Trust Board in Public
Tuesday 12 July 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 10 May 2022** **4.1 Minutes of the meeting held 16 June 2022 (Accounts Approval)** Sean Lyons, Chair	Approval Approval Approval		Attached Attached 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	09.10	Verbal
	Governance			
6	**CEO Report/Covid Update** Chris Long, Chief Executive Officer	Assurance	09.25	Attached
	6.1 Committees in Common Summary Sean Lyons, Chair	Assurance		Attached
	6.2 Audit Committee Summary Tracey Christmas, Audit Chair	Assurance		Verbal
	6.3 Year-end Board and Committee Review Rebecca Thompson, Head of Corporate Affairs	Assurance		Attached
	6.4 Register of Gifts and Interests Annual Update Rebecca Thompson, Head of Corporate Affairs	Assurance		Attached
	6.5 Summary from the Charitable Funds Committee Tony Curry, Charitable Funds Chair	Assurance		Attached
	Strategy			
7	**7.1 Board Assurance Framework Q1 2022/23**	Approval	09.40	Attached

	Suzanne Rostron, Director of Quality Governance and Rebecca Thompson, Head of Corporate Affairs			
	Quality			
8	**Quality Report** Jo Ledger, Acting Chief Nurse/Suzanne Rostron, Director of Quality Governance **8.1.1 Maternity Update** Lorraine Cooper, Head of Midwifery	Assurance	09.45	Attached
	8.2 Infection Prevention and Control Annual Report Greta Johnson, Director of Infection Prevention and Control	Assurance		Attached
	8.3 Infection Prevention and Control BAF Greta Johnson, Director of Infection Prevention and Control	Assurance		Attached
	8.4 Learning from Deaths, Mortality Update Makani Purva, Chief Medical Officer	Assurance		Attached
	8.5 Summary from the Quality Committee David Hughes, Quality Chair	Assurance		Attached
	Workforce			
9	**Workforce Update** Simon Nearney, Director of Workforce and OD	Assurance	10.30	Attached
	9.1 New Equality and Diversity Objectives Simon Nearney, Director of Workforce and OD	Assurance		Attached
	9.2 Trade Union Facility Time Reporting Requirements Regulations 2022 Report Simon Nearney, Director of Workforce and OD	Approval Assurance		Attached
	9.3 Summary from the Workforce, Education and Culture Committee Una Macleod, Chair of Workforce, Education and Culture Committee			Attached
	9.4 Freedom to Speak Up Fran Moverley, Head of Freedom to Speak Up	Assurance		Attached
	9.5 Guardian of Safe Working Report Mahmood Loubani, Guardian of Safe Working	Assurance		Attached
	Performance			
10	**Performance Report** Ellen Ryabov, Chief Operating Officer **10.1 Finance Report** Lee Bond, Chief Financial Officer	Assurance Assurance	11.00	Attached Attached
	10.2 Summary from the Performance and Finance Committee Mike Robson, Chair of Performance and Finance	Assurance		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:** Tuesday 13 September 2022			Verbal

Attendance 2022/23

Name	10/5	16/06	12/07	13/09	08/11	10/01	14/03	Total
Sean Lyons	✓	✓						2/2
S Hall	✓	✓						2/2
T Christmas	✓	✓						2/2
T Curry	✓	x						1/2
U MacLeod	x	✓						1/2
M Robson	✓	✓						2/2
L Jackson	x	x						0/2
A Pathak	x	✓						1/2
D Hughes	✓	✓						2/2
C Long	✓	✓						2/2
L Bond	✓	✓						2/2
M Purva	✓	x						1/2
J Ledger	✓	✓						2/2
S Nearney	✓	✓						2/2
E Ryabov	✓	✓						2/2
M Cady	✓	✓						2/2
S Rostron	✓	✓						2/2
S McMahon	✓	x						1/2
R Thompson	✓	✓						2/2

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 in Public
Held on 10 May 2022

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice Chair
	Mr M Robson	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Dr D Hughes	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Prof M Purva	Chief Medical Officer
	Mrs J Ledger	Interim Chief Nurse
	Mrs S Rostron	Director of Quality Governance
	Mr S Nearney	Director of Workforce and OD
	Mrs M Cady	Director of Strategy and Planning
	Mrs S Macmahon	Joint Chief Information Officer
In attendance:	Mrs L Cooper	Head of Midwifery
	Dr Thozhukat Sathyapalan	Director of Research and Innovation
	Mr J Illingsworth	R&D Manager
	Mrs R Thompson	Head of Corporate Affairs

No	Item	Action
1	**Apologies** Apologies were received from Prof U Macleod, Non-Executive Director and Mrs L Jackson, Associate Non-Executive Director, Dr A Pathak, Associate Non-Executive Director	
2	**Chair's Opening Remarks** The Chairman welcomed members of the public to the meeting. Mr Lyons thanked all staff on behalf of the Board for their hard work and never ending resilience for keeping patients safe in these challenging times. The Healthcare Bill had been passed on 28 April 2022 to formalise Integrated Care Boards and this would be commencing from 1 July 2022. Work was already ongoing in shadow form. Mr Lyons congratulated the Liberal Democrats for their local victory and stated that the Trust would be working with them regarding the healthcare agenda.	
3	**Declarations of Interest** **3.1 Changes to Directors' interests since the last meeting** Dr Hughes advised that he had a new role as a clinical advisor in pathology in North Yorkshire.	

3.2 To consider any conflicts of interest arising from this agenda
There were no declarations made.

4 Minutes of the meeting held 8 March 2022
Mrs Christmas to be removed from the attendees list.

Dr Hughes thanked the patient rather than patience on page 3.
Page 9 – Finance update. The Trust had spent £80m rather than spend. The sentence beginning Procurement to work with….to be removed.
Page 8 – Mrs Ledger advised that the Midwifery staffing report would go to the Workforce Education and Culture Committee in June and then to the Board in July 2022.

Removal the final paragraph on page 9.

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

4.1 Board Work Programme 2022/23
Mrs Macmahon suggested that the Digital Strategy update should be allocated to her as the Chief Information Officer.

4.2 Board Development Framework
Mrs Thompson advised that the Framework had been updated for 2022 and the next Board Development session would include the risks to recovery and the Staff Survey.

4.3 Matters Arising
There were no matters discussed.

4.4 Action Tracker
The two items on the Action Tracker had been completed and could be removed.

5 Patient Story
Prof Purva advised that the patient story came from the daughters of a patient and highlighted the challenges of visiting following the pandemic.

Communication was the key message coming out of the video and how it was important for staff to know their patients and keep families informed of their progress. Prof Purva advised that nominated family members had been a new initiative and regular communications were taking place. There had been a number of lessons learned which had been fed back to services.

There was a discussion around data protection and how to ensure calls reached the correct person and Mrs Ledger advised that key words were used.

The essential care giver initiative put into place by the lead DME nurse had been piloted for delirium and dementia patients but this would be rolled out in the future.

Mr Lyons thanked the family for their open and honest feedback.

6 CEO Report/Covid Update

Mr Long presented his update and advised that there were 52 patients with Covid in the hospital and this was countered by 169 patients that were medically fit with no criteria to reside. This had reduced the bed base by 16%.

Emergency care and flow was still challenged and the Trust had been at Opel 4 for a number of months. ED was crowded and full at all times and not having timely discharges was compounding the issue.

Mr Long thanked staff for their brilliant efforts to recover this position whilst working in this pressurised way. Mr Long did express his concern regarding staff welfare.

