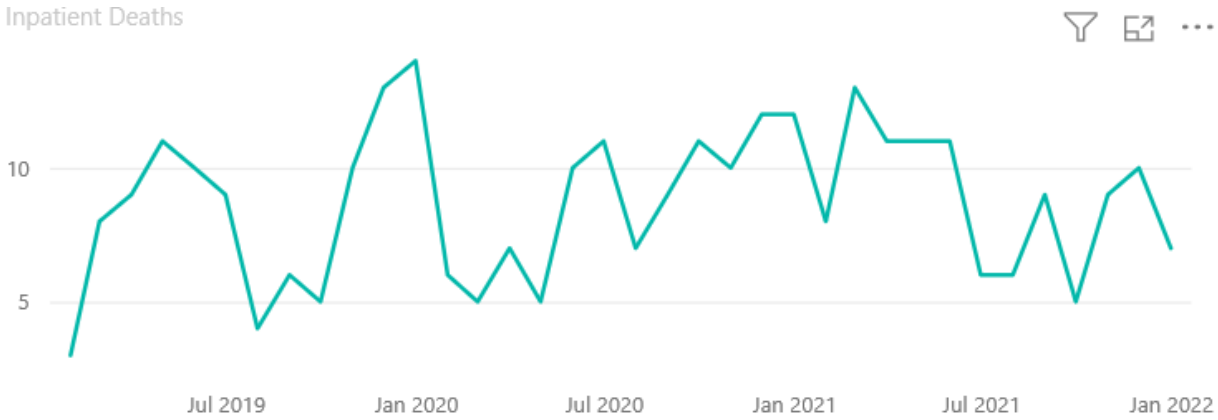
One area of focus for the group has been Stroke 30-day mortality and in response to this have worked with the Clinical Leads and have developed a Stroke Mortality dashboard that monitors HSMR and SHMI for HUTH and against its Peers and compares it against spells, LoS, discharges and re-admissions and the deaths that occur on the Stroke Unit against the deaths that occur on a Ward. The Clinical Lead has presented to the M&M Task and Finish Group and to the Trust Mortality Committee to discuss the planned improvement work and to be able to explore the data to ensure the records are reflective of the service. The Stroke dashboard is continually monitored and the learning from deaths has also improved as detailed in Section 6 below.

The group has been considering the impact of inequalities in the area on the Trust's mortality status and how this differs to other areas in England and how this is reflected in the data. An enquiry was sent to NHSEI. NHSEI are running a Health Equity Improvement Programme to improve the delivery and accountability of national, regional and System health inequalities priorities through a learning and supportive culture. This includes ensuring datasets are complete and timely. Further work is required with the ICS; however, the Trust is committed to improving this area, this will continue.

Work started on the development of a Mortality dashboard in line with best practice as stated by NHSEI. The group have looked at the dashboard readily available on CHKS against what is available internally and have agreed to use these resources to build a dashboard that compares actual deaths against expected deaths, completion of SJRs against the number of deaths and allows the group to focus on the areas with the highest mortality, this section will change as and when the data does. Currently the group is looking more in-depth against Stroke, Sepsis and Pneumonia. The dashboard will also identify 'hotspots' as they appear. The Deputy Chief Medical Officer is also focusing on post-surgery deaths in Vascular and Cardiac as they were the two areas with higher number of in-hospital deaths within 30 days of elective surgery. This will continue into the next quarter and an update will be provided in the Q4 Learning from Deaths report.

6. STROKE MORTALITY & MORBIDITY

The following dashboard provides crude mortality (in-patient) statistics covering the last 36 months to date.



Since July 2021, the number of in-hospital deaths has reduced. Although the crude mortality figures do not work on the same calculations as SHMI/HSMR, it is still important to have oversight of crude statistics.

The following table provides a breakdown, by month and by ward, for the number of in-hospital deaths occurring over the last 36 months.

Per Month

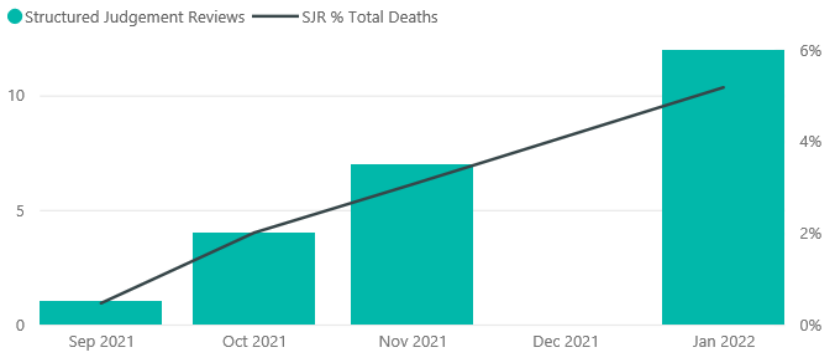
Month	2018/19	2019/20	2020/21	2021/22	Total
Apr		9	7	11	**27**
May		11	5	11	**27**
Jun		10	10	11	**31**
Jul		9	11	6	**26**
Aug		4	7	6	**17**
Sep		6	9	9	**24**
Oct		5	11	5	**21**
Nov		10	10	9	**29**
Dec		13	12	10	**35**
Jan		14	12	7	**33**
Feb	3	6	8		**17**
Mar	8	5	13		**26**
Total	**11**	**102**	**115**	**85**	**313**

Per Ward

Ward	Deaths	% of Total
H110 - Ward 110	212	67.7%
HASU - Hyper Acute Stroke ...	47	15.0%
H11 - Stroke Unit	31	9.9%
HGHD - HICU2	7	2.2%
H9 - Ward 9	6	1.9%
HICU3	4	1.3%
C28 - Ward 28	1	0.3%
H100 - Ward 100	1	0.3%
H37 - Ward 37	1	0.3%
H5 - Ward 5	1	0.3%
H50 - Ward 50	1	0.3%
HAAU - Acute Assessment U...	1	0.3%
Total	**313**	**100.0%**

Structured judgement reviews are undertaken regularly and in good compliance with the proposed plan of action in relation to the outlier status.

The following graph shows that the number of SJR's undertaken within Stroke is increasing each month.



The table below provides an overall summary of Structured Judgement review care scores that were completed during the reporting period.

Section	Avg Score	1 Poor	2	3	4	5	6 Good
1. Phase of Care							
Admission & initial care (1st 24hrs)	3.6		2	10	11	3	
Care during a procedure							
End of life care	4.2			2	16	8	
Ongoing care	3.6		2	10	10	4	
Overall assessment of care	3.7		1	11	10	4	
Perioperative care							
2. Avoidability of death							
Avoidability of death judgement							
3. Themed Analysis							
Ceiling of care	2.0		1				
Communication with patient/family	4.5				1	1	
Documentation							
End of life care	4.8				1	3	
Fluid balance	2.7		1	2			
Interventions	2.0		1				
Management plans	4.0			1	1	1	
Medication \ Prescribing	2.5		1	1			
Multi-disciplinary care							
Other	2.6		5	3	1		
Senior clinical involvement	3.0			2			
Sepsis management							

Good practices identified from completed SJR's include:

- Fast access to Specialist Palliative care review
- Early recognition of the dying patient, with appropriate and compassionate discussions held with the family/NoK.
- Fast access to CT scan, within 1 hour.

Areas for improvement include:

- Relatively large gaps in documentation, giving the impression that the patient was not assessed in good time.

There was a case that received an SJR that requires further investigation, which is currently underway. The outcomes from this will be shared in the next quarterly report.

7. LEARNING FROM THE REVIEW OF PATIENTS WITH LEARNING DISABILITIES

The Trust aims to undertake SJR's on all patients who pass away in the hospital and have a learning disability, in addition to partaking in the LeDER review program. The majority of SJR's for this patient cohort are undertaken by the Trust safeguarding specialists.

Overall, the completed SJR's reflect good care delivered to patients with a learning disability.

Some of the recurrent themes in terms of improvement include:

- Gaps in documentation in relation to pressure care
- Lack of ReSPECT plan within the case-notes / Lorenzo, thus potentially leading to a patient not dying in their preferred location.
- Communication with community care settings – in some cases it appears that there were delays in communicating the patient's deterioration to the hospital.
- Incomplete recording of capacity status on ReSPECT plan

SJR's for patient with learning difficulties continue to be undertaken and form part of their minimal criteria for review set by the National Quality Board.

8. MEDICAL EXAMINERS UPDATE

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 from February 2022 and to also cover community deaths, along with the improvement of capturing themes, identification of learning and reporting.

During Q3 2021/22, there were 690 deaths at HRI. Scrutiny was undertaken on 544 deaths (**78.8%** of all HRI deaths).

Themes and Trends Identified from the Medical Examiners Process

Poor documentation continues to be a theme, especially in regards to illegible handwriting. It is in some cases very difficult to read a clinicians signature, which in turn makes it difficult to assess if a patient was reviewed appropriately as per national guidelines and Trust policy. Also a lack of documented GMC number in some cases continues to add to this issue. There continues to be difficulty in communicating with Wards, in many instances the telephone is not answered, or the wrong number is in use/advertised. In one case, lack of communication with the Ward led to a family not being able to be present for the death of their family member.

9. PLANNED IMPROVEMENT WORK

A number of areas for further improvement, implementation and action have been identified to be undertaken during 2021/22. Some of these improvement areas are detailed below:

Collaborative Review with the CCG – ED Re-presentation

A sample of 20 case notes is to be reviewed collaboratively by the Trust and Hull CCG to assess re-presentations to the Emergency Department, for patients who:

1. Attended twice to the ED within 48 hours
2. Were coded as either
   - Abdominal pain
   - Chest pain
   - Confusion
3. Were admitted on the second presentation

To assess:

1. Source of first attendance
2. Follow up arrangements in place after first attendance
3. Communication
4. Source of second attendance
5. Disposition

A report shall be produced and circulated at the Trust Mortality and Morbidity Committee in April 2022.

Continuing to Engage with Speciality M&M Meetings
The Effectiveness and Improvement Manager is currently engaging with each speciality M&M lead in order to understand how M&M meetings are taking place within their speciality, such as what format is adopted (presentations/case studies), and how frequently they are happening, as well as attending as many M&M meetings as possible.

Regular Mortality Statistics for Specialities via Power BI
An updated business intelligence report has been deployed to allow the production and dissemination of Speciality level mortality statistics. This means that each M&M lead can have access to details of all deceased patients, in addition to Speciality level statistics.

Feedback of SJR for M&M Inclusion
All completed Structured Judgement Reviews will now be fed back to the M&M lead to allow for discussion within the M&M setting. The aim is that any outcomes and learning, themes and trends, from all M&M meetings are to be recorded in a standard manner, thus allowing for a higher level of thematic analysis, increased reporting robustness and better governance. All outcomes and learning will also be fed back to the SJR reviewer to allow for learning to be shared and acted upon.

10. RECOMMENDATIONS
The Board is recommended to receive this report and:

- Decide if this report provides sufficient information regarding Mortality and Learning from Deaths
- Decide if any further information and/or actions are required

Chris Johnson
Effectiveness and Improvement Manager
February 2022

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

RESEARCH AND INNOVATION STRATEGY & ANNUAL ACTIVITY 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 and annual activity report.

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 (objectives achieved in 2021-22 highlighted in green)*.

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 ongoing. 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 166% of its 2021-22 'NIHR portfolio' participant recruitment target with over 7,200 recruits. In total, nearly 8,000 participants volunteered to undertake a research opportunity in our Trust in 2021-22.

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, and was 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 research activity for 2021-22.

Following the Trust's tremendous contribution to COVID-19 research over the past two years, 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 and North Yorkshire Health and Care Partnership.

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 expand, 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 have now secured a Genetically Modified Organisms (GMO - Contained Use) license from the Health and Safety Executive. This will initially support the delivery of a specific Hepatitis-B 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.
- **Expanding our research capability** - Our Infectious Disease team continues the crucial COVID-19 vaccine trial work. The latest project, led by Moderna, recruited staff to take part in a new vaccine trial targeting the Omicron variant of Covid-19.
- **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. To date, over 4,500 patients have consented to this important study. The Respiratory and Therapies teams are working with colleagues across the patch in a major new research consortium, which will inform medium- and longer-term policy and health system responses to long COVID. Our Trust will support the delivery of an important 'Long-COVID' study 'STIMULATE-ICP'.

- **Exploiting our research potential –** A concerted effort by our local partners (HYMS, UoH) to bring together all key stakeholders to embed a pipeline of PET-CT research is gathering momentum with one study in the advance stages of negotiation with an international commercial company.
- **Exploiting our research potential –** The R&I Office has seen a rapid increase in the number of projects using Artificial Intelligence to explore the impact on clinical decision-making, resource allocation and service pathway design. The Trust is currently in early feasibility discussions with two commercial companies including projects to use AI technology in breast screening (supported by NHSx) and improved detection of abnormal chest x-rays. Academically, partnerships between clinicians in Cardiology and staff at the University of Hull are beginning to explore the use of large datasets with AI technology. Furthermore, following a strategic attempt to align clinical and academic to enhance research delivery, colleagues were invited to submit potential AI projects that could be taken up with support from MSc students at the University of Hull's Faculty of Science and Engineering. Six potential projects have been chosen to be taken forward. This is the first time such a collaboration has been attempted and it is hoped this can create a mutually beneficial mechanism to unify the clinical and academic skills on our doorstep.

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.
- **Research Workforce Strategy** – the Trust's Lead Research Nurse is embarking on the development of a number of initiatives that will support the growth and development of our established research workforce (nurses and support staff) as well as providing a platform for inclusivity and integration of all staff in the delivery of great care through unified research and innovation activities. This includes the development of a research and innovation 'link nurse' on each ward/departmental area.
- **Research communications and engagement strategy** – a number of initiatives were enacted in 2021-22 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&I office, a refresh of the R&I Website, the creation of an e-newsletter, an external communications campaign, development of promotional materials and videos for social media. This rebranding was formally launched in the week commencing 11th April 2022 as part of a focused 'celebrating research and innovation' week.
- **Research 'Celebration' Event** – Hull University Teaching Hospitals NHS Trust, the University of Hull and Hull York Medical School hosted a 'research celebration event' on Friday 8th April 2022. The aim was to showcase the exceptional research and innovation collaborations that are underway across our institutions. It highlighted the opportunities for staff at all levels and disciplines to get involved in clinical research and innovation and provided a forum for informal networking to stimulate future collaborations that, it is hoped, can directly or indirectly deliver a real and lasting difference to the quality and experiences of clinical care for our patients.

c) Positive Proactive Partnerships:

- ***Humber and North Yorkshire Health and Care Partnership* -** The Trust wishes to lead the establishment of a Humber and North Yorkshire Health and Care Partnership 'Research Collaborative' initially of the Acute Providers in the patch; Harrogate, HUTH, NLAG and York. In the second half of 2021-22, plans to cement our research

relationships with our immediate neighbours (NLAG and Humber) have taken shape, culminating in an agreed Memorandum of Understanding. An initial meeting with the HCV ICS and acute Trusts was held in March and established a blueprint for a formal governance pathway for research and innovation activities.