Mr Curry asked about the no criteria to reside patients and how the numbers had changed since the pandemic. Mr Long advised that before the pandemic it had been around 50 patients and is now approximately 160 daily. Mr Robson expressed his concern regarding social services and its capacity to take the no criteria to reside patients.

Mrs Christmas asked about the App only parking and Mr Long advised that pay machines were also being installed.

Mrs Ledger added that staff were tired with the relentless challenges but were upbeat and learning lessons from the last 2 years. Prof Purva added that the clinicians were keen to get started on the recovery of normal activity.

6.1 Committees in Committees in Common

Mr Lyons presented the paper and advised that the committee had taken substantial assurance around the planning of the programmes, but there was uncertainty around the capital funding.

Concerns were raised regarding Programme 1 and this would be monitored at the Joint Development Board.

6.2 Standing Orders

Mrs Thompson presented the report and requested retrospective approval for use of the Trust's seal.

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

6.3 Audit Committee Summary

Mrs Christmas presented the summary and highlighted the audit report relating to Accounts Payable and Credit Card Expenditure. IT purchases were discussed due to their high value. The Board Assurance Framework audit had received substantial assurance and part of this was due to the Board engagement and governance processes in place.

The Internal Auditors' draft audit plan for 2022/23 had been agreed and progress on the year-end accounts by External Audit noted.

Mrs Christmas advised that there was nothing to escalate to the Board.

6.4 Annual Report Progress Report
Mrs Thompson presented the report and advised that production of the Annual Report was on track and would be presented to the Audit Committee on 16 June 2022.

6.5 Trust Self-Certification
Mrs Thompson presented the Trust's self-certification against NHS Improvement requirements for approval by the Board. Once approved the document would be uploaded to the Trust's website.

Resolved: The Board approved the self-certification.

6.6 Fit and Proper Persons Test Report
Mrs Thompson presented the report which detailed the fit and proper status of the Trust Board. She advised that there were no issues with declarations or background checks.

Resolved: The Board received the report for assurance

6.7 Statement of Mixed Sex Accommodation
Mrs Thompson presented the report and advised that there had been no breaches or complaints relating to Mixed Sex Accommodation in 2021/22. The statement would be uploaded to the Trust's website.

Mr Lyons stated that it was a credit to the nursing teams that this had been achieved when the Trust was under extreme pressure.

7 Operating/Financial Plan 2022/23
Mrs Cady presented the plan and commended the teams that worked to develop it.

She highlighted that the planning guidance had been received in December 2021 and the teams had worked with the ICS and CCGs with the focus on emergency care and the general workforce issues. The plan was to achieve 110% of 2019/20 activity and 120% of the 2019/20 diagnostic performance as well as reducing long waits.

Work was ongoing with partners to increase capacity but the plan was challenging due to the high numbers of patients that should be cared for elsewhere.

The financial plan guidance was a break even position but the Trust was planning a £19.1m deficit which was mainly attributed to inflationary pressures. Discussions were ongoing to secure financial support.

The Trust had an efficiency target of 4% (£29.7m) and the financial plan came in at 78% of this target (£23m).

The capital plan included the funding to complete the Day Surgery Unit at Castle Hill as well as £7m for technology upgrades. There was insufficient capital funding to realise the Trust's development provisions which meant that there was a risk on delivery for strategic aspirations.

Mr Curry challenged the costs of scaling up capacity and asked if it was built into the plans. Mrs Cady advised that it was and that there were plans in place with CHCP and a ward at Castle Hill to contain patients with no criteria to reside.

Dr Hughes expressed his concern around the number of years the recovery would take against the challenging plan that had been developed and the challenging financial position. Mrs Cady explained that a number of trajectories were in place and that good assurance had been given that the patients waiting the longest were the safest so the priority planning had been worked around this.

Mr Hall asked if the 104 week standard target to have zero by the end of October had been agreed with all stakeholders and Mrs Ryabov advised that is had but it was recognised nationally that this would be very difficult to meet.

Mrs Ryabov added that the number of 52 week waits had been reduced by 50% and was now at 5000. This areas was a risk for the organisation and very challenging to reduce.

7.1 Board Assurance Framework Q4 Year-End Report
Mrs Rostron presented the report which highlighted the year-end strategic risk ratings and the 2022/23 new risks which had been discussed at the Board Development Session in April 2022.

The 2021/22 BAF showed that 5 risks had achieved their target, 4 had not achieved and 1 target risk rating had increased. The reason for increasing the rating was due to the Staff Survey results being poor.

Resolved: The Board approved the 2021/22 Board Assurance Framework ratings.

Mrs Rostron also presented the new risks for 2022/23 that had been agreed at the Board Development. She advised that the new BAF would be written using these headlines.

Mr Bond suggested that there might be advantages to splitting the revenue and capital risks into long and short term and Mrs Rostron stated that the short term risks could be added to the Corporate Risk Register and the long term risk be included on the BAF.

Action: Revenue/Capital risk discussion to be followed up at the next Performance and Finance meeting. **RT**

Resolved: The Board approved the 2022/23 BAF risks.

8 Quality Update
Mrs Ledger presented the update and advised that the Quality Accounts had been circulated to the Board and would be finalised by 30 June 2022. She asked that the Board reviewed the document within a week so that any comments could be included.

The CQC insights data had highlighted that the HSMR, SHMI, CAS Alert and Never Events were in the much worse category. Prof Purva advised that the SHMI was an annualised score and the spike in 2021 due to Covid had reduced in 2022 but it would take time for the data to catch up. Work was ongoing to review primary care capacity, deprivation and health inequalities to add context to the figures.

A number of Serious Incidents had been closed and had been presented to the Quality Committee. There was work ongoing in ophthalmology, tissue viability and falls to reduce incidents although falls with harm had not increased.

Mr Lyons asked about sharing learning across Trusts and Mrs Ledger advised that the new Chief Nurse appointed to the ICS Board was keen to take that approach.

8.1.1 Maternity Update
Mrs Cooper presented the reports and advised that the Maternity self-assessment tool report ensured that the Trust was meeting national and regulatory standards. Out of the 167 requirements, 72% were green, 25% were amber and 3% were red. Action plans were in place to address the reds and ambers and fed into the Ockenden action plan. There was nothing worrying to report.

Avoiding Term Admissions into Neonatal units programme
Q3 data showed that admissions had reduced by 2.6% and this was to be celebrated. Mr Hall commended the teams for this work.

Perinatal surveillance report
Mrs Cooper advised that the report covered any HSIB investigations, coroners, safe staffing as well as service user and staff feedback.

The pandemic had impacted on midwifery staffing and this had in turn impacted on training and staff survey results. Learning was being shared quarterly at the LMS and good practice was being identified across the patch.

Perinatal mortality review tool
Mrs Cooper presented the report which highlighted the process around reviewing deaths of babies to the required standard. She advised that the Trust was compliant in all 5 standards.

The greatest risk was staffing. Mr Long stated that the Board should support the leadership team and that it was important the Head of Obstetrics and the Head of Midwifery worked closely together.

Mr Lyons thanked Mrs Cooper for her leadership and hard work in the maternity setting.

8.2 Learning from Deaths
Prof Purva presented the item and advised that the Trust was good at undertaking Structured Judgement Reviews and was consistently higher than the 5% expected rate.

There was an example in the report showing how the reviews were carried out. It related to ED paediatrics and showed the extent of anlysis that is undertaken, the peculiarities or the region and lack of primary care.

All stroke patients were being reviewed which had resulted in a great degree of assurance in this area.

There was a discussion around handover documentation, electronic patient records and electronic prescribing and how this would help with data gaps in the future.

8.3 Research and Innovation Annual Report
Mr Illingsworth presented the report and advised that in 2021/22 the services had achieved 166% of its NHR improvement target. The service had recruited 8000 patients for trails.

Work was ongoing to expand contact with the University of Hull to enable clinicians to do more and more research including new AI work.

The recent research celebration event had been successful and there was vital work ongoing with Smith and Nephew.

The Research directorate was expanding with the recruitment of engagement support between departments.

Mr Curry asked about the Family and Women's Health Group and the research opportunities and Mr Illingsworth advised that there currently was not a dedicated research midwife but there would be some work being carried out around Born and Bred in Hull.

Dr Hughes was keen for the Board to support Research and Innovation in any way it could and Mr Lyons suggested a Board Development Session be held to discuss opportunities.

Action: Research and Innovation Board Development session to be held. **RT**

8.4 Summary and Minutes from the Quality Committee
Dr Hughes presented the summary and advised that there had been a good discussion regarding the BAF at the March committee that had fed into the Board Development session.

Dr Hughes flagged the enhanced monitoring by the regulators and advised that the teams were in the process of agreeing the exit strategy.

The PALs service was now in the Quality Governance Directorate and patient complaints would help link with other sources of quality information.

The Chief Pharmacist had attended the meeting to highlight what developments were ongoing in Pharmacy.

The April meeting had not been quorate but there had been no decisions made by the Committee. National audits, Ockenden and IPC were discussed in detail and there had been a focus on MRSA Bacteraemia and the changes in Covid infection prevention measures.

9 Performance Report

Mrs Ryabov advised that the Performance report had been updated and performance remained challenging.

Ambulance waiting time performance had not improved and there had been an increase in 12 hour trolley waits which were due to flow issues through the hospital and the impact of no criteria to reside patients.

104 week waits were being reviewed nationally and weekly calls with the regional and national teams were now in place.

Cancer performance was also under scrutiny due to the volume of patients on the cancer list.

Mrs Ryabov expressed her concern about the out of hospital issues that were out of the Trust's control and the impact on patients.

9.1 Finance Report

Mr Bond presented the Finance Report and advised that the Trust was reporting a £200k surplus for the year 2021/22.

There were still issues in the Clinical Support and Family and Womens' Health Groups and the Continuity of Care initiative.

Mr Bond's main worry related to offsetting recurrent costs with non-recurrent income in the coming year.

There was £26m in the Capital plan which included the day surgery build at Castle Hill and the Urgent and Emergency Care schemes.

Mr Bond advised that the Trust had a good end of year financial position and the only area of review on the balance sheet would be stock holding and this would be reviewed in 2022/23 to ensure modern day practices were in place.

Mr Lyons thanked the financial teams for a strong year end performance.

9.2 Summary and Minutes from the Performance and Finance Committee

Mr Robson presented the summary and minutes and advised that the Non-Executive Directors were now receiving flash reports relating to performance.

He advised that the Committee had given limited assurance to the performance section of the meeting but there were many things outside of the Trust's control, e.g. patients with no criteria to reside.

The Committee had received and scrutinised the Operational Plan.

Mr Robson informed the Board that the Committee would be receiving presentations from challenged areas and Outpatients would be attending in May to present.

Action: Mr Lyons suggested that the NED Flash Report be reviewed by Mrs Macmahon to make it more automated. **SM**

10 Workforce Report

Mr Nearney presented the report and advised that staff absence was at 6.71%, this was mainly due to Covid.

The vacancy rate was healthy at 2.2% and staff engagement was at 6.6 out of 10.

Executive sessions were being held with staff to ascertain how the Trust achieves great care and what are the obstacles preventing this happening.

10.1 Summary and Minutes from the Workforce Education and Culture Committee

Mr Nearney advised that the Trust LGBTQ+ representatives had attended the meeting and had discussed their challenges and the support available.

There were ongoing staff issues due to the pandemic but assurance was received around staff vacancies and turnover.

11 Questions from the public relating to today's agenda

There were no questions received.

12 Chairman's summary of the meeting

Mr Lyons thanked everyone for their contribution and the clear reports that had been received.

Mr Lyons stated that the Board meetings were still very operational due to the pressures faced by the Trust and hoped for a more strategic agenda in the near future.

Board development sessions were discussed and Structured Judgement Reviews, Research and Innovation and Staffing would feature in 2022.

Mr Lyons asked for direct feedback regarding the Board meeting.

13 Any other business

There was no other business discussed.

14 Date and time of the next meeting:

Thursday 16 June 2022 to approve the annual accounts

Hull University Teaching Hospital Teaching NHS Trusts
Minutes of the meeting to approve the Annual Accounts 2021/22
Held on 16 June 2022

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice Chair
	Mr M Robson	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Dr D Hughes	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mrs J Ledger	Interim Chief Nurse
	Mrs S Rostron	Director of Quality Governance
	Mr S Nearney	Director of Workforce and OD
	Mrs M Cady	Director of Strategy and Planning
In attendance:	Mrs R Thompson	Head of Corporate Affairs

1. **Apologies**
   Apologies were received from Prof M Purva, Chief Medical Officer and Mr T Curry, Non-Executive Director

2. **Declarations of Interest**
   2.1 Changes to Directors' interests since the last meeting
   There were no declarations made.

   2.2 To consider any conflicts of interest arising from this Agenda
   There were no conflicts raised.

3. **Audited Accounts 2021/22**
   Mr Bond presented the accounts and advised that Mazars had commended the Accounts in the Audit Committee earlier that day.

   There were 3 issues raised, 2 were not adjusted and 1 was adjusted as it was £700k for a boiler system which should have been included in buildings that was included in plant and equipment.

   Mrs Christmas advised that there were some elements of the audit to be concluded and would be ready by 23 June 2022.

   Mr Bond advised that there was a modified audit opinion relating to the stock count at the end of the previous financial year and Dr Hughes asked if this was due to the Auditors not being on site because of the pandemic. Mr Bond advised that it was.

   Resolved: The Board approved the Audited Accounts 2021/22

3.1 Audit Findings Report (Mazars)
The Audit Findings Report was presented for information.

4. **Letter of Representation**
   Mr Bond presented the Letter of Representation for approval by the Board. This letter is drafted by the Auditors and signed by the Trust's Accountable Officer. Mr Bond added that the contents of the letter had been endorsed by the Audit Committee.

   Resolved: The Board approved the Letter of Representation

5. **Annual Report 2021/22**
   Mrs Thompson presented the Annual Report to the Board.

   Dr Hughes asked whether the Chief responsible for Information Governance and the Caldicott Guardian should be named. Mrs Thompson agreed to add these to the report.

   Mrs Christmas advised that the report could not be published until the Auditors have sent a letter to the Trust detailing the closure of the Audit. This would be August 2022.

6. **Any Other Business**
   Mrs Thompson asked the Board to consider merging the Audit Committee and Board meeting next year to approve the accounts. The reason for doing this was from a time efficiency point of view.

   Resolved: The Board approved this approach.