- **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. A seconded Trust employee, Aarthi Rajendran, commenced in post as 'Health Innovation Manager' in April 2022. Over the next 12 months, the post-holder will be crucial in identifying our collective innovation assets as well as 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. HYMS will also be supporting the academic component of another senior clinical academic post in diabetes and endocrinology over the next financial year to increase the critical mass of clinical academics working in our Trust.
- **Cancer Data Network (IQVIA)** – The RDI 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. Although there are plans to extend beyond cancer, 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 RDI 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 with one project underway in 2021-22. It is hoped this will be a vehicle to increase the understanding of research by 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 in 2022-23 and beyond if unresolved.

a) Risks:

- The inevitable reduction of support services capacity (i.e. imaging, labs, pharmacy) dealing with clinical service delivery backlogs which may limit the ability to take on some new research activity as well as slowing down existing activities. This is being addressed on a national level by DHSC and NIHR but local strategies are needed.

- 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. 2021-22 has shown our staff have worked incredibly hard to ensure our recovery from a 'COVID legacy' is ahead of trajectory.
- Reconfigurations and the implementation of social distancing have led to several research areas experiencing accommodation issues. Capital developments will need to ensure research and innovation activities can be accommodated and staff appropriately housed.

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 two years 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 Humber and North Yorkshire Health and Care Partnership.

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 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 is sought in the pursuit of the outlined strategic initiatives.

Prof Thozhukat Sathyapalan
R&I Director, Hull University Teaching Hospitals NHS Trust

May 2022

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 as at 31.03.2022

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 03/04/2022)

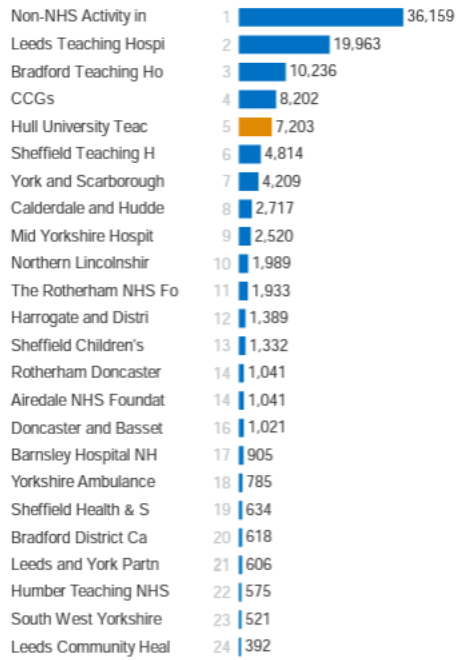
Recruitment	Total: 7,203	Queried: 66
Percentage of YTD Recruitment Targets *	166%	
Percentage of Year End Recruitment Targets **	166%	
Trust Share of LCRN Recruitment	6.5%	
Commercial : Non-Commercial Recruitment Ratio	4% : 96%	

* YTD = Activity & Target to end of AprMay. Performance against YTD target will be underestimated if data cut is early in m...

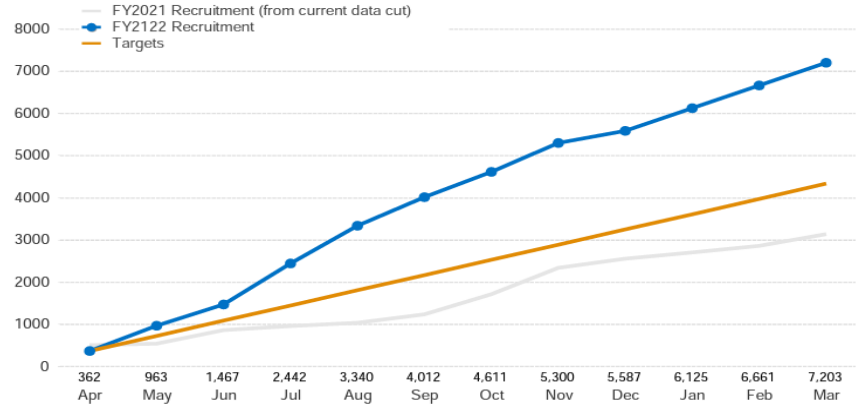
** Year end Local Target = 4,331, 100% of year elapsed

LCRN Recruitment FY2122 (data cut 03/04/2022)

Recruitment

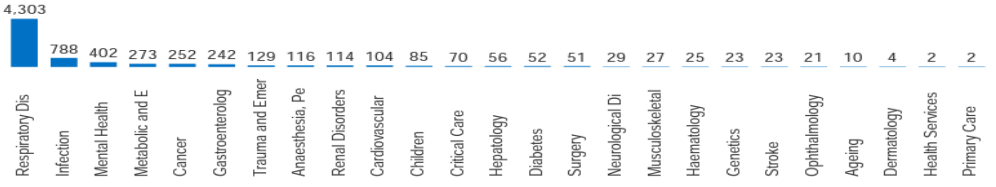


Monthly Recruitment Trend (data cut 03/04/2022)

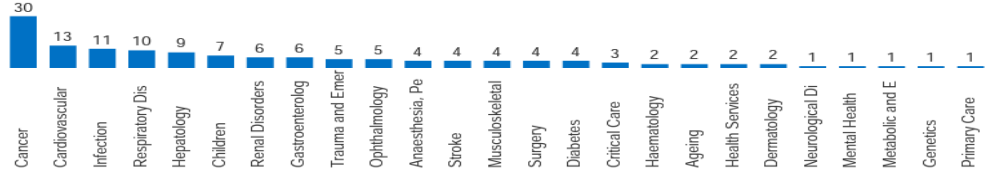


Recruitment by Specialty FY2122 (data cut 03/04/2022)

Recruitment



Recruiting Studies



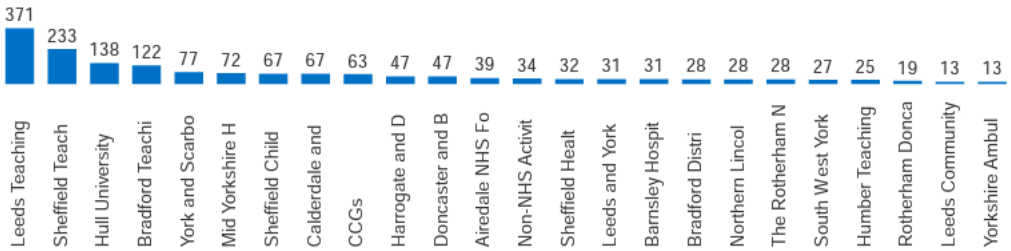
Appendix 3: Research Activity by study type as at 31.03.2022

NIHR | Clinical Research Network Yorkshire and Humber

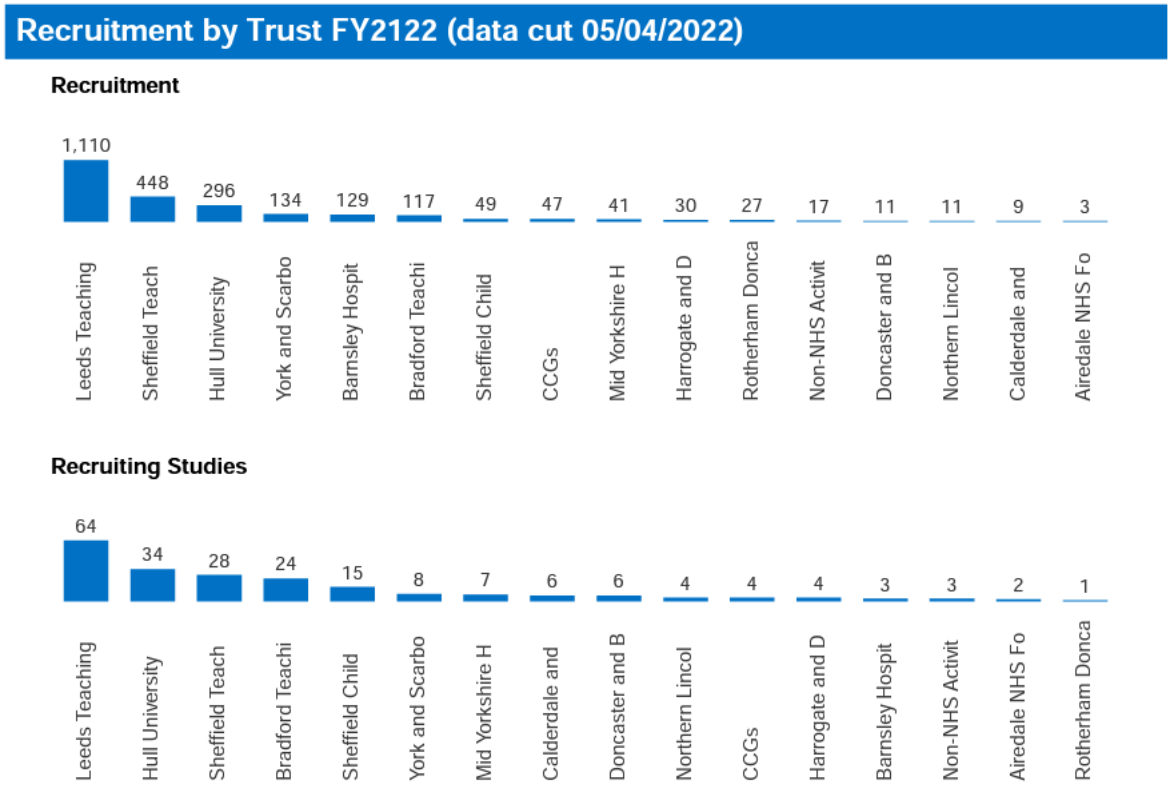
LCRN Recruitment by ABF Category
ABF Year: Apr 2021 to Mar 2022

TrustName	Large Observational	Observational	Large Interventional	Interventional	Commercial	Total Recruitment	Total Weighted Recruitment
Total						**111,006**	**323841.02**
Non-NHS Activ...	8,168	5,488	21,860	629	17	36,162	56155
Leeds Teachi...	2,826	6,995	7,085	1,944	1,110	19,960	90622.42
Bradford Teac...	5,329	2,461	1,188	1,141	117	10,236	29520.03
CCGs	2,428	3,579	1,006	1,214	47	8,274	33784.5
Hull Universi...	**4,693**	**1,234**	**248**	**736**	**296**	**7,207**	19346
Sheffield Teac...	175	2,619	373	1,210	448	4,825	24912.63
York and Scar...	2,899	678	272	233	134	4,216	8963.75
Calderdale and...	1,730	658	227	106	9	2,730	5818.84
Mid Yorkshire...	1,648	221	186	425	41	2,521	7593.32
Northern Linco...	974	953	14	37	11	1,989	4740.5
The Rotherh...	1,657	208	64	6	0	1,935	2525
Harrogate and...	794	389	33	143	30	1,389	3891.5
Sheffield Child...	210	752	0	326	49	1,337	6428
Airedale NHS...	604	363	25	46	3	1,041	3017.33
Rotherham D...	501	416	0	97	27	1,041	3024
Doncaster and...	421	317	8	264	11	1,021	4435.2
Barnsley Hosp...	590	168	0	18	129	905	1376
Yorkshire Am...	46	656	0	101	0	803	3453
Sheffield Heal...	280	239	0	118	0	637	2414.5
Bradford Distri...	306	127	0	187	0	620	2807.5
Leeds and York...	179	220	0	212	0	611	3281
Humber Teach...	244	187	56	105	0	592	2109.5
South West Yo...	290	146	0	111	0	547	2022
Leeds Comm...	149	185	0	73	0	407	1599.5