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

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

Finance Report	Chief Financial Officer	Deputy Director of Finance	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Peformance and Finance Committee	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Covid-19 Recovery Report	Director of Strategy and Planning	AD Strategy and Planning	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on Covid-19 recovery plans	No	To update the Board regarding Covid-19 planning and activity	Assurance
Summary and minutes from the Performance and Finance Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	Peformance and Finance Committee	As part of overall governance of the Trust	Assurance
Quality														
Quality Report	Chief Nurse/Chief Medical Officer/Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key quality indicators	Quality Committee	The Trust has an obligation to meet operational, financial and contractual targets, including SI s and Never Events	Assurance
Summary and minutes from the Quality Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	Quality Committee	As part of overall governance of the Trust	Assurance
IPC BAF	Chief Nurse	Director of Infection Prevention and Control	✓				✓			Twice per year	To provide an update on the Trust's Infection Prevention and Control activities and information on actions in place	Quality Committee	To provide assurance to the Board	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 Information 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		Learning from Deaths – SJR Review		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 (July 2022)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
May 2022						
01.05	BAF	Capital risk to be reviewed at PAF	LB/RT	June 2022		Short term risk now on Corporate Risk Register
02.05	R&I Annual Report	Board Development Session to be arranged	RT	Dec 2022		On the workplan
03.05	PAF	SM to review the NED flash report	SM	July 2022		
COMPLETED						
March 22	Board Development Framework	Updated framework to be presented to the Trust Board	RT	May 2022		
March 22	Trust Strategy	Meeting to discuss alignment of HUTH and UoH strategies	MC/UMc	May 2022		

Actions referred to other Committees

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

Hull University Teaching Hospitals NHS Trust

Trust Board

15 JULY 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:	ICB establishment, review of waiting lists, chemotherapy clinics, entonox project, solar field	

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
- Reseach, development and innovation
- Sustainability – Zero30

1. KEY MESSAGES FROM MAY/JUNE 2022

Formal establishment of ICB
NHS Humber and North Yorkshire Integrated Care Board (ICB) was formally established on 1 July 2022, when it held its first official meeting of the board.

The ICB will become a key part of the Humber and North Yorkshire Health and Care Partnership, replacing Clinical Commissioning Groups (CCGs) as the statutory organisation with responsibility for NHS functions and budgets. Details and papers regarding this meeting are available at www.humberandnorthyorkshire.icb.nhs.uk/meetings-and-papers

COMPASSIONATE CARE

Chemotherapy Clinic offers full breadth of experience to patients
A broader approach to supporting patients through chemotherapy treatment is being introduced at the Queen's Centre, Castle Hill Hospital.

Patients receiving treatment for colorectal, upper GI and gynaecological cancers are already receiving consultations with different health professionals, and this approach will be rolled out to other cancer specialties over the course of the year.

This means that, at appropriate stages of their treatment, patients could meet with a specialist nurse or a pharmacist for example, rather than a consultant, and benefit from their additional knowledge and technical expertise. Our multi-disciplinary team (MDT) approach now means that, where it's safe and appropriate to do so, patients could have their appointment with someone other than a doctor, such as a pharmacist or a clinical nurse specialist.

Around 1,900 patients from across the Humber and parts of North Yorkshire receive either intravenous or oral chemotherapy treatment through the Queen's Centre at Castle Hill Hospital every month.

Review of waiting lists
Our Trust has begun contacting patients in an attempt to speed up care for thousands of people on hospital waiting lists.

From Thursday 30 June, we began contacting 31,000 people who are waiting for either an outpatient appointment or routine procedure at Hull Royal Infirmary or Castle Hill Hospital. Patients will be contacted in batches of 500 to 1,000 people at a time, and they will be asked

whether they wish to continue waiting, whether they no longer need to be seen, if they have had their treatment elsewhere, or if they wish to delay treatment.

The work is being carried out in an attempt to reduce hospital waiting lists by ensuring the information held is up to date, and only those who need to be seen remain on the list.

Patients will receive either a text message inviting them to complete a short online, or a letter inviting them to contact the Trust by phone to indicate their current position.

Wellbeing suite opens officially
The new WISHH Health and Wellbeing Suite was opened officially at Castle Hill Hospital in June.

The £150,000 suite has been created by WISHH, the independent charity supporting Hull's Hospitals, as a safe haven for staff to relax and recharge their batteries. Located next to Nightingales Restaurant, the suite has two large rooms, separated by a foldable partition to create one larger space. It has two showers for staff to get washed and changed after cycling or running to work or taking part in our trust activities. It also has a bank of key-operated lockers for staff to keep items like cycling helmets or running shoes.

It is a great asset for the Trust which staff can use for their downtime, somewhere people can come for quiet contemplation or to take part in fun activities.

WISHH's Covid-19 Appeal, supported by the public, businesses, Hull Live's Helping Hull's Hospital's Appeal and charities in Hull and the East Riding, raised £78,000 for the suite as one of its long-term legacy projects to support staff at Hull. WISHH were also successful for securing funds from NHS Charities Together, the charity supported by the late Captain Sir Tom Moore, receiving £72,000 to make the suite a reality.

International recognition for Thoracic Trauma Team
A team specialising in the care of seriously injured patients has received international accreditation for its work.

Our Trust has been awarded 'Collaborative' status from the Chest Wall Injury Society (CWIS) for its often life-saving work with patients with rib fractures and other chest injuries.

Hull is one of just 26 specialist Major Trauma Centres across England, with patients arriving into Hull Royal Infirmary, often by helicopter, from as far afield as North Yorkshire, Lincolnshire and the Midlands.

Following receipt of urgent care on arrival, patients with rib fractures would normally go on to be cared for in either HRI's Major Trauma Centre, ward H40, or in the cardiothoracic surgical ward, C27, at Castle Hill Hospital. Patients may also be admitted to intensive care or to one of the trust's general medical wards, according to their needs.

The accolade from the CWIS is a reflection of the quality of care provided by the multi-disciplinary team, and serves as great reassurance for patients affected by such injuries.

ZERO30

Carbon offsetting scheme
Constructed by Helix CMS in 2021, the new three-storey ICU unit at HRI is helping to transform the care we provide to our patients. But the company behind the building have been keen give something more back as part of their commitment to environmental issues.

They have now donated a small woodland of new trees in North Yorkshire as part of an offsetting scheme, which will sequester 55 Tonnes of CO2 over the next 40 years.

The woodland dedicated to the ICU is part of a wider project called 'Make it Wild' which promotes carbon offsetting through the creation of green spaces and tree planting. Helix has arranged for a special plaque, engraved in oak, to be sited within the woodland space which officially dedicates the area to Hull's Intensive Care Unit.

Thousands of pounds and tonnes of carbon emissions saved as part Zero30
A team working to reduce carbon emissions across Hull Hospitals has turned its attention to the anaesthetic gases given during labour – with staggering results.

Until recently, almost one fifth of all the carbon emissions generated by Hull University Teaching Hospitals NHS Trust, around 17% or 5,000 tonnes, have come from anaesthetic gases. Of these, around 4,000 tonnes have been generated through the use of Entonox as a pain relieving gas for women giving birth in Hull Women and Children's Hospital.

Anaesthetic gases have significantly higher environmental impacts than other sources of emissions and are hundreds to thousands of times more harmful than carbon emissions.

With a self-set target to halve gas emissions by 2025 as part of its Zero30 ambitions, a hospital team including midwives, pharmacy and estates staff, and colleagues from PFI company Apleona, began to investigate Entonox use.

Since September 2021, the replacement of seals combined with a simple change in practice by the maternity team has led to a significant reduction in the consumption of Entonox, and seen associated carbon emissions drop by 87% – from 347 tonnes per month to just 45.

Over an average year, emissions associated with Entonox use amounted to over 4,000 tonnes, equivalent to an average car driving round the earth 592 times, but this has now fallen by over 3,500 tonnes per year, or 514 round-the-world trips, to just 540 tonnes.

Saving gas has also helped the Trust save money, some £3,300 per month to be precise or £40,000 per year. Plus, with the number of gas cylinders being delivered to site falling from 250 to just 33 each month, this has freed up more time for porters and estates teams to work on other jobs and further reduced carbon emissions by cutting the number of journeys required to collect and deliver cylinders.

Castle Hill completely powered by solar energy
It took just five months to install, but HUTH's investment in solar technology is paying dividends.

We began installing solar panels on land adjacent to the Castle Hill Hospital site in Cottingham in September 2021. The project saw 11,000 panels installed at a cost of £4.2m in order that the Trust could begin to lower its carbon footprint and generate its own electricity.

Work was completed in February 2022, and with the arrival of longer days it has meant that the panels are now generating enough electricity to meet the complete daytime power needs of the entire Castle Hill site. Not only does this represent a significant contribution towards our plan to become carbon neutral by 2030, but the project is also saving us a significant amount of money on hospital energy bills; approximately £250,000 to 300,000 every month.

2. MEDIA/SOCIAL MEDIA ACTIVITY

In May there were 36 articles published about the Trust:

- 29 positive (80%)
- 2 factual (6%)
- 5 negative (14%)

- 0 neutral (0%)

Most negative coverage related to car parking, including national coverage of staff parking tickets. Most positive coverage related to Zero30 projects – Entonox/solar field.

Social media

Facebook

Total "reach" for Facebook posts on all Trust pages in May – 251,646

- Hull Women and Children's Hospital – 63,999
- Castle Hill Hospital – 65,216
- HEY Jobs page – 14,700
- Hull Royal Infirmary – 54,593
- Hull University Teaching Hospitals NHS Trust – 53,138

Twitter @HullHospitals

- 65,200 impressions in May 2022
- 10,124 followers
- Tweets with highest number of impressions related to our solar farm meeting the daytime running needs of Castle Hill Hospital and the reduction of Entonox waste in maternity services.

In June there were 36 articles published about the Trust:

- 21 positive (58%)
- 0 factual (0%)
- 12 negative (33%)
- 3 neutral (9%)

Most negative coverage related to ambulance waiting times and hospital visiting policy.

Social media

Facebook

Total "reach" for Facebook posts on all Trust pages in June – 245,754

- Hull Women and Children's Hospital – 79,990
- Castle Hill Hospital – 69,787
- HEY Jobs page – 10,690
- Hull Royal Infirmary – 54,440
- Hull University Teaching Hospitals NHS Trust – 30,847

Twitter @HullHospitals

- 126,000 impressions in June 2022
- 10,196 followers
- Tweets with highest number of impressions related to the retirement of safeguarding nurse Chris Davidson and the launch of the Trusts zero tolerance to racism policy.

Report to the Board in Public
Humber Acute Services Development Committee held on 15 June 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. The consultation period would be commencing mid-September with a view to finish in March 2023. Key risks: mapping of workforce, ICS approach, Ockenden and out of hospital care.	
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. Potential slippage for build timelines up to 2035.	
Item: Integrated Care Programme Update	Level of assurance gained: Reasonable
The Joint Delivery Board (JDB) had met to discuss the ICP specialities. Haematology, Oncology , Neurology, ENT and Dermatology were on track to be part of a lead provider model within HUTH's service portfolio. Terms of Reference and governance arrangements have been agreed for the JDB. Recruitment process has been agreed.	

Report to the Board in Public
Audit Committee April 2022

Item: Internal Audit Progress Report	Level of assurance gained: Partial
A number of audits had been carried out by RSM (Internal Audit) which included: Accounts Payable, Credit Card use, Board Assurance Framework process and Follow up actions.	
Item: Draft Annual Report and Head of Internal Audit Opinion	Level of assurance gained: Reasonable
The audit opinion highlighted that the organisation had an adequate process for risk management and internal control, however work has been identified for further enhancements to the framework or risk management governance.	
Item: Internal Audit Plan 2022/23	Level of assurance gained: Reasonable
RSM presented their audit plan for 2022/23. The areas agreed so far are: Safe Safeguarding/Mental Capacity Act, E-Rostering and medical bank (Liaison), Quality and Safety Improvement, Performance Management Framework – Health Groups, Cyber Security, Learning from Serious Incidents – RCAs, Sickness absence management, Freedom to speak up, Trust risk management strategy/risk management maturity, Data protection and security toolkit, Follow up work The audit plan was approved	
Item: Counter Fraud Progress Report	Level of assurance gained: Reasonable
The Committee received an update of the current fraud cases and the emerging risk of using credit card point of sale machines. A benchmarking exercise had been carried out relating to Gifts and Hospitality and the Trust had received positive feedback regarding staff being cautious about accepting gifts.	
Item: Draft LCFS Workplan 2022/23	Level of assurance gained: Reasonable
The 50 day plan was presented. Key areas to be reviewed are: Junior Doctor annual leave, asset disposals, overtime payments, declarations of interest and ABPI declarations.	
Item: External Audit Report	Level of assurance gained: Reasonable
The Audit of the Accounts was on track and no matters were brought to the attention of the Committee.	
Item: Risk Management Review	Level of assurance gained: Reasonable
The annual risk management review was presented and highlighted implementation of the Risk Management Strategy, training package and a new Operational Risk and Compliance Committee.	
Item: Annual Accounts	Level of assurance gained: Reasonable
Progress relating to the Annual Accounts was presented. The Trust had achieved a surplus of £212k and this meant the accounts were being submitted on a 'Going Concern' basis.	

Item: Single Source Waivers	Level of assurance gained: Reasonable
Single Source Waivers were mainly due to single source suppliers. Gaps in non-compliant contract extensions were usually due to continuity of service and not progressing procurement in a timely way. A new Director of Procurement had been appointed to review and transform procurement for the Trust.	
Item: Terms of Reference	Level of assurance gained: Reasonable
The Terms of Reference were approved by the Audit Committee.	
Item: Freedom to Speak Up	Level of assurance gained: Reasonable
The Committee received an update from the Freedom to Speak up Guardian. Highlights included: drop in sessions for staff, NED FTSU champion, the increase in contacts and the links to HR.	

Report to the Board in Public
Audit Committee June 2022

Item: Audit Findings Report (Mazars)	Level of assurance gained: Reasonable
The Annual Accounts were given a clean opinion with minor amendments. The same limitation relating to the closing stock balance remained as the end of last year.	
Item: Audited Accounts 2021/22	Level of assurance gained: Reasonable
The Audited Accounts were endorsed by the Committee.	
Item: Letter of Representation	Level of assurance gained: Reasonable
The Committee endorsed the letter of representation and recommended approval at the Board.	
Item: Annual Report	Level of assurance gained: Reasonable
The annual report was presented to the Committee. Both internal and external audit had reviewed the report and it would be published after the auditors letter announcing the completion of the Audit.	
Item: Annual Governance Statement	Level of assurance gained: Reasonable
The AGS was presented to the Committee. Workforce, performance, finance, governance, ED and the staff survey were highlighted.	

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.07.22
Title	Board and Committee Year-End Review				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report to be considered by the 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:

The Trust Board is requested to:

- review the contents of the report and request any further information or assurance as required.
- consider not holding Boards and Committees in August and January, starting in 2023.

Year-End Board and Committee Review

1. Purpose of the paper

To present the Committee Terms of Reference and Workplans and to report on the outcome of the annual review of Board Committees.

2. Introduction

During 2021/22 there has been a full Governance Review and Team restructure and a number of changes have been made. Included in these changes were a refresh of the Quality Committee structure and Board and Committee front sheets.