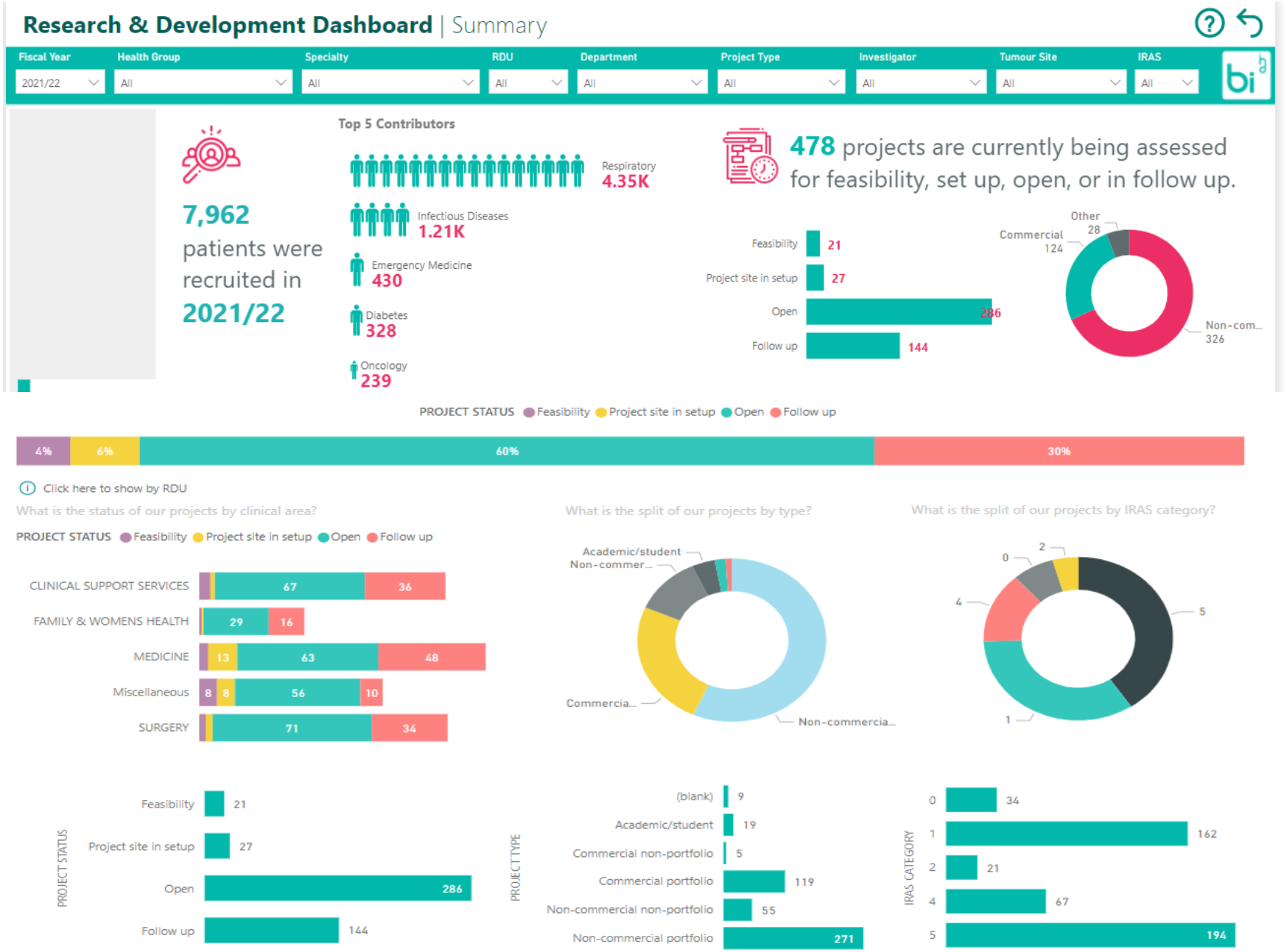
Recruiting Studies



Appendix 4: Commercial Research Activity as at 31.03.22



Appendix 5: R&I Summary Dashboard as at 31.03.22



Report to the Board in Public
Quality Committee
April 2022

Item: CQC Update	Level of assurance gained: Reasonable
The Committee agreed reasonable assurance with regard to the CQC update, ongoing work was highlighted in relation to the insight report released in March 2022. The Trust remain outliers in five national audits and the committee were able to be mindful of the data delay with the assurances received in the sub-committees. The internal assurance visit schedule was now in place with the next unannounced visit planned in April. External representation for the next visit will be a CCG representative.	
Item: Quality Accounts Update	Level of assurance gained: Reasonable
The Committee agreed reasonable assurance with regard to the quality accounts update, the publication timetable was provided and is on target.	
Item: QRP / Enhanced Monitoring	Level of assurance gained: Reasonable
The committee agreed the assurance level was reasonable, the Trust continue to provide substantial assurance at the meetings and agreement remains to pursue an exit strategy.	
Item: Quality Risks / Board Assurance Framework 22/23	Level of assurance gained: Reasonable
The committee agreed the assurance level was reasonable. A Board development sessions was held on 12th April in which the Board Assurance Framework was drafted, the framework will be endorsed in May and June and sign-off at Board in July.	
Item: Maternity Reports / Ockenden Update	Level of assurance gained: Reasonable
The committee agreed the assurance level was reasonable. The committee received the update on the Ockenden report following final report publication in March along with the Perinatal Quality Surveillance Tool, Avoiding Term Admissions into Neonatal Units (ATAIN) and Perinatal Mortality Review Tool reports. The maternity team are working with the quality improvement team to review the action plan in response to the updated Ockenden report, which will be shared with the committee and will combine all key priorities. The main areas of focus will be staffing levels, governance roles and responsibilities, promoting an open culture and learning from families, incidents and events.	
Item: Infection Prevention and Control Quarterly Update	Level of assurance gained: Reasonable
The committee agreed the assurance level was reasonable. It was noted that there will be a focus on MRSA Bacteraemia during 2022/2023 due to six cases being reported in 2021/2022. It was highlighted that the guidance for living with covid had significant changes.	
Item: Patient Experience Quarterly Report	Level of assurance gained: Reasonable
The committee agreed the assurance level was reasonable. The report was provided in a new format providing additional detail and provided an overview of all areas including volunteers as well as sharing the work being introduced as part of the team now sitting in the Governance Directorate.	
The following reports were shared with the committee for information; • Research and Innovation Strategy • Patient Safety and Clinical Effectiveness Sub-Committee • Non-Clinical Quality Sub-Committee	

Hull University Teaching Hospitals NHS Trust
Quality Committee
Held on 28th March 2022, 10 – 11am
Via MS Teams

Present:	Mr D Hughes	Chair
	Prof Purva	Chief Medical Officer
	Mr E Quider	Associate Director of Quality
	Mr P Sedman	Deputy Chief Medical Officer
	Mrs M Stern	Patient Representative
	Dr A Green	Lead Clinical Research Therapist
	Mrs R Thompson	Head of Corporate Affairs
	Dr A Pathak	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Mrs J Goode	Chief Pharmacist
In Attendance:	Miss R Boulton	Quality Governance Officer (Minutes)
	Mrs D Lowe	Hull CCG

No	Item	Action
1	**Apologies** Mrs Rostron, Director of Quality Governance Mrs B Geary, Chief Nurse Mrs J Ledger, Deputy Chief Nurse Miss L Coneyworth, Head of Effectiveness and Improvement.	
2	**Declarations of interest** Mrs Lowe declared that she works at NHS Hull CCG. Dr Hughes declared that he currently works at Sheffield Teaching Hospitals NHS Trust and will be taking up an advisory role to NHSEI from 1st April.	
3	**Minutes, Action Tracker and Workplan** **3.1 Minutes of the meeting held 28th February 2022** The minutes for February's committee were reviewed and agreed with the below minor changes. Prof MacLeod required her apologies noting. Page 4, paragraph 7 amended to read Dr Purva explained that recently 2 patients who could have been discharged to a care home , were not, as the relatives felt it was not suitable. Another patient who could have been discharged was not due to the ambulance not securing the correct equipment in time for transfer. This resulted in 3 patients having prolonged stay in the hospital. Dr Hughes noted that he wished to make some minor amendments to wording in 5.4 which would be addressed post meeting. **Post meeting Note** Page 7, paragraph 1, second sentence was amended to read; Mental Health patients remain a key concern due to no improvements having been seen in progression of patients presenting with acute mental health issues particularly in teenage patients. Page 7, paragraph 7 was amended to read; Dr Hughes reflected that it is a real operational issue currently and high risk of patient harm as not in a therapeutic environment.	
	3.2 Matters Arising No maters arising were raised.	

	3.3 Action Tracking List The tracker was reviewed within the meeting, no outstanding actions.	
	3.4 Workplan 2022/23 The work plan was available Dr Hughes confirmed that the fundamental standards updates were yet to be finalised in the plan.	
4	**Quality Governance** **4.1 Board Assurance Framework (BAF)** Mrs Thompson shared the board assurance framework and confirmed today was presenting the year-end position and confirmed next year's BAF would be developed and agreed at April's Board Development session. The committee were asked to discuss the three areas for quality and agree the proposed final targets. Mrs Thompson shared that for BAF 3.1 the target was achieved due to the actions undertaken to the new quality committee structure, the quality improvement redesign work and the development of the Quality, Service Improvement and Redesign (QSIR) faculty supporting the Trust to embed quality improvement. The governance team have also developed an assurance visit schedule, which was trialled last year and the well-led session completed with the Board. Prof MacLeod agreed that the risk had been reduced to the appropriate level and has provided the mechanism to achieve 3.2. Mrs Lowe advised that the commissioners and stakeholders had been invited to be involved in the assurance visits and welcomed the openness. Which was echoed by Dr Hughes and the committee agreed we had achieved the target. Mrs Thompson advised that we were not going to meet the target risk for 3.2 due to the waiting lists and still being monitored under the Quality Risk Profile (QRP) framework. Outside factors had impacted on the Trust's ability to deliver the proposed recovery trajectory including Omicron and the rising numbers of 'no criteria to reside' Dr Hughes shared that 3.1 was within our gift to deliver but there were a lot of outside factors impacting our delivery but it was our responsibility to mitigate the risks within our control. Mrs Lowe noted that it was a broad risk and a long trajectory, which may benefit from breaking down as some areas highlighted maybe much easier to shift the scoring and better to separate to demonstrate changes. Mrs Thompson responded that corporate risks are broad by nature but acknowledged it is important to capture the secondary level. Proposed we keep the risk as it currently captured but suggest we keep under review and would take the comments to board development. The committee agreed the proposal was an accurate reflection of where we are and that we had not achieved the target for 3.2. Mrs Thompson confirmed that Research and innovation achieved the target risk for BAF 6 earlier in the year, and that were looking to re-scope the risk in next year's BAF to focus on investing in the support structure. Prof Purva shared that covid has enabled the Trust to raise their research profile; we have managed to get to on the international front by participating in covid research. The positive reputation will enable the Trust to get future buy in and support for future Research and Development and financial sustainability. Additional funds have been requested to achieve the Research and Innovation plan for 2022/23. The risk going forward would reflect the importance of getting the funding.	

	Dr Hughes confirmed he was aware of the HUTH research and development position prior joining the Trust and shared that during pandemic the good news stories from research was a positive that we would like to maintain. Prof Macleod shared that a lot of clinical trials were losing funding as were no longer supported, which is a trend of the past few years. Mrs Lowe noted that there may be opportunities within the ICS which may contribute to reducing the risk. Mrs Thompson shared that the remaining risks were to be discussed in Performance and Finance and Workforce, Education and Culture committees. The committee confirmed they were in agreement with the end of year position and welcomed the report, which supported the committee confirming the decision. Dr Hughes noted that the committee has an interest in BAF 4 (There is a risk to access to Trust services due to the impact of Covid-19) and welcomed comments, as we have not met the proposed target, which has been impacted by external factors. Prof Purva indicated that the current climate will be an issue for some years and the Trust had issues prior to covid with manageable waiting lists, so we have some work to do to get things under control. Dr Hughes confirmed they commended the report to Board.	
	4.2 Annual Committee Report and Effectiveness Review Miss Boulton shared the outcome for the committee's effectiveness review confirming that the committee scored 'four' most of the time / above average in all areas of the review. There was a positive comment related the Strategy, 'The BAF has certainly helped with aligning the work of the QC to the Trust Strategy' which was noted. There were comments for the committee to consider in relation to Quantity and Quality of Information, 'There is a lot of information presented – sometimes, perhaps without thought for the needs of the Committee. Shorter more succinct papers would be sufficient and would not reduce effectiveness.' Prof Macleod shared that whilst it was appreciated some papers were submitted to multiple forums, a paragraph on the front sheet would be helpful to committee members. Dr Hughes confirmed that he would support the committee receiving succinct papers or a paragraph on the front sheet and confirmed the committee held reasonable assurance from the report.	
	4.3 QRP / Enhanced Monitoring Mr Quider updated the committee that the last meeting was stood down due to operational pressure and the next meeting was 11th April. The trust were still providing positive assurance each month and continued to pursue the requested support to exit enhanced monitoring. Prof Purva related the frustrations regarding what we are being measured against, the group has expanded its remit and questioned the relevance of some of the attendees. Mrs Lowe acknowledged the frustrations and shared that it was not something that could just be stood down as it is a stakeholder process. Initiating the enhanced monitoring involved commissioners and stakeholders, all involved need to be agreement to stand-down. Mrs Lowe agreed the meeting needed to limit discussions to the initial 7 key areas and then determine what is business as usual and what is post pandemic and supported the discussions about needing system wide support to identify who holds the lead for each of the 7 areas.	

	Dr Hughes confirmed that there was value to that mutual understanding and agreed the remit did not drift and the recognition some issues are system wide was positive. Dr Pathak asked how other Trusts in the process were managing the risks as some of the issues were national risks. Prof Purva responded that the trust was an outlier in certain areas, we have a high level of 'no criteria to reside' and 104 week waits which is the highest in our ICS this is compounded by external factors of high level of deprivation and second lowest GP levels in the country. Dr Hughes confirmed it would be a challenge to assess ourselves against other organisations as there are no direct comparable trusts but there are indicators that we are outliers in certain areas.	
5	**Patient Safety** **5.1 Quality Report** Mr Quider shared that the work on the IPR was ongoing with the Business Intelligence team and improvements to the process being agreed so the committee would continue to receive updated reports. Mr Quider advised that the Statistical Process Control (SPC) charts regarding Duty of Candour was still not reflective of the data from Patient Safety. The Duty of Candour policy is being updated and will be brought to the Quality Committee once completed. There were 230 Patient Advice Liaison Service (PALS) concerns received in January, treatment continues to be the highest reason related to delays and cancellations. The complaint process is being reviewing in-line with the new standards framework Patient Safety Incident Response Plan. The Patient Experience team will move into Quality Governance directorate from the 1st April so will work closely with the wider team to make improvements. The SI backlog is reviewed at the weekly meeting and we are revisiting the trajectory. Training is to be arranged to establish more chairs and leads for investigations. There is no escalation to raise today for Infection Prevention and Control, there will be a quarter four update from the Director of IPC mention in April's meeting. The trust is an outlier in our SHMI scores, among only 10-12 Trusts in the country who are outliers. The high nosocomial covid infection rate in January – March 2021 contributed to our outlier status. We will remain an outlier for the next 4-5 months until the scores are updated. The trust is looking at data collection and also using structured judgement reviews to ensure that there is nothing untoward contributing to a higher mortality rate. Dr Pathak queried if there were any particular speciality for the increased mortality we should monitor and what were the reasons for the cancellations experienced by patients were, being mindful that patients are in the mind-set to have a procedure and then being cancelled at short notice has a significant impact on those patients. Prof Purva shared that a key area for mortality is sepsis and there were a number of possible reasons including under and over diagnosis and shared that there was a quality improvement project to deliver antibiotics within the first hour. Cancellation is a lot more complex, as there are a number of factors affecting the reasons for last minute cancellation with covid still having significant impact with both patient and staff testing positive, which resulted in inpatient staffing being unpredictable. We need a number of staff to facilitate the admission, and do not know until the day that all staff are all available and then also the patient turning up non-covid positive. We do try to bring in other patients in case of cancellations, and there are a list of patients willing to take a cancellation. We anticipate this situation will continue for some time unless there are changes to testing guidance. Professor Purva confirmed that we maintain detailed statistics on cancellation reasons.	

	Dr Hughes agreed the report held a lot of information and was a work in progress and confirmed that this provided reasonable assurance to the committee	
	5.2 Medicines Safety and Optimisation and Medicine Management Annual Report Mrs Goode shared her presentation with the committee, since starting last year she has now been able to share her first 100 days in post. She has set out to identify the risks at an organisational level around discharge and the outpatient pharmacy contract and review the medicine optimisation strategy and framework. The HRI site has a new pharmacy location and robot, although there are still capacity issues and we are there is still some work to do around KPI's. The HRI site produces twice as much volume of work as CHH. Mrs Goode provided an insight into the CQC positive engagement meetings throughout covid and annual meeting and shared that there is a move towards more patients focused issues e.g. anti-microbial stewardship but there still remains an interest in storage, fridges and controlled drugs. The committee were also provided with medicine and covid vaccination spend in 2021, corresponding spikes in costs were in-line with the pandemic peaks and vaccination rollouts. The Hull COVID Medicines Delivery Unit (CMDU) this was set up at short notice a week prior to Christmas and seen 2101 referrals in the period 16th December – 28th February. The team have been treating high risk of covid community patients, and as time has progressed other Trusts are picking up other responsibilities. The Trust is currently still triaging for NLAG but they are looking at alternatives, so we are expecting those numbers to reduce but as infection rates increase we have been prescribing more. Mrs Goode in regards to Medicines Governance meets with Prof Purva on a regular basis and there are a number of meetings in place Trust wide and health group governance meetings. The medicine safety officer reviews all medicine incidents and serious incidents. There is good assurance on controlled drugs with 6 monthly Pharmacist audits, the trust has automated cupboards and CCTV on wards, all incidents are reviewed with security and nursing. An annual report is produced to the Safe Medicine Practice Committee. Regarding issues across the interface, we need to review discharge and we are trialling pharmacists prescribing for discharge to speed discharge. There are some joint posts with NLAG being explored and we are working towards joint formularies with NLAG and aligning red/amber drug lists and HASR work. The large project in the Trust is Electronic Prescribing and Medicine Administration (EPMA) which will be going live in May 2022 at the HRI site as the CHH site went live at the end of 2021. We hope this will reduce of dispensing times, targets are 93 minutes for discharges and 120 for all others currently the average is 69 CHH and 105 at HRI and believe EPMA will assist to bring this inline. We have trialled in outpatients which is going well and this will be expanded.. Hull and NLAG have separate prescribing systems which don't communicate so work is ongoing to improve the alignment of the systems. Prof Purva acknowledged the work done in the CMDU and the work in the ICS and asked what impact the increased work had on the workforce and if it had impacted negatively on our internal activity if not resources. Mrs Goode responded that staff have come in over the weekend and staying late to support this work, we are costing the extra costs and taxi costs, which are currently funded by pharmacy budget. The additional costs to the trust have been escalated at the regional meetings but currently informed there are no additional funds. Prof Purva agreed that the good will of staff needs recognition for the work they have carried out.	