3. Board Committee Review

Attached at Appendix A are the Terms of Reference, Workplans and Committee effectiveness reviews for the following Committees:

- Audit Committee
- Quality Committee
- Performance and Finance Committee
- Workforce, Education and Culture Committee
- Remuneration and Terms of Service Committee
- Charitable Funds

The minutes of each of the Committees are reviewed by the Audit Committee at each meeting to ensure that all Committees are discharging their responsibilities in line with their Terms of Reference. There have been no issues raised at the Audit Committee in 2021/22.

In January 2022 the Quality, Audit and Performance and Finance Committees were stood down. Quality and Audit Committees met in February due to the nature of the agenda items but Performance and Finance did not meet until March 2022.

There have been changes to the Quality Committee sub-committee structure during 2021/22 to ensure that relevant information is being escalated and appropriate assurance gained. The Sub-Committees are:

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

5 Board

The Board was stood down in January 2022, but any urgent business was conducted via email. The Risk Management Strategy and the Q3 Board Assurance Framework were approved virtually.

There have been some turnover in Board roles in that the Chief Nurse has left the organisation and a Joint Chief Information Officer has been appointed. The Trust has appointed a new Joint Chair with Northern Lincolnshire and Goole NHS FT as well as a new Non-Executive Director (Quality Chair). An interim Chief Nurse has been appointed.

New NHS guidance regarding NED champion roles has been reviewed and in the majority of cases these new roles are covered. The NEDs cover the outstanding roles as part of their Committee commitments. A copy of roles is attached at Appendix B.

6 Meeting Dates 2022/23

Attached at appendix C is the proposed meeting dates for 2022/23.

The Trust Board is asked to consider the idea of removing the August and January Board and Committees due to staff holidays and operational pressures (particularly in January). The Trust has stood committees and the Board down in January in previous years.

A verbal only Quality Committee would be held for assurance purposes.

This would commence January 2023 if approved.

7 Recommendation

The Trust Board is requested to:

- review the contents of the report and request any further information or assurance as required.
- consider not holding Boards and Committees in August and January, starting in 2023.

Rebecca Thompson
Head of Corporate Affairs
May 2022

Hull University Teaching Hospitals NHS Trust

AUDIT COMMITTEE Audit Committee

TERMS OF REFERENCE Terms of Reference

1 Constitution

1.1 Establishment

The Trust Board has established an Audit Committee (The Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. This committee reports directly to the Board.

1.2 Membership

The Committee shall be appointed by the Board from amongst the Non Executive Directors of Hull University Teaching Hospitals NHS Trust ("the Trust") and shall consist of not less than three members. The Chairman of the Trust shall not be a member of the Audit Committee. Appointments to this Committee shall be made by the Board in consultation with the Audit Committee Chairman. Appointments to be for an initial period of up to 3 years, extendable by no more than one additional 3 year period.

1.3 Quoracy

A quorum shall be two members.

1.4 Attendance

(a) The Chief Financial Officer, Director of Quality Governance, Head of Internal Audit, the Trust's nominated Local Counter Fraud Specialist and representatives of the External Auditors shall normally attend meetings advising the Committee on pertinent issues / areas. The Committee will meet in private with External and Internal Auditors without any Executive Directors or members of the Trust staff present at least once a year.

(b) The Chief Executive, other Directors or lead officers may be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that individual.

(c) The Chief Executive will be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

(d) The Head of Corporate Affairs, or assistant, shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair of Committee and its members.

1.5 Meetings

Meetings shall be held not less than five times a year. The Chair of the Committee can call additional meetings as required to discuss urgent business. Members are expected to attend at least 75% of meetings per year.

2 Authority

2.1 Authority to investigate and seek information

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

(b) The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant expertise if it considers this necessary.

3 Role and Purpose of the Audit Committee

The duties of the Committee are:

3.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:-

(a) All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board.

(b) The structures, processes and responsibilities for identifying and managing key risks facing the organisation in particular the Board Assurance Framework -including the link with the corporate risk register.

(c) The underlying control and assurance processes that indicate the degree of the achievement of strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements.

(d) The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

(e) Consider and review the Annual Information Governance Toolkit (or replacement requirements) and the Data Quality Reports.

(f) Trust arrangements to meet the requirements of the General Data Protection Regulations that apply from 25 May 2018

3.2 Power to seek reports and assurances

In carrying out this work the Committee will primarily utilise the work of Internal Audit, Counter fraud**,** External Audit and other assurance functions, but will not be limited to these audit functions. It may also seek reports and assurances from Directors and managers as appropriate, concentrating on the over arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. The Committee will receive the

minutes of the Board's Performance and Finance Committee, Quality Committee and Charitable Funds Committee to inform its assurance work.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.3 **Internal Audit**

The Committee shall ensure that there is an effective internal audit function established by management; that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee.

It will:-

(a) Recommend the appointment of the Internal Auditors to the Board, approve the annual fee and consider any questions of resignation and dismissal.

(b) Review and approve the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework and Strategic Plans.

(c) Consider the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources.

(d) To review progress on implementing internal audit recommendations.

(e) Ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

(f) Monitor the effectiveness of internal audit through their annual review

3.4 **External Audit**

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.

This will be achieved by:-

(a) Recommending to the Trust Board the appointment of the External Auditor.

(b) Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan.

(c) Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

(d) Review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission

to the Board and any work undertaken alongside the annual audit plan together with the appropriateness of management responses.

(e) Review and monitor the external auditor's independence and objectivity, taking into account relevant UK professional and regulatory requirements.

3.5 **Financial Reporting**

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focussing particularly on:-

(a) The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.

(b) Changes in, and compliance with, accounting policies, practices and estimation techniques.

(c) Unadjusted mis-statements in the financial statements.

(d) Letter of Representation.

(e) Significant judgements in preparation of the financial statements.

(f) Significant adjustments resulting from the audit.

3.6 **Other Assurance Functions**

3.6.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Improvement, NHS Litigation Authority etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

3.6.2 In addition, the Committee will consider the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This Committee also needs to be review the assurances gained from clinical audit activities in the organisation.

3.6.3 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

3.6.4 The Committee will seek annual assurance that a current, clear and effective Whistleblowing or Protected Disclosures Policy is in place and that all Trust staff have access to this policy. One Non Executive Director under the current policy (reference CP169) will be one of a number of internal contacts available to consult and be the "Whistleblowing Champion" of the Trust.

3.6.5 The Committee's stakeholders are the Trust Board, Board Committees, Chief Executive Officer, Chief Financial Officer, Audit Partners and any party with interest in changes to the Trust's accounting systems, business processes and external stakeholders.

3.7 **Reporting**

3.7.1 The minutes of the Audit Committee meetings shall be approved by the Chairman of the Audit Committee and submitted to the Board. The Chairman of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

3.7.2 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and effectiveness of risk management in the organisation, the integration of governance arrangements and produce an annual work plan.

3.8 **Other Matters**

The Committee shall undertake reviews of:

- Risk register
- Write offs and compensations
- Outstanding debtors over £50,000 and 90 days or more outstanding.
- Fraud register
- Decision to waive tender procedures
- Offers of hospitality/gifts and sponsorship
- Review of Standing Orders and Standing Financial Instructions and approval of proposed changes
- Waiver of Standing Orders
- Going Concern Reviews
- Corporate credit card expenditure
- Legal expenditure

3.9 **Administration**

The Committee shall be supported administratively by the Head of Corporate Affairs, or assistant. Their duties in this respect will include:

- Agreement of each agenda with the Chairman and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent issues
- Enabling the development and training of Committee members

4 Monitoring Compliance with these Terms of Reference

The Head of Corporate Affairs and the Chairman of the Committee have a joint responsibility for ensuring compliance with these Terms of Reference. Any member or person in attendance who considers compliance with these Terms of Reference is at risk should bring their concerns to the attention of the Head of Corporate Affairs.