	In addition to the monetary spending noted on the SPC chart are we monitoring the safety of medication we are prescribing. Mrs Goode confirmed the Bluetek forms were alongside the costs and we have highlighted specific areas of concern which we will be discussing at the next drug and therapeutic meeting, which a consultant will be presenting at. Prof Purva sought assurance that the pharmacy participated in the internal assurance visits and Mrs Goode confirmed that they been involved in the pilot last year and would be going forward as well as ward visits. Dr Pathak shared there was nothing but praise for the staff and the excellent work which is sometimes less recognised. Dr Pathak also asked about the number of SI's related to pharmacy and how the workforce would be impacted with the changes proposed. Mrs Goode responded there was an SI regarding wrong administration that was investigated and was found to have been due to a lapse by an individual. This is the only one recently and is ongoing and which will be fed back later. Skill mix will change the way we work, at NLAG their robot talks to the electronic prescribing system at HUTH we have to have a human translator, so we are investigating how we could free those staff up to be able to available on the wards to check medical cards on the wards, which will be a QI project lead. Dr Hughes acknowledged the ongoing work and confirmed the committee had reasonable assurance in relation to the information shared today.	
6	**Patient Experience** **6.1 Clinical Assurance of Cash Release Efficiency Savings (CRES) / Quality Impact Assessments (QIA)** Mr Quider shared that the QIA main focus was on the pandemic and asked the committee to review the QIA from respective Health Groups, which are used to inform all decisions made by the Trust's Command and Control System during the COVID-19 Omicron surge period relating to changes to clinical services and its impact to patient safety and outcomes. The QIAs will continue to be developed as appropriate and existing QIAs will be reviewed at set intervals. Throughout the pressure we maintained the serious incident review group and the weekly patient safety meeting to ensure that no concerns were missed. Dr Pathak requested further information regarding the high risks and Mr Quider agreed that he would send a summary of the high risks and advised the high risks had been returned to the health groups for further detail. Dr Hughes confirmed the committee held reasonable assurance.	
7	**Sub-Committees Escalation Reports** **7.1 Operational Risk and Compliance Sub-Committee** Mrs Thompson shared the assurance summary and that reasonable assurance had been received in all reported areas. The sub-committee held good discussions regarding risk and the board assurance framework was presented and agreed to be shared within the health group governance meetings to support the health group risk registers. **7.2 Patient Safety and Clinical Effectiveness Sub-Committee** Prof Purva shared the assurance summary which provided reasonable assurance in all areas and noted that there had been no regulation 28's. It was shared that the claims team would be managed by the Head of Legal Services at NLAG following the departure of HUTH's claims manager. Prof Purva confirmed following questions that the team had been communicated throughout and currently there were only limited specialities and support services that had aligned with NLAG and that clinical areas would be a much slower process.	

	Four medical quality improvement leads have been appointed, with each consultant having very differing backgrounds and had been allocated priorities across the health groups. Dr Hughes welcomed the appointed medical quality leads. **7.3 Patient Experience Sub-Committee** The patient experience assurance summary was submitted to the committee and reasonable assurance was provided for areas noted. The Maternity Picker report has a developed shared action plan for improvement. The sub-committee escalated to the quality committee that the mental health / autism strategy won't meet the target date for completion.	
8	**Any Other Business** None raised.	
9	**Chairman's Summary to the Board** Dr Hughes summarised the committee's assurance levels following relevant reports which would feed into the summary report.	
10	**Date and time of the next meeting:** Monday 25th April 2022 – 10am – 11.30am via Teams	

Agenda Item	9	**Meeting**	**Trust Board**	**Meeting Date**	**10th May 2022**
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:

The Trust Board members are asked to receive, discuss and accept this update on key performance issues.

Performance and Activity Report

March 2022 Performance

February 2022 for Cancer data

Produced April 2022

Table of Contents

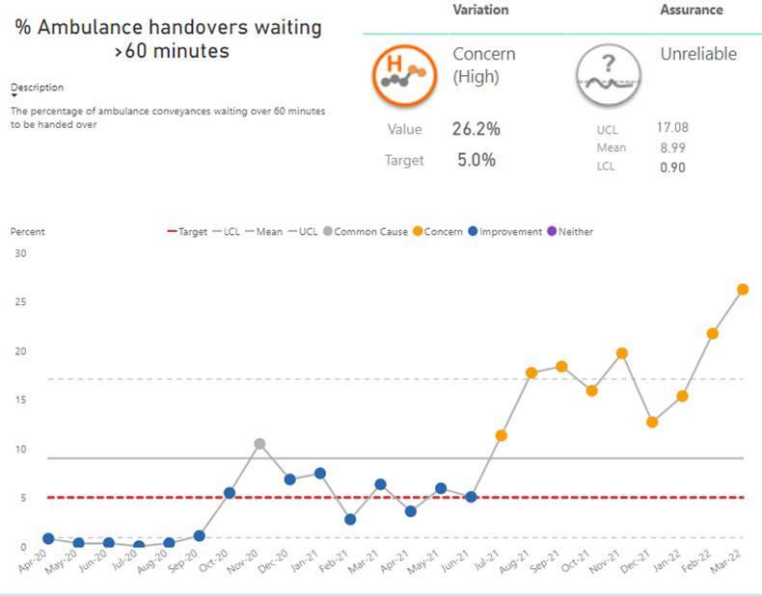
1. Executive Summary

Areas requiring improvement	
Urgent Care performance – ED and Ambulance handovers	• The Ambulance handover improvement plan continues albeit with ongoing flow issues improvement in key areas is slower than expected. YAS conveyances to ED have reduced when compared to pre-covid times, however the ongoing impact of flow issues has resulted in ongoing challenges with handover times particularly during peak hours of activity. We have also seen an increase in the acuity of the patients who do require the ED, and in some cases a deterioration in patient resulting from the increased level of lodging in ED. In order to support an improvement in handover, both YAS and HUTH Trusts have agreed an escalation protocol and implementation plan detailing the order of agreed actions, up to and including co-horting of patients, which will support patient safety and service delivery requirements during times of severe pressure, including the delivery of a timely community response. • Health Groups have also been tasked with developing plans to reduce waiting times to see a clinician, either from arrival in Department or from time referred to service and to further reduce the time waiting for admission from the Emergency Department, including a plan to increase the volume of patients through the SDEC pathways. • The Trust, in line with the National requirements are now managing flow using Total time in Department rather than the previous metric of time from Decision to Admit (DTA) and this better reflects the patient's experience in term of overall time to treatment, decision and discharge or admission.
Cancer performance	• Overall cancer performance remains comparable with previous months, and whilst 2ww referrals have increased 6% from previous years, there is no significant increase in confirmed cancers for any tumour site. • 2 of 9 cancer waiting times' national standards were achieved (28 day Faster Diagnosis Standard and 31 day Radiotherapy Treatments). • The number of patients on the 62 days from referral to treatment pathway continues to increase and total waiting list volume is now over 1,500, against a sustainable list size of circa 900. The Trust performance on 62 day treatment pathway has been flagged as an outlier through NHSE/I assurance processes and in line with the ongoing review of

	patients over 104 weeks, performance on the 62 day pathway will be subject to weekly updates to the Regional NHSE/I, ICS and National Team review meeting May 2022. • The Trust Cancer transformation programme continues to identify constraints with individual pathways and further action plans are being developed to enable handover of proposed improvements to service areas for implementation.
Recovery of elective activity	• Recovery of elective activity in 2021/22 was in line with the submitted H1/H2 plans, other than those expected for Ordinary Elective which delivered 91% of plan and 71% of 19/20 baseline; this overall reduction in output for elective work is predominantly due to the Omicron wave in Quarter 4 where routine elective activity was stood down. • The ongoing capacity demand for Covid+ patients, as well as those designated No Criteria to Reside (NCTR) continues to impact service ability to deliver increased elective work with circa 65 beds lost at CHH. From the beginning of May 2022, there will be a reconfiguration of the NCTR wards this will increase elective inpatient capacity at Castle Hill Hospital for surgical and orthopaedic patients.
Improving treatment times for long waiting patients	• At the end of March 2022, there were 532 patients who had waited over 104 weeks for treatment • For 2022/23 Quarter 1, the starting position is that there are 794 patients to treat, who have breached/or are at risk of breaching by the end of June 2022. The Trust has been designated a Tier 1 organisation and is required to meet weekly with NHSE national leads. • The aim is to have zero patients waiting over 104 weeks by the end of June 22, the current risks to delivery of this plan is circa 160 patients for who no definitive plan has been agreed at this point. • Enhanced internal governance processes are in place, daily monitoring against the trajectories and ongoing work to identify capacity internally and seek/take up offers of mutual aid from other providers. • There are 5,077 patients who have waited more than one year, and this number has reduced significantly in the last 12 months.

Reducing the delays in people leaving acute setting	• Nationally, there has been an increase in the number of patients who no longer "meet the criteria to reside in an acute hospital" – i.e. are medically fit from an acute perspective, but may still have other care needs – and are delayed in receiving that care, either moving home with care, or to a community or care home setting for their needs. • Across HUTH, at the end of March there were 165 NCTR, around 16% of our general and acute beds (total G&A beds 680 HRI and 347 CHH) are occupied by patients who no longer need acute care and should be receiving appropriate care elsewhere with the support of other partner organisations or settings. A single point of access model for discharge was implemented at the beginning of April, this is currently being refined to ensure all partners work to a standard operating procedure which has been collectively agreed to reduce administrative delays and help smooth the transfer between hospital wards to other settings.

2. Ambulance Handovers waiting over 60 minutes



What the chart tells us

There were 507 over 60 minute ambulance handover delays in March 2022 which equated to 26% which is a significant deterioration in the position of Feb 22% and January 15% which highlights the ongoing challenge.

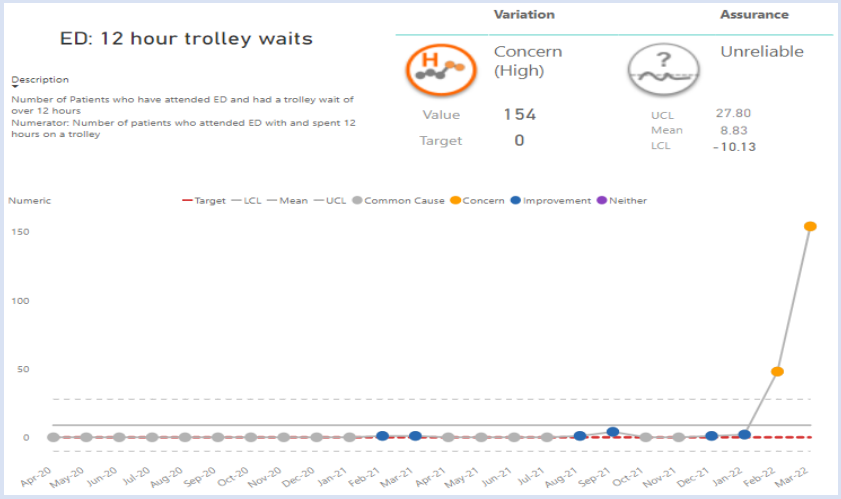
Intervention and Planned Impact

- Improvement team to observe Ambulance handover process in ED to identify further improvement opportunities – will begin with paediatric pathway.
- Co-horting space identified and management process agreed with YAS which provides opportunity to release long waiting Ambulances, will not impact on this metric but will support community response times.

Risks / Mitigations

- No Criteria to reside patients continue to occupy 165 or more acute beds thereby reducing availability of capacity and ability to appropriately manage flow out of the ED.
- Continue to work with partners on how they can support discharge for these patients who require non-acute care to transfer to the correct setting in a timely manner.

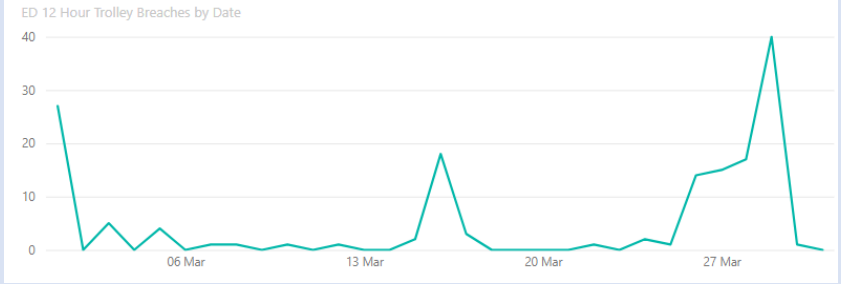
3. 12 Hour Trolley Waits (from DTA to Depart)



Date

01/03/2022 31/03/2022

Day of Week Number	1 Mon	2 Tue	3 Wed	4 Thu	5 Fri	6 Sat	7 Sun	Total
ED Departures (Type 01)	1,535	1,848	1,773	1,874	1,423	1,306	1,272	**11,031**
ED 12 Hour Trolley Breaches	18	71	19	11	1	19	15	**154**
ED 4 Hour Standard Performance (Type 01)	51.3%	48.4%	49.8%	44.9%	47.3%	50.2%	48.4%	**48.5%**



What the chart tells us

There were 154 12 hour trolley wait breaches in March 2022 with the longest wait from Decision to Admission (DTA) of 24.4 hours. Tuesday has shown the highest daily figure, which is primarily impacted by the large number of attends on Monday, some of whom are then lodged in ED overnight.

The national standard now measures total wait from arrival in department and not from DTA for those waiting over 12 hours. Performance against that standard for March was that 11.2% of patients waited over 12 hours against a tolerance of 2%.

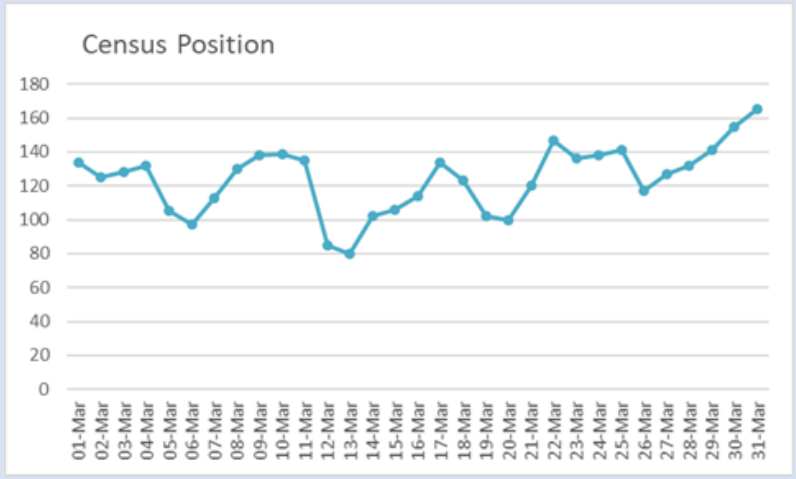
Intervention and Planned

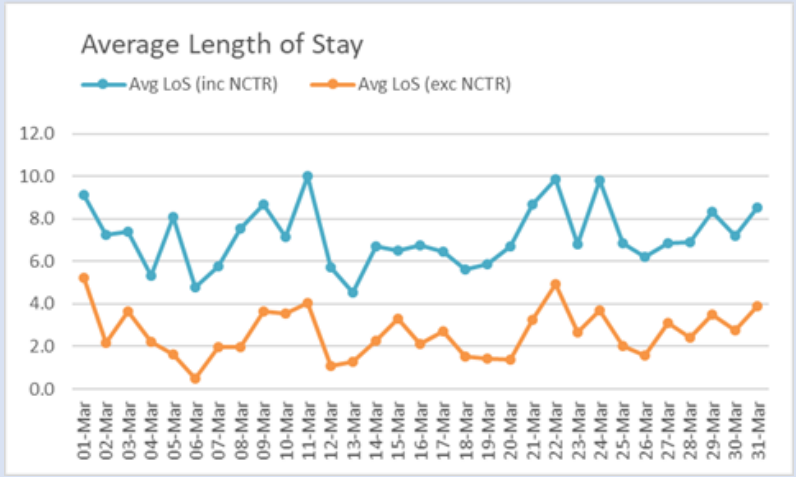
- The national reporting standard has moved from 12hr trolley wait to 12hr from time of arrival in ED, this is leading to an increase in 12hr breaches that would not have been reported previously.
- Work will continue with our partners to reduce the level of No Criteria to Reside patients to support improvement in flow.
- Review IPC guidance to reduce the number of empty but closed beds due to Covid contact.

Risks / Mitigations

- No Criteria to reside patients continue to occupy 165 acute beds thereby reducing the capacity for acute work
- Reinforce the requirements for escalation and implementation of professional standards for service delivery across all teams to support flow and management of risk.

4. No Criteria to Reside





What the chart tells us

There was a peak of 165 patients with No Criteria to Reside at the end of March. There was an average impact of 4.5 days increase on Length of Stay due to the NCTR.

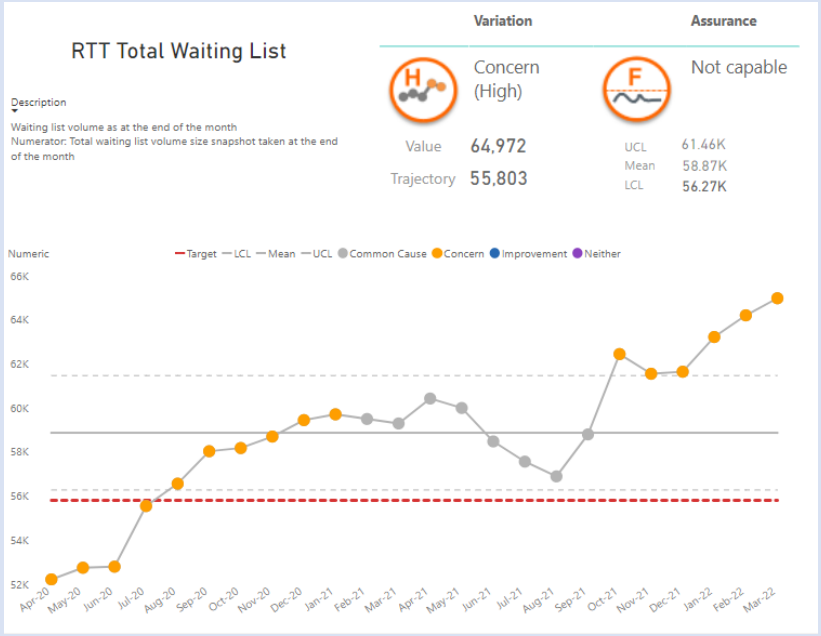
Intervention and Planned Impact

- Single Point of Access for discharge to be operational from mid-April to reduce the number of rejected/diverted referrals.
- Increased focus on compliance with Safer to enable more effective tracking of discharges.
- Focus on Hospital only Discharge (pathway 0) any patients not discharged same day are escalated to the Health Group Nurse Director.

Risks / Mitigations

- Increased time for social worker assessment.
- Continued Covid outbreaks closing community capacity.
- Domiciliary capacity remains lower than demand to address it.

5. Referral to Treatment – Total Waiting List Volume



What the chart tells us

The Trust's total waiting list volume (WLV) continues to increase; with 6 data points above the mean. At the end of March the position was 64,972. The sustainable list size to achieve 92% incomplete performance is circa. 34k.

There has been a 19% increase in referrals (+34,197) in 2021/22 compared with the previous year, which is partly driving the increase. The decrease in referrals in 2020/21 was due to the Covid pandemic. The operational plan for 2022/23 assumes no further increase in referrals.

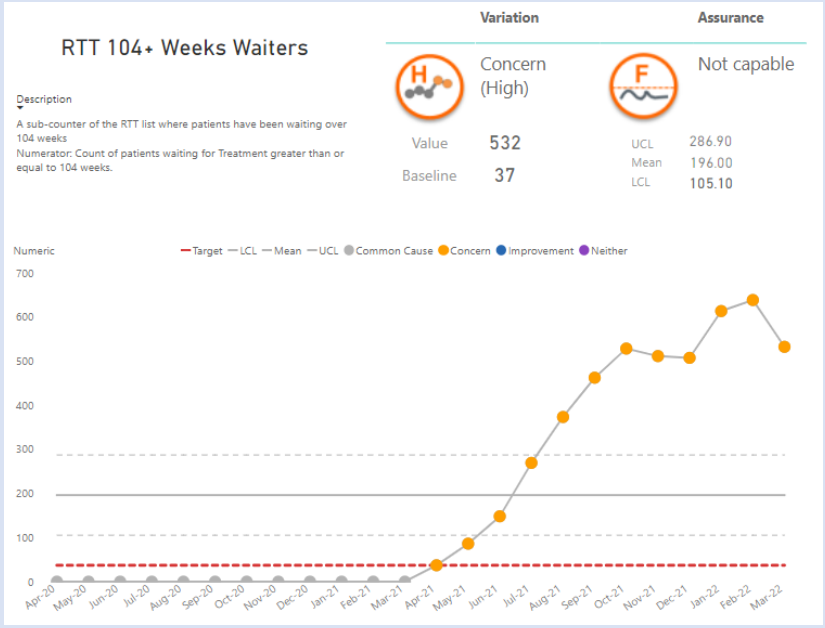
Intervention and Planned Impact

- Increased focus and support to reduce the 104-week risks to zero and to ensure a position which is no worse than 160 at 30 June 2022
- Mutual aid from other providers which is supporting the total WLV reduction overall
- Increased inpatient bed capacity at Castle Hill site for pressured specialities in regards to cancer, P2 and 104-week risks from 3 May 2022 – supported by focussed changes to the theatre programme
- Targeted speciality meetings to focus on the risks related to achievement of no patient waiting more than 78-weeks at 31 March 2023
- On-going validation of the full PTL by Source Group – the removal rate average is between 7-8%; the PTL has been consistently described as "clean". The first phase of the project was due to be completed by the end of May 2022; this will run over in to June 2022.
- The next phase will be to implement/deliver revised RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management
- A process of text validation on 31,000 pathways will commence during June 2022 delivered by Healthcare Communications. This process will focus on patients confirming whether they still require treatment.

Risks / Mitigations

- Further increase in GP referrals
- Patients with No Criteria to Reside does not reduce
- Covid and Covid Contacts does not reduce
- Increase in non-elective demand displacing elective capacity

6. 104 Week Waits & Planned Trajectory to June 2022



What the chart tells us

At the end of March there has been a decrease in actual 104 week waits to 532. Risks in Quarter 1 have reduced from a start position of 794 to 472 at 2nd May, and is under trajectory.

Intervention and Planned Impact

- Focussed and speciality specific micro-management of patients dated and/or risks in 2022/23 Q1 and Q2
- Trust and speciality level clearance trajectories agreed and monitored
- Revised Trust trajectory agreed with NHSE:
  - 30/06/2022 no worse than 160
  - July 2022 x 56
  - August 2022 x32
  - September 2022 x13
  - and 31 December 2022 x0
- Full validation of risks to end of June 2022 complete – small number of removals
- Clinical Admin Service contacting all patients to check if treatment is still required – underway, small number of removals
- Q2 non-admitted risks to be dated into next available capacity
- NCTR revised staffing model implemented to support step-up in elective beds at CHH
- Hull & East Riding system plan to create additional care home/intermediate bed capacity to further reduce NCTR patients in elective bed base
- Improved staffing availability on ICU has allowed return of sufficient theatre staff to open 3 additional day case lists; and the theatre programme has been revised to support high-risk specialties
- Progressing mutual aid support from providers within and without of H&NY
  - NLAG (Orthopaedics, Urology & Upper GI)
  - York (Orthodontics, Plastic Surgery)
  - HCA London (Complex Spine)
  - Rotherham (Oral Surgery)
  - Mid Yorkshire (Colorectal Surgery)
  - South Tees (Cardiac Surgery)

Risks / Mitigations

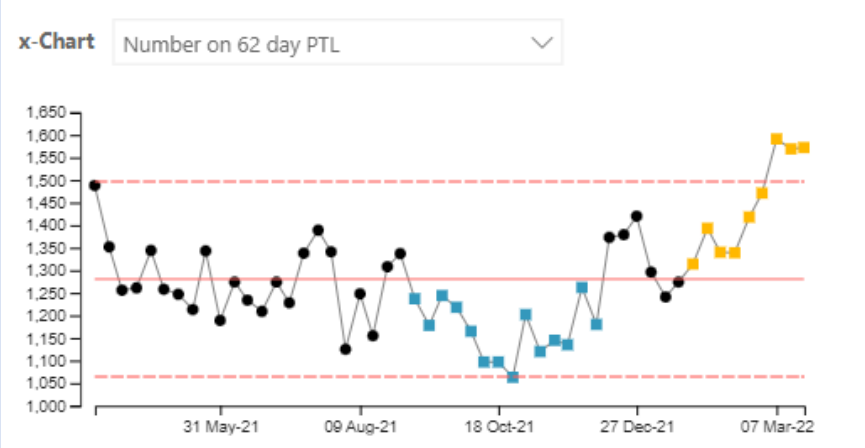
- Patients with No Criteria to Reside does not reduce
- Covid and Covid Contact patient does not reduce
- Staff absence increases or does not reduce

- Non-elective demand increases – impacting on elective bed base
- Priority 2 demand increases
- Patient choice & willingness to accept alternative providers affects our ability to use the mutual aid - focussed group (NB: national clarification of patients refusing an alternative provider is outstanding)
- Current patients dated are treated as planned – delivered through micro-management
- Validation – no long wait "pop-ups"
- July to September 2022 remains a risk due to the number of patients tipping to 104- weeks (624 at 25/04/2022 - being tracked)
- Mutual aid offers - patients do not meeting criteria to transfer to alternative provision
- Risk – colorectal & ENT (cancer demand & bed base), orthodontics (clinical capacity) and oral surgery (surgeon capacity)

Week Commencing	28/03/2022	04/04/2022	11/04/2022	18/04/2022	25/04/2022	02/05/2022
Trajectory	794	750	706	662	618	574
Target Clock Stops	44	44	44	44	44	82
Actual Position	794	718	642	604	548	472
Removals Required (straight line)	61	60	58	60	61	59
Actual Removals	76	76	38	56	76	

Planned Trajectory to June 2022

7. Cancer 62 day Waiting List Volume



What the chart tells us

The number of patients waiting to start treatment on a 62 day pathway is increasing and there are 9 consecutive weekly data points above the mean.

The main increases are in the tumour sites of Colorectal, Gynaecology and Urology however referrals in those tumour sites have not seen an increase.

The tumour sites with the largest proportion of the PTL are:

- Colorectal (+700/40%) with 30% over 63 days
- Urology (+250/14%) with 22% over 63 days
- Skin (250/14%) with 16% over 63 days
- Gynaecology (200/11%) with 17% over 63 days

A large proportion (circa 90%) at the end of April 2022 were recorded as not yet having a diagnosis.

Intervention and Planned Impact

The capacity and/or pathway issues fall into 4 broad categories.