Review date: April 2022

AUDIT COMMITTEE WORKPLAN 2021/22

ITEM	Apr-21	Jun-21	Jul-21	Oct-21	Jan-22	Apr-22
Governance						
Board Assurance Framework			x			
Review Risk Management - Annual review	x					x
Review Board Committee minutes	x		x	x	x	x
Review the Trust's Annual Report	x	x				x
Review Annual Governance Statement		x				
Changes to Accounting Policies, Standing Orders, SFIs				x		
Half-year update from Quality and Remuneration Committees on governance and control issues discussed	x			x		x
New Governance Arrangements	x					
Finance						
Annual Accounts	x	x				x
National Cost Collection				x		
Review of Credit Card Spending			x	x	x	
Review of Directors' Expenses			x		x	
Review of Losses, Special Payments and Write Offs				x		
Review of Debts >£50k and over 3 months old			x		x	
Review of single source tender waivers and contract renewals			x			x
Update on Financial Overview and Going Concern	x				x	
Internal Audit						
Review and approve Annual Internal Audit Plan	x					x
Review Internal Audit Progress Reports	x		x	x	x	x
Review progress on implementing audit recommendations				x		
Review Internal Audit Annual Report and Opinion Statement	x					x
Review the Effectiveness of Internal Audit						x
Changes to provider						
External Audit						
Annual Accounts, timetables and plans (approval)	x					x
Agree External Audit Plans and Fees	x				x	
Receive External Audit report and sector update	x			x	x	x
Review progress on implementing audit recommendations	x			x		x
Receive External Audit Annual Audit Letter and Annual Report	x	x				
Receive Letter of Representation		x				
Receive External Audit Review of Quality Accounts						
Review External Audit - including effectiveness, independence and objectivity						
Changes to provider	x					
Clinical Audit						
Review Annual Clinical Audit Plan and Clinical Audit Annual Report			x			
Review Clinical Audit Progress Reports		x				
Review the Effectiveness of Clinical Audit			x			
Counter Fraud						
Review and approve Annual Counter Fraud Plan	x					x
Review Counter Fraud Progress Reports	x		x	x	x	x
Review the Effectiveness of Counter Fraud			x			
Receive Counter Fraud Annual Report			x			
Trust Matters						
Receive Audit Committee Annual Report (included in Annual Report)		x				
Review draft Quality Accounts	x					x
Update on Quality Accounts delivery (QIP Delivery)	x					x
Review Audit Committee Terms of Reference						x
Review the Effectiveness of the Audit Committee					x	
Receive Gifts and Hospitality Report/Declarations of Interest Register					x	
Review Business Interests Policy						x
Receive Data Security and Protection Toolkit Report					x	
Review of Whistle Blowing procedures/Freedom to speak up						x
Clinical Negligence Claims (Claims Annual Report)				x		
Serious incidents requiring investigation		x				
Legal Fees			x		x	
Private Meeting with Auditors				x		
Annual report on external agency visits - compliance and control focus	x					x

Key: Green = report received as scheduled
Amber = report not received as scheduled but received at a subsequent meeting
Red = report not yet received

Agenda Item	14	**Meeting**	Audit Committee	**Meeting Date**	24.02.22
Title	Effectiveness Review				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The report is received by the Audit Committee 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:
Recommendation: The Audit Committee is asked to receive the report for assurance.

Hull University Teaching Hospitals NHS Trust

Audit Committee

Audit Committee Effectiveness Review

1. Background

It is good governance practice to review the effectiveness of the Board and Board Committees periodically. The Trust undertakes this annually and adopted a more detailed pro forma last year to gain greater levels of feedback.

2. Process

Each Committee member has been asked to complete the pro forma overleaf. Responses are anonymous to give confidence in providing narrative comments as well as scores. The scores for each statement are from 1 (poor or never) to 5 (excellent or always).

The attached pro forma includes all questions asked and the scores given by Audit Committee members. The verbatim comments are taken directly from forms. Each sentence represent one person's individual view, where offered.

There were 4 responses submitted from a possible 7. Each response gave a score to each question.

3. Summary of feedback

Overall, members and attendees feel that the Audit Committee is performing effectively in all areas.

Audit Committee members are invited to share their thoughts on the collective scores and comments and agree any action that would make positive progress in board effectiveness.

4. Recommendation

The Audit Committee is asked to review the attached report and average scores and agree any relevant improvement actions that should be taken in response.

Rebecca Thompson
Head of Corporate Affairs

February 2022

Assessment of the effectiveness of Board Committees

Audit Committee – 4 responses received.

Key

1. Hardly ever / poor
2. Occasionally / below average
3. Some of the time / average
4. Most of the time / above average
5. All of the time / fully satisfactory

Please give each question a score or N/A by entering 'x' in the appropriate box. You can provide comments against any question to give examples, illustrate what improvement would look like or describe something that is done well, and you would want to see remain the same.

Behaviours

	Question	N/A	1	2	3	4	5	Comment
1.	**Strategy** All Committee members have a clear understanding of the orgainisation's strategy, and how the work of the Committee links to it.					xx	xx	
2.	**Managing Committee meetings and discussions** Committee meetings encourage a high quality of debate with robust and probing discussions.					x	xxx	
3.	**Managing internal relationships** Committee members make decisions objectively in the best interests of the organisation and feel collectively responsible for achieving organisational success.					xx	xx	
4.	**Consideration of impact** Consideration is given to the impact of decisions on stakeholders/patients.					x	xxx	
5.	**Committee members' own skills** Committee members recognise the role which they and each of their colleagues is expected to play and have the appropriate skills and experience for that role.					x	xxx	
6.	**Reaction to events** The Committee responds positively and constructively to events in order to enable effective decisions and implementation and to encourage transparency.					x	xxx	

	Question	N/A	1	2	3	4	5	Comment
7.	**There are no surprises** Committee members are kept fully informed of relevant sensitive and difficult issues.					xx	xx	
8.	**Committee Chairman** The Committee Chairman's leadership style and tone promotes effective decision-making constructive debate and ensures that the Committee works as a team.					x	xxx	The committee chair is fair but firm, offers great challenge but is also supportive
9.	**Decisions** After a decision has been made, it is clear who is responsible for implementing it, and by when.					xx	xx	
10.	**Attendance and contribution to meetings** All Committee members attend and actively contribute at meetings.					x	xxx	
11.	**Open channel of communications** The Committee has open channels of communication with the Board and others and is properly briefed.					x	xxx	
12.	**Risk and control frameworks** The Committee's approach to reviewing risk in the organisation is open and questioning, and looks to learning points from events, rather than blame.					xxx	x	This is developing alongside the RM strategy and BaF

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.					xxx	x	Hopefully we can have a period of stabilisation within the NED Group
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.					x	xxx	
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee..						xxx x	Rebecca and Suzanne are very helpful

4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.					x	xxx	There are often a huge number of pages because of the format of individual reports, but it's always straightforward focussing on the pages which matter. Perhaps there could be an attempt to be more concise and focussed.
5.	**Quantity of information** The quantity of information received is appropriate and helps Committee members fulfil their role.						xxx x	The quality compensates for the slightly over the top quantity of documentation.
6.	**Quality of information** The quality of information received is appropriate and helps Committee members fulfil their role.					x	xxx	
7.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.					xx	xx	
8.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.					xx	xx	
9.	**Annual reporting** The Committee makes best use of its annual reporting.					x	xxx	Effectiveness of meetings throughout the year ensures that there are no surprises
	Question	**N/A**	**1**	**2**	**3**	**4**	**5**	**Comment**
10.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.	x				xx	x	Not sure if this has explicitly been done
11.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.					xxx x		Again this is developing alongside the RM strategy and BaF