Imaging/Diagnostic waiting times/capacity review underway supported by the Operational Improvement Team and enhanced performance management meetings with the CSSHG Imaging Division to address:

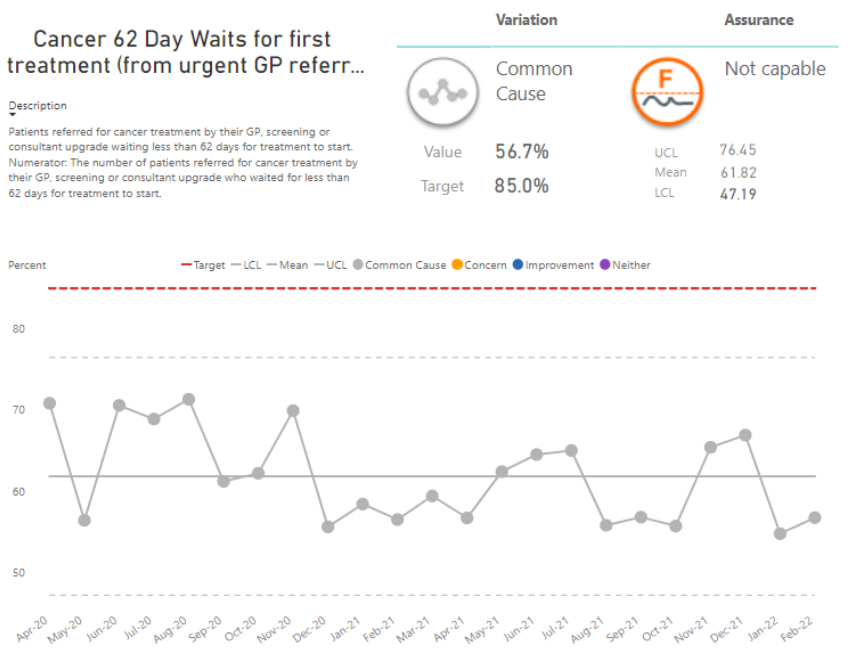
- Administration process review in Radiology department (CTC)
- CTC demand and capacity analysis: slot utilisation
- CTC mutual aid being provided by NLAG and the Spire
- CT delays to form part of wider discussion with radiology department
- Colonoscopy waiting times

Histology capacity/delays – circa 250 patients on the Cancer PTL are awaiting results

- Pathology TATs will be addressed with the SHYPS Cellular Pathology Laboratory Manager as part of the enhance performance management arrangements
- A formal letter has been sent to the SHYPS Triumvirate regarding histopathology services with performance meetings being implemented

	Tracking capacity and decision making • HCVCA funding secured to employ additional tracking resource to reduce the numbers on the PTL (12 month only) • Review of guidelines for tracking staff to remove patients from the PTL following test results (clinically agreed) Other • Consultant led triage • Access to surgical beds (Urology) has been released and surgical treatment TCI dates beginning to improve; further elective beds were made available to Colorectal from 3 May 2022 • There is a Cancer Transformation Programme which includes: Colorectal; Upper GI; Lung; Head and Neck and Prostate - Faster Diagnosis Standard is the main focus of the programme • Standard of Care are being developed with the HCV Cancer Alliance for implementation
	Risks / Mitigations • Referral rate catch up impacts on the cancer PTL and waiting times • Staff gaps (vacancies and absence) further impact on diagnostic capacity & waiting times • Further increases in the elective colorectal bed base cannot be supported • Tracking demand continues to outstrip capacity • Histology tracking systems implemented locally to prioritise long-wait patients • Mutual aid sourced for CTC • Mobile CT capacity continues to be provided by the IS

8. Cancer 62 day Performance



What the chart tells us

Performance for February 2022 was 56.7% and common cause is being displayed as the mean is 61.8%; performance has not been achieved for some time.

The Faster Diagnosis Standard (combined) February 2022 achieved/exceeded the target with performance of 76.4% and March 2022 is currently showing at 74.8%.

Delays in imaging, pathology and the volume of tracking required is leading to reduced performance.

Intervention and Planned Impact

Largely the same as Section 7. Above.

- Colorectal – timely access to CTC is the major rate-limiting factor for patients receiving a diagnosis, the current wait time is 10-weeks. This test adversely affects the performance of the Faster Diagnosis Standard and consequently the 62-day RTT target if patients are diagnosed with cancer.
    - A full review of the administration processes for CTC to include booking rules has been scoped to begin in April 2022; demand and capacity analysis of the slots available and the utilisation will be included in the review
    - Mutual aid from NLAG at x5 per week and the same from the Spire is being mobilised
- Access to timely CT scans are having an impact across a number of cancer pathways; the current wait is 4-weeks – enhanced performance monitoring has been implemented together with a capacity and demand review supported by the Operational Improvement Team.

Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times
- Staff gaps (vacancies and absence) further impact on diagnostic capacity & waiting times
- Further increases in the elective colorectal bed base cannot be supported
- Tracking demand continues to outstrip capacity
- Histology tracking systems implemented locally to prioritise long-wait patients
- Mutual aid sourced for CTC
- Mobile CT capacity continues to be provided by the IS

Agenda Item	9.1	**Meeting**	Trust Board	**Meeting Date**	10.05.22
Title	Finance Report – Month 12				
Lead Director	Lee Bond, Chief Finance Officer				
Author	Stephen Evans, Deputy Director of Finance				
Report previously considered by (date)	Performance and Finance Committee, April 2022				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2021/22**	
Trust Board Approval		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:

Trust Board is asked to note the following:

a) The H2 reported year-end position of a £0.2m surplus, an improvement on plan.

b) The total annual position of a £0.2m surplus.

c) The level of non-recurrent income received in year which impacts on the 2022/23 plan as per planning updates.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

PERFORMANCE & FINANCE COMMITTEE: MONDAY 25th APRIL 2022

FINANCIAL UPDATE - MONTH 12 REPORTING

1. Purpose of Paper

To update the Board on the month 12 position.

2. Background

The Trust delivered its control total target for H1 of a deficit of £1.7m. The Trust has a plan to deliver a surplus of £1.7m in the H2 so that it will be able to report a balanced financial position for the overall 2021/22 year.

3. Month 12

The table in appendix 1 shows the month 12 reported position against the NHSI plan, at health group level. The Trust is reporting a surplus of £1.9m at month 12 (H2), which is £0.2m better than plan. Appendix 2 shows the plan and actual for the full year, a £0.2m surplus.

For H2 year to date (month 12) Health Groups and corporate are showing as £2.1m overspent, a deterioration of £0.9m from Month 11. The movement from Month 8 by Health Group/Corporate area is shown in the table below:

							In-Month
	Month 8	Month 9	Month 10	Month 11	Month 12		Change
Health Group	**£000**	**£000**	**£000**	**£000**	**£000**		**£000**
Surgery	(8)	46	306	337	160		-177
Medicine	(29)	19	(37)	31	(235)		-266
Emergency Care	126	210	415	476	492		16
Clinical Support Services	(379)	(517)	(706)	(890)	(1,396)		-506
Pass-Through Drugs	238	110	(244)	(268)	(258)		10
Family & Women's Health	(296)	(492)	(313)	(494)	(832)		-338
Corporate Directors	4	(39)	(59)	(130)	(6)		124
Estates, Facilities & Development	(17)	(141)	(155)	(286)	(4)		282
TOTAL	**(361)**	**(804)**	**(793)**	**(1,224)**	**(2,079)**		**(855)**

Clinical support position deteriorated by £0.5m in month. Pressures included recruitment of international nurses who are currently supernumery to the ward budgets or support no criteria to reside (NCTR) wards. Activity remains high and is above 19/20 levels in Oncology and Haematology driving pressure on consumables and agency medical staff. Family & Women's Health Group deficit has increased by £0.3m in month. Large part relates to increased Wet AMD activity and pass through devices with the remainder relating to staffing levels to support continuity of carer and Paediatric Gastroenterology. Also arrival of international nurses. Surgery and Medicine also saw additional international nurses and additional support for NCTR wards. Estates position improved due to funding for Allam Diabetes development and new ITU.

The Trust spent £0.9m on dealing with Covid19 in month as per the following categories:

	Months	Months	Month	Month	Month		Total
NHSEI Category	1-6	7-9	10	11	12		Year to Date
	£000	£000	£000	£000	£000		£000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	1,661	414	168	186	198		2,627
PPE associated costs	35	12	3	11	3		64
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	172	467	436	43	215		1,333
Remote management of patients	702	291	41	57	56		1,147
Support for stay at home models	38	12	4	4	4		62
Segregation of patient pathways	751	498	152	147	265		1,813
Decontamination	775	330	115	186	119		1,525
Remote working for non-patient activities	28	8	1	0	0		37
Total	4,162	2,032	920	634	860		8,608

The biggest areas of spend in-month were expanding the workforce, increasing ITU capacity, segregation of pathways and decontamination.

The Trust received £1.5m ERF in month 12 from the ICS, offsetting previous under recovery and moving the H2 position to £0.9m above plan.

The Trust received £5.3m of additional funding from the ICS to support the Trust financial position. This offsets the expenditure pressures that the Trust has experienced including health group overspends, Clinical Excellence Awards back pay and the ICS system risk that was included within the Trust H2 plan.

The Trust has also received £4.0m of additional funding to support Digital Aspirant, recovery of screening services, perinatal mental health support, waiting list validation, diagnostic services and the transfer of Neurology services from NLAG. The income is matched by additional expenditure funded through reserves.

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

The final SOFP and SOCF for the full year are still undergoing finalisation and will be presented to Audit Committee next week.

Capital

The reported capital position at month 12 shows gross capital expenditure of £84.3m, in line with expected from prior month forecasts. This is against an original plan of £58.1m. The main areas of expenditure relate to the Salix Energy Efficient scheme (£12.2m); Day Surgery (£10m); Medical Equipment (£14.4m) and Urgent & Emergency Care (£16.4m). The capital programme has increased from the original plan by £26.2m mainly due to additional PDC funding and ICS slippage.

Cash

The Trust's liquidity position remains healthy with a cash balance of £79.4m at the end of March.

To date the Trust has paid 96.6% by volume and 89.7% by value of non-NHS invoices within best practice terms. In March, the figures were 97.1% and 94.0% respectively.

Stocks

Stock levels are at £15.9m, a decrease of £0.7m in month but still £0.9m higher than the year-end figures.

Health Group	Mar 21 £000	Feb 22 £000	Mar 22 £000	Change from March 21 £000
Clinical Support	7,460	7,872	7,178	(282)
Surgery	4,247	4,445	4,489	242
Medicine	1,026	2,091	2,325	1,299
F & WH	1,174	1,152	1,096	(78)
Other	439	424	434	(5)
PPE Stock	635	635	345	(290)
Total	14,982	16,619	15,867	885

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

Debtors

The Trust currently has £3.8m of debt that is over 90 days. This is £0.1m less than month 11. The main debtors are as follows

Debtors over 90 Days	February 21	March 21	Change
	£	£	£
Northern Lincolnshire And Goole Nhs Ft	426,539	528,012	101,473
City Health Care Partnership	342,176	499,871	157,695
York & Scarborough Teaching Hospitals Nhs Ft	420,304	344,918	-75,387
Humber Teaching Nhs Foundation Trust	389,959	214,142	-175,817
East Riding Fertility Services Ltd	102,860	103,359	500
University Of Hull	106,179	101,618	-4,561
Fresenius Medical Care Renal Services Ltd	77,505	77,505	0
Crawford & Company Adjusters (Uk) Ltd	70,320	70,320	0
East Riding Of Yorkshire Council	68,760	69,030	270
Ge Healthcare	51,962	51,962	0
Welsh Health Specialised Services Committee	91,823	1,544	-90,279
Others	1,712,385	1,713,280	895
Total	3,860,772	3,775,562	-85,210

NLAG invoices mainly relate to Haematology recharges and the Oral & Maxillofacial Consortium. They are not in dispute. £51k of the CHCP invoices need to be credited as they were invoiced incorrectly. Service working through with York and CHCP regarding pathology data for sexual health service re appropriate backing data. This relates to about £150k of the outstanding balance. Remaining balance should be paid and service are chasing CHCP to clear.

5. Recommendations

The Board is asked to note the following:

d) The H2 reported year-end position of a £0.2m surplus, an improvement on plan.

e) The total annual position of a £0.2m surplus.

f) The level of non-recurrent income received in year which impacts on the 2022/23 plan as per planning updates.

Stephen Evans
Deputy Director of Finance
April 2022

APPENDIX 1

Financial Year 2021/22 Month 12

	M7-12 Budget £000 (H2)	H2 YTD Budget	H2 Actual	H2 YTD Variance £000	M1-6 Variance £000	Cumulative Variance £000
Nhs Contract Income	327,492	327,492	336,806	**9,314**	281	9,595
Nhs Other Clinical Income	80	80	104	**24**	0	24
Education + Training Income	11,010	11,010	10,780	**(230)**	0	(230)
Other Income	5,580	5,580	8,560	**2,980**	(3,162)	(182)
Covid Donated		0		**0**	3,301	3,301
ERF	9,879	9,879	10,739	**860**	1,326	2,186
Total Income	**354,041**	**354,041**	**366,989**	**12,948**	**1,746**	**14,694**
Surgery	(74,086)	(74,086)	(73,926)	**160**	(472)	(312)
Medicine	(46,026)	(46,026)	(46,261)	**(235)**	(458)	(693)
Clinical Support Services	(51,627)	(51,627)	(53,023)	**(1,396)**	(454)	(1,850)
Pass-Through Drugs	(39,989)	(39,989)	(40,247)	**(258)**	(675)	(933)
Family + Womens Health	(45,294)	(45,294)	(46,125)	**(831)**	(441)	(1,272)
Corporate Directorates	(42,091)	(42,091)	(42,097)	**(6)**	(8)	(14)
Estates Facilities & Developmt	(24,444)	(24,444)	(24,448)	**(4)**	9	5
Reserves	5,249	5,249	(2,674)	**(7,923)**	759	(7,164)
Other Operating Expenditure	(4,139)	(4,139)	(4,185)	**(46)**	82	36
Emergency Care Health Group	(9,556)	(9,556)	(9,064)	**492**	439	931
Total Operating Expenditure	**(332,003)**	**(332,003)**	**(342,050)**	**-10,047**	**(1,219)**	**(11,266)**
Donated Asset Income	(4,420)	(4,420)	(7,369)	**(2,949)**	(527)	(3,476)
EBITDA	**17,618**	**17,618**	**17,570**	**(48)**	**0**	(48)
Depreciation	(9,102)	(9,102)	(9,109)	**(7)**	0	(7)
Interest Payable	(2,956)	(2,956)	(2,798)	**158**	0	158
Interest Receivable		0	41	**41**	0	41
Pdc Dividends	(4,190)	(4,190)	(4,190)	**0**	0	0
Profit / Loss On Disposal	0	0	(117)	**(117)**	(63)	(180)
Transfer by absorption		0	(1,066)	**(1,066)**	0	(1,066)
Total Non Operating Expenditure	**(16,248)**	**(16,248)**	**(17,239)**	**-991**	**(63)**	**(1,054)**
Impairment	0		(232)	**(232)**	0	(232)
Net Surplus/Deficit	**5,790**	**5,790**	**7,468**	**1,678**	**464**	**2,142**
Donated Asset Adjustment	(4,120)	(4,120)	(6,915)	**(2,795)**	(527)	(3,322)
Adjusted Financial Performance Surplus/Deficit	**1,670**	**1,670**	**553**	**(1,117)**	**(63)**	**(1,180)**
Reported Financial Position for NHSEI Performance *	**1,670**	**1,670**	**1,882**	**212**	**0**	**212**

* Excludes impact of transfer by absorption, covid donated assets loss, gains on disposal of assets and covid PPE adjustment

APPENDIX 2

Financial Year 2022 Month 12

	Annual Budget £000	Actual Annual £000	Variance £000
Nhs Contract Income	644,100	653,695	9,595
Nhs Other Clinical Income	160	184	24
Education + Training Income	21,383	21,154	(229)
Other Income	16,333	16,151	(182)
Covid Donated	0	3,301	3,301
ERF	17,426	19,612	2,186
Total Income	**699,403**	**710,739**	**14,694**
Surgery	(144,338)	(144,650)	(312)
Medicine	(89,209)	(89,902)	(693)
Emergency Department	(18,659)	(17,728)	931
Clinical Support Services	(105,325)	(107,175)	(1,850)
Pass-Through Drugs	(73,690)	(74,623)	(933)
Family + Womens Health	(87,956)	(89,228)	(1,272)
Corporate Directorates	(80,956)	(80,970)	(14)
Estates Facilities & Developmt	(47,951)	(47,946)	5
Reserves	2,534	(4,630)	(7,164)
Other Operating Expenditure	(8,181)	(8,145)	36
Total Operating Expenditure	**(653,731)**	**(664,997)**	**(11,266)**
Donated Asset Income	(14,013)	(17,489)	(3,476)
EBITDA	**31,659**	**28,253**	**(48)**
Depreciation	(18,204)	(18,211)	(7)
Interest Payable	(6,075)	(5,917)	158
Interest Receivable	0	41	41
Pdc Dividends	(7,980)	(7,980)	0
Profit / Loss On Disposal	0	(180)	(180)
Transfer by Absorption	0	(1,066)	(1,066)
Total Non Operating Expenditure	**(32,259)**	**(33,373)**	**(1,054)**
Impairment	0	(232)	(232)
Net Surplus/Deficit	**13,413**	**12,137**	**2,142**
Donated Asset Adjustment	(13,413)	(16,735)	(3,322)
Adjusted Financial Performance Surplus/Deficit	(0)	**(1,180)**	(1,180)
Reported Financial Position for NHSEI Performance *	**0**	**212**	**212**

* Excludes impact of transfer by absorption, covid donated assets loss, gains on disposal of assets and covid PPE adjustment

Hull University Teaching Hospitals NHS Trust
Minutes of the Performance and Finance Committee
Held on 28th March 2022

Present:	Mr M Robson	Chair
	Mr S Hall	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr S Evans	Deputy Director of Finance
	Mrs R Thompson	Head of Corporate Affairs
	Mrs A Drury	Deputy Director of Finance
	Mr T Curry	Non-Executive Director
	Mrs J Mizon-Harrison	Deputy Chief Operating Officer
In Attendance:	Miss R Boulton	Quality Governance Officer (Minutes)

No	Item
1	**Apologies:** Apologies were received from Mrs Ryabov, Chief Operating Officer and Mrs Christmas, Non-Executive Director.
2	**Declarations** There were no declarations made.
3	**Minutes of the meeting held on 29 November 2021 and Matters Arising.** Minutes were reviewed and agreed as an accurate record and no matters arising were noted.
4	**Action Tracking List** Nothing to pick up on
5	**Workplan 2021/2022** The work plan is due for renewal and will be updated prior to April's committee; changes that are required were asked to be raised with Miss Boulton.
6	**Board Assurance Framework** Mrs Thompson presented the end of year BAF position with the committee and today would focus on BAF 4 and 7 Mrs Thompson proposed that BAF 4 ratings remain the same and the risk is carried into next year. A lot of external factors have affected the Trust's ability to achieve an improvement in performance. Mr Bond challenged the scoring and suggested that due to failing performance targets the ratings should be likely 5 and impact 4 and encouraged a debate on the revised scoring proposed. Mr Hall and Mr Robson agreed with the revised scores proposed by Mr Bond, and it was noted that although performance targets were not achieved the Trust were taking steps to address and without the controls, the risks would be higher as we were doing a lot to mitigate the risks. Mr Curry suggested that we should focus on what we are doing to mitigate the risks and improve performance.

	Mrs Thompson shared that the April board development session would be focused on setting the new strategic BAF risks and could review and discuss the new risks in detail. Mr Robson agreed that we have not achieved the risk target for BAF 4. Mrs Thompson shared that BAF 7.1 had achieved the control target and proposed to close the risk and re-open in the 2022/23 BAF. BAF 7.3 also has achieved the control target and is proposed to be re-scoped 2022/23. Mrs Thompson confirmed that the end of year position would be presented to the board in May for approval. Mr Robson acknowledged that the BAF has been a much greater tool to support decision making this year and confirmed the committee's assurance.
7	**Performance** **7.1 / 7.2 Performance Report Including: National Standards Performance and Elective Recovery** Mr Robson shared with the committee that the non-executive directors (NED) held a lengthy discussion at this morning's NED meeting so did not wish to repeat in detail but asked that the decisions were shared. Mrs Mizon-Harrison provided an overview of the performance report and highlighted that performance against the 4 hour target standards are not being achieved with a significant increase in 12 hour breaches seen including 30 breaches in the past weekend. Ambulance handover times continue to be a challenge. The Urgent Treatment Centre (UTC) had not functioned as expected and shifts had not been supported therefore activity had gone back into the core business in ED, the UTC was due to cease at the end of March 2022. There was a high level meeting held last week regarding ambulance handover times which requested action plans to deliver the new national targets. Cancer performance continues to be a challenge and is due to multiple challenges; including delays to diagnosis and histology and bed availability, some cases are being micromanaged to ensure progress. The waiting list remains significant and we are not achieving the trajectory of 52, and 104 week wait breaches. The trust is undertaking a piece of work person marking all patients breaching the targets to ensure we meet the end of June target of 0 breaches. The number of covid cases and no criteria to reside patients is causing patient flow issues and affecting overcrowding in ED and boarding and reverse boarding. A national meeting was held last week in regards to 104 week waits and we will be submitting our action plan. A business case is being costed and will be submitted to the ICS to request additional resources to validate lists and micromanagement of pathways including contact and concierge of patients to mutual aid or external providers matching capacity and outsourcing where possible. Mrs Mizon-Harrison will be chairing all patient level meetings from today to support the validation of waiting lists and the micromanagement of pathways. Two specialities that have validated their waiting list and any risks clinicians had are being raised in relation to mutual aid concerns as this needs to addressed with fact as the reality is these patients will not be treated at the Trust.

Mr Curry questioned why the UTC was ceasing in March and why the performance had not been impacted by its introduction. Mrs Mizon-Harrison confirmed it was a combination of factors and we will look to deliver internally with a different workforce model.

Mr Curry questioned what skill mix the workforce had in paediatrics that worked and if it could be replicated across the department. If we have no beds in the hospital the ED remains backlogged, are we still working on diversion in the pathway. Mrs Mizon-Harrison confirmed that risk taking with YAS was an ongoing separate piece of work and their knowledge and confidence in alternative pathways needed developing. Mr Walker would need to respond regarding the effectiveness in the paediatric skill mix.

Mr Robson noted that nurse triage had been stepped back up and queried if the combination of both triage and UTC would have been better. Mrs Mizon-Harrison responded that due to the UTC not being as productive as we hoped streaming patients the nurse triage was required for safety and that we needed the correct workforce to deliver both.

Mr Bond shared that the UTC model was dependent on CHCP releasing staff and they were not able to release and locate sufficient numbers of GP's to sustain the service. There were also some relationship and interface issues. NLAG which has been successful in their implementation of a UTC have access to a GP collaborative which can provide resources at an expense. Would like to replicate this side of the river.

Mr Bond questioned how many planned care theatres lists should we be running and how many are running and how efficient and the same for Outpatient. The information is not within the IPR, no assurance that we are operating as efficiently as we can do currently.

Mrs Mizon-Harrison confirmed that theatres are up to 100% but cannot get to utilise fully due to pressure on beds, future performance reports can include that information.

Mr Bond questioned the purpose of additional investment in further validation as feedback suggests our data is one of the best the validation team have seen and that little benefit would be seen from further investment. Funding is also not available unless available nationally. Mrs Mizon-Harrison suggested that the support was required until March 2023 to enable us to continue to address issues as we find them and can train our staff and replicate the work internally.

Mr Hall relayed that the national calls focussed attentions and questioned what we were on a number of aspects;

- Inpatients, look at operating practices, can we increase day cases;
- Outpatient appointments can we shorten time between follow-up, how can we reduce 28k follow-ups as not manageable in 3 months;
- How to clean up follow-ups, are they clinically required if over a year
- PIFU, what are the plans to expand from the 5 specialities;
- Theatres productively, what's the maximum we can do?
- Where SDEC fit;
- DNA rates at 10% what happens to repeat DNA's;
- Ambulance handover, are we freeing up dependent on the type of patient being received.

	Mrs Mizon-Harrison responded to each area raised by Mr Hall and confirmed that capacity for day surgery would increase with the new day case surgical unit being built at Castle Hill site and will also be looking at varying the length of sessions. Outpatient follow-up are standard times, but we are doing virtual appointments where possible to maximise time and the outpatients have been transformed and continue to work with the workforce PIFU remaining specialities were asked to identify reductions in follow-ups, looking at risk management and challenging what we can. The hospital uses the DNA access policy. The ED move patients that can walk arriving by ambulance into minors so that the crew are not required to wait, YAS use this tactically as the patient is our responsibility once they arrive. Mr Robson asked if the issues are with liaison between ED and other departments are systematic or their approach as there are so many issues. Mrs Mizon-Harrison shared that there was work underway regarding managing relationship and expectations. Mr Curry relayed that there was a discussion earlier regarding the continued level of 'no criteria to reside' patients and the possibility of our own care facility to free up medical beds. Mr Bond reflected that the trust has raised issues of discharge for a number of years but the number of patients has significantly increased and now equates to five wards. The proposed social care beds at CHH still do not meet the current needs and there is no recovery plan for social care to step-up and fill the deficit. There is a discussion required to scope if the trust would be better placed to contract a facility and recruit to ease the pressure, as there is a certainly a market for the beds and we could mobilise quickly. Mr Robson reflected that there is a general work force issue locally for lower paid roles, but the NHS may recruit more easily than other employers. At the NED meeting this morning it was discussed there will be increased involvement for board members, starting with a plan of visits. There was a query if the NED's should we be involved in key meetings and receive reports which is something that the centre are indicating. Mr Bond understands the centre's motive but the NED's also need to remain objective although could target an area to support assurance and agreed that we can provide any necessary information requested. Mr Hall stated that at a recent regional meeting they suggested NED's should have daily updates, however got to be careful as too much is just as problematic and suggested trends would be better than volumes of data. **ACTION: Mrs Mizon-Harrison agreed to look at something with the BI team and Mr Hall would assist with development and update the chair.**

7.3	**Operational Plan** Mrs Mizon-Harrison shared the operational plan was not yet ready for discussion and is still being drafted. The committee agreed to hold an extra-ordinary PAF on the 7th April prior to final draft submission to the ICS on the 12th to review and agree the plan. The final operating plan submission is the 25th April.
8	**Finance** **8.1 Financial Report** Mr Evan shared the month 11 financial position. The Trust is reporting that it will deliver its planned position for H2 of a £1.7m surplus. As noted above the Trust has received an additional £5.3m of income from the ICS, which has removed the previously reported risk to delivery of the financial position. Pressures remain within Clinical Support and Family and Women's Health Group and covid expenditure continues. The planned capital expenditure for 2021/22 is £84.8m; this includes PDC allocations. Capital spend in month 12 will be £27.5m. We are in the week of payments, investment certificate and invoices. There will be two payment runs this week and valuations for part built buildings received. Mr Bond raised that his limit would need increasing to sign off invoices for payment in the Chief Executives absence. Mr Robson clarified if the £5.3m was non-recurrent and it was confirmed that it was and had been received from the centre.
8.2	**Financial Planning 2022/23** Mr Evans presented the detail within the financial planning report for the committee which included; • Non-Recurrent Income and Expenditure • Full Effects • Growth and Inflation • CIP • Covid 19 Funding • Investments • Implications of Increased Capital • Activity Plans and ERF • Opportunities to Close the Gap The position from to deficit as a Trust and ICS from a positive was explained in line with the increased costs and inflation. Mr Bond shared the largest income was related to productivity and every 1% increase from our 94% core capacity saves £1m. We need to improve activity to improve finances, improvements gain finances and we need to complete this within capacity to make the cost improvements, which externally benefits the patient. Mr Bond confirmed there were still some questions to be resolved within the plan, there were still some discussion required to have with commissioners. Mr Bond is meeting with the ICS and at national level, who indicate they want to see improvement. What we are doing we need to be doing well in relation to activity.

	Workforce triangulation work with finance and operational will need to be deliverable. Cash will become an issue, this has been managed well in the last two years but under the current forecast, next year will be different. Mr Hall questioned the inflationary costs and what is in it for the staff to increase productivity? Mr Bond noted the clinicians to deliver the best care for their salary but as there is more work than we can manage, there is overtime available to deliver the extra work. Waiting list incentives are being worked up and we need to hit the ground quickly get up to 104% activity. The Trust needs to work smarter and become more commercial in how we deliver services. Mr Robson suggested that it sounded like payment by results for elective recovery and Mr Bond agreed.
8.3	**Capital Plan 2022/23** Mrs Drury presented the draft capital plan. Publication of the ICS envelopes was made during February and this notification confirmed a provider capital allocation for the Humber Coast & Vale (HCV) ICS of circa £72.6m with 27.8m allocated for HUTH. The Trust also applies for any grants or donations and any projects allocated to those funds only proceeds if the granted the funds. Full list of capital applications are discussed though Capital Resource Allocation Committee and allocations from the budget to address top priorities and pre-commitments. Updated costs have been requested for priorities identified for the 2022/23 capital plan. There was currently £2m unallocated in the budget which needs to be reviewed according to priority. Noted and approved in principle and look forward to unallocated funds.
8.4	**Independent Sector Contracts Update** Mrs Drury provided a paper seeking approval from the committee to approve the contracts with the independent sector providers for 2022/23 to enable the Trust to continue with the elective recovery. Mrs Drury confirmed all contracts retained the clause to exit if required. The committee agreed to approve all contracts noted in the report.
9	**Assurance and Governance** **9.1 Capital Resource Allocation Committee** Draft minutes were available with the papers and noted by the committee

10	**Any Other Business** **10.1 Contract for Provision of Patient Meal Services** The contracts had been received prior via email requesting approval via voting in the absence of the committee meeting. Mr Hall made note that as an anchor institution we should source local where possible. **10.2 Contract Recommendation Service Maintenance Of Autoright Fluoroscopy System HEY20/476/SM** The contract was noted to have an 8% increase but had been tendered. **10.3 Contract Recommendation Autoimmunity Analyser HEY/19/095** Sizable increase in cost was noted but will increase additional testing capacity, which lead to savings. The committee agreed to approve all three contracts that were presented for approval.
11	**Chairman's Summary to the Board** Mr Robson summarised the committee's assurance levels following relevant reports which would feed into the board summary report and that the committee had limited assurance in regards to performance and finance.
12	**Date and time of the next meeting** Monday 25th April 2022, 1.30pm – 4pm MS Teams

Report to the Board in Public
Performance and Finance Committee
April 2022

Item: Performance Report	Level of assurance gained: Limited
The Committee agreed limited assurance with regard to the performance report, due to the ongoing challenges of achieving targets.	
Item: Elective Recovery Report	Level of assurance gained: Limited
The Committee agreed limited assurance with regard to the elective recovery report, although it was acknowledged there had been improvement with the 104 week waits which was reducing ahead of the trajectory there was still a substantial amount of work to be done in regards to elective recovery.	
Item: Finance Report	Level of assurance gained: Significant
The committee agreed the assurance level was significant following the report and discussion of the month 12 finance report.	
Item: Long-Term Financial Planning 2022/23	Level of assurance gained: Limited
The committee agreed the assurance level was limited. This was largely due to the plan having a significant deficit and the ICS being clear there could be no new investments if in deficit.	
Item: CRES Delivery 2022/23	Level of assurance gained: Limited
The committee agreed the assurance level was limited. Concerns were raised about the efficiency savings to be achieved and discussed the targets and efficiencies identified.	
The following reports were shared with the committee for information; • Scan 4 Safety	

Report to the Board in Public
Workforce, Education and Culture Committee April 2022

Item: Board Assurance Framework	Level of assurance gained: Reasonable
The Committee agreed reasonable assurance with regard to the board assurance framework. The committee were able to have detailed discussions regarding the target, achieved risk, and were able to agree targets were not achieved but recognised the work that had been undertaken to improve the risk and acknowledge that there were external factors influencing the Trust's abilities to achieve the risk ratings.	
Item: People Management Performance Report	Level of assurance gained: Reasonable
The Committee agreed reasonable assurance. The Trust's vacancy rate is low at 2.7% and on investigation at health group level for turnover there were no significant issues raised. An update was also provided on the expansion of the HYMS foundation trainee, which is due to increase by 50 foundation posts from August 2022.	
Item: Nursing and Midwifery Staffing Report	Level of assurance gained: Reasonable
The committee agreed the assurance level was reasonable, the Trust continue to have a robust recruitment strategy for nursing staff and vacancy levels are low at 1.77% for nursing staff with recruitment for newly qualified and international nursing well established.	
The following updates were shared with the committee for information; • Presentation and update from The LGBTQ+ Network • Variable Pay Report • Staff Vaccination Progress Report • Learning & Development Update – April 2022	

Hull University Teaching Hospitals NHS Trust
Minutes of the Workforce, Education and Culture Committee
Held on 13 December 2021

Present:	Professor U Macleod	Chair
	Mrs S Rostron	Director of Quality Governance
	Mr J Kastelik	Director of Medical Education
	Mr Nearney	Director of Workforce and OD
	Mrs R Thompson	Head of Corporate Affairs
In attendance:	Miss R Boulton	Quality Governance Officer (Minutes)
	Mr U Kempanna	Associate Medical Officer
	Professor M Loubani	Guardian of Safe Working

No **Item**

1 Apologies:

Apologies were received from Mrs Geary, Mr Desborough and Dr Pathak.

Professor Macleod confirmed the meeting was not quorate but would still discuss the items but any decisions would need to be deferred to the next committee meeting.

2 Declarations of Interest

Prof Macleod declared that she was the Dean of the Medical School.

3 Minutes of the meeting held 11 October 2021

The minutes of the previous meeting were reviewed and agreed as an accurate record.

3.1 Maters Arising

Professor Macleod requested LGBTQ+ to go on the work plan and that LGBTQ+ representatives from the network would come to talk to this committee in February, 2022.

Undergraduate Placements would be covered on the agenda today.

Professor Macleod requested a brief overview of the current position in the Trust prior to progressing with the agenda.

Dr Purva shared the Trust is now scaling up our vaccine clinics in line with the government request to roll out booster vaccines to all eligible adults. This is impacting on our already stretched resources, the vaccine clinic is staffed with existing staff not additional so frontline staff will be diverted and will result in scaling back elective work, with resources prioritised in key priority areas.

The Trust has seen a reduction in the last few days in COVID+ patients but we anticipate a surge as currently seen in the South East of the UK.
There is still a significant amount of medically fit patients in the hospital equating to four wards and we have two open COVID wards, which will have a significant on patient flow.

Dr Purva shared that we were expecting a high level of infection in the locality but hoped it would be a low mortality rate.

Workforce absence was a concern as there is no slack in the system and is already stretched. The Trust is anticipating the worst winter ever seen if it all plays out as expected.

Mr Nearney shared that there was a national debate currently regarding releasing staff for the vaccine sites and stepping down elective work. The Trust runs the Covid Vaccination programme bank for the ICS.

Dr Purva raised that we needed to include pregnant patients this year into the figures as they were excluded last year.

4 Action Tracker

The action tracker was reviewed and all actions were completed.

5 Board Assurance Framework

Mrs Thompson shared that the BAF for quarter three. The paper provides updates on the actions taken in the previous quarter with a plan for the following quarter. The BAF is supported by the operation and corporate risk register. The are no proposed changes to the risk ratings in quarter three and the Committee was asked to consider the risk ratings and decide:

- If there are any gaps in controls, sources of assurance or further actions to add.
- Consider whether the Workforce risk ratings are on track to deliver

Mrs Thompson asked the committee if the risks for BAF 1 and 2 were on target.

Mr Nearney responded that in regards to the BAF 2 we have made progress in reducing the vacancy rate so are in a good position but acknowledged that there are still pockets of shortages in areas but overall numbers are good. Absence rate is above normal rate. Staff support is in place but the key risk is the increase in self-isolation. Recommendation would be to leave the rating at the current position.

Mr Nearney stated that in regards to the BAF 1 the staff survey which would be available in January would provide a better picture. Recommended that the rating would remain the same and acknowledged it would be a challenge to deliver.

Dr Purva agreed that we are working towards all the actions, despite the challenges and think we will achieve. Medical staffing is in a better place than where we have previously been. EMC capture where the gaps are and how to be more productive. Agreed that the rating should remain at the current level.

Mrs Rostron asked the committee to be clear what will be difference to enable us to achieve the target rating, what we are expecting to see to say we have achieved it as it needs to be clear for audit how achieved it and what is different.

Mr Nearney responded that the staff survey in January which will be presented at February's meeting would be a key indicator and that we are on target to reduce the Trust's overall vacancy position.

Dr Purva stated that there is a specific action plan around medical workforce, which will enable us to show progress and the Associate Chief Medical Officer and the Director of Medical Education can share actions.

6 Workplan

Professor Macleod requested that the committee reviewed the work plan to ensure that everything relevant was on the work plan. Miss Boulton will be reviewing to spread the reports across the year where possible.

ACTION: Miss Boulton to liaise with committee members to alter the workplan.

7 Governance

7.1 People Strategy Progress Report

Mr Nearney shared the report with the committee which covered the following key areas:

- The Trust vacancy level
- Turnover
- Sickness
- Recruitment

Mr Nearney stated that the vacancy rate was in a healthy position, where the gaps are the Trust is redoubling efforts and meeting with HR business partners to support the Health Groups with recruitment plans.

Some work will be undertaken about the number of staff leaving within a year of starting as this needs to be further understood to be able to reduce this number.

Absence levels are above average but we are not alone in this increase. Staff wellbeing programmes are available and HR are supporting managers to support their staff.

Professor Macleod stated that she was reasonably assured by the data but aware that we don't know what's to come. In relation to staff leaving the NHS, asked if we should be thinking creatively to reduce the number of staff that may opt to retire early that may not have considered it pre-pandemic.

Mr Nearney responded that the challenge currently was in getting the time to support that type of planning when the operational pressures are so great. A demoting factor for some will be not being able to see their patients whilst for others it will be a case of being overwhelmed by patients.

The future of NHS Human Resources and Organisational Development which will be discussed later on in the meeting will be seeking to keep the people issues at the heart of the NHS and for the ICS to work differently together.

8 Recruitment and Retention

8.1 Nursing and Midwifery Staffing Report

Mr Nearney shared key points from the paper for the committee on behalf of Mrs Geary.

There are currently three additional wards and ICU beds open.

The nurse vacancy rate will reduce when the 106 new nurses receive their PIN and move from the auxiliary role into the registered role which will also then show a drop in the auxiliary numbers.

Professor Macleod stated that on reviewing the paper there was no cause for concern and that the committee had assurance regarding nurse staffing.

Mr Nearney added that our international nurses retention rate was 97% and that 30 more nurses were on target to get there OSCE at the end of December. Along with the improved access to nursing apprenticeship degrees and the associate nurse roles, the Trust was in a positive position.

8.2 Medical Undergraduate Training
Dr Purva shared the paper with the committee.

It was noted that the activity was more recent than the report date of the 14th June date, which was incorrect.

Dr Purva meets regularly with the new clinical dean, who recently took over the role and has done admirably as there has been considerable disruption within the undergraduate medical education team, with significant changes to staffing.

The key issues have been the expansion of students into year 4 22/23 academic year and the curriculum recovery and how to deliver the placements.

Phase 1 early IPC discussions have enabled us to set boundaries for students on wards and non-clinical areas. Sessions adapted and planned to allow for this. To date, no Phase I face-to-face clinical placement sessions have had to be cancelled.

Phase 2 The key issues to note are gaps in timetables due to difficulties in recruiting Consultant tutors. This is unsurprising given the current pressures on our colleagues due to the ongoing pandemic. Previous planning has mitigated this to a large degree with CTFs back filling the majority of gaps. No immediate solutions but in the near future when recruiting we are looking to build into the business cases that the role includes an academic within the job plan to strengthen the position of us being a teaching hospital.

The key risk is that if the staffing/tutor issues do not resolve we will not be in a position to take an increase in student numbers when expansion reaches year 4 (academic year 22/23).

We are looking at how we can modify current clinic rooms within the HRI HYMS building to create more multipurpose areas on the ground floor. Although this will not solve the issue, it will help to use what space we do have more creatively. Alternative options have also been explored.

Professor Loubani requested that when job planning for new consultants the provision of teaching post-graduate doctors was included in the discussion to provide dedicated support.

Dr Purva responded that it certainly be included. Future recruitment needed to be clear that the full 12 PA's are not all clinical but needed to factor in clinical supervision and academic and are a required part of the role.

Professor Macleod shared her gratitude for the work undertaken and acknowledged the expansion was always going to be challenging. The school are also looking to ensure we are using the placements effectively to prepare the doctors. Previously we have just done more of the same and the pandemic have given an opportunity to review and get the best of what we have.

It was suggested to review questions for consultant's interviews so setting the expectation there is teaching in a teaching hospital from the start.

Professor Macleod confirmed that the committee had assurance regarding the Medical Undergraduate Training.

9 Health and Wellbeing

9.1 Staff Vaccination Progress Report

Mr Nearney shared that the Trust's Flu vaccination position was above national average and that for the Covid booster 81% of staff had received.

Mandatory Covid vaccination for NHS staff was due to be discussed at the Board development discussion tomorrow. There is a choice but the government have made it very clear and it expected to be law on 6th January which will require health staff to have the Covid primary vaccinations.

We have identified a preliminary figure for those staff still requiring the vaccine although we are aware that some staff may have received externally to the Trust. Staff have been asked to provide access to their data held on NIVS by the 17th December, following this date we will be able to drill down into that data and reduce ie. establish who has not had the vaccinations and begin conversations with staff.

Mr Nearney stated that the possibility of redeployment is slim. Some staff have been very clear about not having the vaccine and there is an impact for these staff and some negativity around the teams.

Professor Macleod acknowledged that this would create a lot of extra work for the organisation.

9.2 National Staff Survey

Mr Nearney shared that 3,800 staff completed this year's national staff survey a 40% response rate which is the highest response in 5 years. We will receive a rough cut of the data in January and will bring to the February committee to look at the challenging areas.

In January we will also be running the staff survey for the 4th quarter, which is a national requirement, with 9 set questions.

10 National Committees

10.1 The future of NHS Human Resources and Organisational Development

Mr Nearney shared that the NHSE/I Chief People Officer has launched 'The Future of NHS HR and OD' which sets out a national vision for health and social care staff through 8 people statements and an action plan which articulates what should be addressed at Trust level, ICS system level and nationally. The Director of Workforce and OD will be formulating a Trust plan in response and will bring to the committee in February, and will be happy to add metrics into the People Strategy performance report.

Professor Macleod asked if we were already aware what would be delivered at national and ICS level, as there is competition between local acute Trusts.

Mr Nearney responded that collaboration is important and sharing resources between acute trusts at ICS level.

Dr Purva shared that our ICS was still in its infancy where those in place longer had developed good working relationships, the crisis will accelerate that way of working and FastTrack the changes to enable discussions to be held in regards to patient or staff reallocation to support operational pressure within Trusts.

11 Employee Engagement, Communication And Recognition

11.1 Guardian of Safe Working Report

Professor Loubani shared that the redeployment of junior doctors was managed better in the subsequent waves, in the current climate the same concerns are present but limited number affected currently.

E-rostering roll-out remain poor within only 29% now using the system. Administration staff have now been employed to improve.

Phlebotomy provision within the Trust continues to be an issue for trainees. A business case has been put forward which will be considered in March for approval.

Self-development time (STD) needs to be embedded in all trainee's rotas. Due to staffing levels and work pressures, some departments are finding it difficult to allocate this time to their trainees. This is a contractual requirement therefore we should have 100% of trainees accessing but we are currently reporting 85%

There were a total of 204 exception reports (204 episodes) reported by trainees. The most common reason for submitting an exception report still appears to be related to the volume of work which leads to trainees staying beyond their contracted hours. Other reasons include missed educational and training opportunities. This includes missed self-development time and teaching. As well as staying beyond contracted hours in the interest of patient care and staff shortage. There were 9 fines issued.

Dr Purva confirmed that STD was only a contractual requirement for foundation junior doctors and asked that the report also highlighted what we were doing well with in addition to areas that required improvement. The previous year we didn't report exceptions so it shows the junior doctors now feel able to raise the exceptions.

Professor Macleod asked if we were able to get national or regional figures to provide a comparison.

Mr Kastelik shared that in regards to redeployment, it has been managed very well so far with only small amount of doctors moved and for short periods. This took a lot of organisation from the team working closely with clinical managers. We feel that other Trusts have done something similar without saying its redeployment. There is no current impact on training.

Mr Kastelik confirmed they were aware of issues within elderly medicine and have been in communicated with the dean and a plan is in place for the next rotation.

Mr Nearney stated that Health Education England were raising phlebotomy as an issue and asked if we were confident it will come to fruition following the business case. Dr Purva responded they were confident but would be happy to have additional support for the business case from Professor Macleod.

Professor Macleod stated she would be happy to escalate to the board and would email her support to the Chief Finance Officer.

12 Any Other Business

None raised within the meeting.

Date and time of the next meeting:

Monday 14 February 2022, 10am – 12pm, via Teams