Hull University Teaching Hospitals NHS Trust

Quality Committee

Terms of Reference

1. Formation of this committee

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

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

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

2. Role

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

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

3. Membership of the Committee

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

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

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

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

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

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

4. Chairman of the Committee

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

5. Quorum

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

6. Meetings

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

7. Attendance at meetings

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

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

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

8. Notice of meetings

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

9. Agenda and action points

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

10. Reporting arrangements

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

11. Duties and Responsibilities of the Committee

The committee is required to fulfil the following responsibilities:

11.1 Meet the annual objectives of the committee.

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

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

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

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

12. Authority

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

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

13. Relationships with other committees

The committee receives escalation reports from the:

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

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

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

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

14. Administration

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

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

QUALITY COMMITTEE WORKPLAN 2022/23

AGENDA ITEM	WHO	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
Quality Governance																
Annual Committee Report and Effectiveness Review	SR			x												
Board Assurance Framework	SR/RT	X		X				X			x			x		
Care Quality Commission Update	SR	X		X				x			x			x		
Quality Strategy Updates	SR	x			x			x			x			x		
Risk Strategy Update	SR/RT				X						x					
Quality Accounts (Jan – progress / Apr process / Jun draft approval)	SR	x			X		x							x		
Fundamental Standards (*twice a year)*	JL									x						x
Infection Prevention and Control Board Assurance Framework	JL						X			X			X			X
CQUIN (Quarterly Updates)	SR							x			x			x		
Patient Safety																
Quality Report	JL	x	x	x	x	x	x	x	x	x	x	x	x	x	X	x
Patient Safety and Clinical Effectiveness	JL			x			x			x			x			x
Mortality - Learning from Deaths framework (inc Medical Examiner)	MP		x			x			x			x			X	
Infection Prevention and Control Update	JL	x			x			x			x			x		
CNST Maternity Report	LC			x			x			x			x			x
Medicines Safety and Optimisation – Bi-Annual report	JG			x						x						
Patient Experience																
Patient Experience Update	JL	x			x			x			x			x		
Safeguarding Update	JL			x			x			x			x			x
Safeguarding Annual Report and Action Plan	JL							x								
Clinical Effectiveness																
Research and Innovation Strategy	MP				x						x					
Clinical Assurance of CRES/QIA	JL			x												x
Committee Escalation Reports																
Ethical Clinical Prioritisation Policy Committee	MP/JL		x			x			x			x				
Patient Experience Sub-Committee	**JL**	x		x		x		x		x		x		x		x
Patient Safety and Clinical Effectiveness Sub-Committee	MP		x		x		x		x		x		x		x	
Operational Risk and Compliance Sub-Committee	SR	x		x		x		x		x		x		x		x
Non Clinical Quality Sub-Committee	SR		x			x			x			x				
Deep Dive / Escalation Reports																
Mental Health Patients	BG	x					x									
QRP / Enhanced Monitoring	SR	x	x	x	x	x	x									
Cardiology	MP						x									

Falls Annual Report	JL						x									

Hull University Teaching Hospitals NHS Trust

Agenda Item	4.2	**Meeting**	Quality Committee	**Meeting Date**	28.03.22
Title	Committee Effectiveness Review				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rachel Boulton, Quality Governance Officer				
Report previously considered by (date)	The effectiveness review is carried out 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 Committee is asked to review the attached report and mean average scores and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Hull University Teaching Hospitals NHS Trust

Quality Committee

Committee Effectiveness Review

1. Background

It is good governance practice to review the effectiveness of the Trust Board and its reporting committees periodically. The Trust undertakes this annually and has adapted a more detailed pro forma for this year's review to gain greater levels of feedback.

2. Process

Each Committee member has been asked to complete the pro forma overleaf. Responses are anonymous to give confidence in providing narrative comments as well as scores. The scores for each statement are from 1 (poor or never) to 5 (excellent or always).

The attached pro forma includes all questions asked and the mean average of the scores given by committee members in respect of these meetings.

The verbatim comments are taken directly from forms. Each sentence represent one person's individual view, where offered.

There were 7 responses submitted out of a possible 12. Each response gave a score to each question.

3. Summary of feedback

Of the members and attendees that responded the Committee scored 4 in all areas of the review.

There are some narrative comments to draw the Committee's attention to. These are highlighted in the amalgamated report attached and are in connection with the strategy, the quantity and quality of information and stakeholders.

Strategy
'The BAF has certainly helped with aligning the work of the QC to the Trust Strategy.'

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.'

Stakeholders
'Quality Accounts does this and to some extent Quality Strategy. Not sure that the Committee does.'

4. Recommendation

The Committee is asked to review the attached report and mean average scores and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Rachel Boulton
Quality Governance Officer

March 2022

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Quality Committee

Key

1. Hardly ever / poor
2. Occasionally / below average
3. Some of the time / average
4. Most of the time / above average
5. All of the time / fully satisfactory

Please give each question a score or N/A by entering 'x' in the appropriate box. You can provide comments against any question to give examples, illustrate what improvement would look like or describe something that is done well, and you would want to see remain the same.

Behaviours

	Question	N/A	1	2	3	4	5	Comment
1.	**Strategy** All Committee members have a clear understanding of the orgainisation's strategy, and how the work of the Committee links to it.					X		The BAF has certainly helped with aligning the work of the QC to the Trust Strategy.
2.	**Managing Committee meetings and discussions** Committee meetings encourage a high quality of debate with robust and probing discussions.					X		
3.	**Managing internal relationships** Committee members make decisions objectively in the best interests of the organisation and feel collectively responsible for achieving organisational success.					X		
4.	**Consideration of impact** Consideration is given to the impact of decisions on stakeholders/patients.					X		
5.	**Committee members' own skills** Committee members recognise the role which they and each of their colleagues is expected to play and have the appropriate skills and experience for that role.					X		
6.	**Reaction to events** The Committee responds positively and constructively to events in order to enable effective decisions and implementation and to encourage transparency.					x		

	Question	N/A	1	2	3	4	5	Comment
7.	**There are no surprises** Committee members are kept fully informed of relevant sensitive and difficult issues.					X		
8.	**Committee Chairman** The Committee Chairman's leadership style and tone promotes effective decision-making constructive debate and ensures that the Committee works as a team.					X		
9.	**Decisions** After a decision has been made, it is clear who is responsible for implementing it, and by when.					X		
10.	**Attendance and contribution to meetings** All Committee members attend and actively contribute at meetings.					X		
11.	**Open channel of communications** The Committee has open channels of communication with the Board and others and is properly briefed.					X		
12.	**Risk and control frameworks** The Committee's approach to reviewing risk in the organisation is open and questioning, and looks to learning points from events, rather than blame.					X		

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.					x		
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.					X		
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee..					X		
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.					X		
5.	**Quantity of information** The quantity of information received is appropriate and helps Committee members fulfil their role.					x		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.
6.	**Quality of information** The quality of information received is appropriate and helps Committee members fulfil their role.					X		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.
7.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.					X		
8.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.					x		
9.	**Annual reporting** The Committee makes best use of its annual reporting.					x		

	Question	N/A	1	2	3	4	5	Comment
10.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.					X		Quality Accounts does this and to some extent Quality Strategy. Not sure that the Committee does.
11.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.					X		

Hull University Teaching Hospitals NHS Trust

Performance and Finance Committee

Terms of Reference

1. Formation of this Committee

The Performance and Finance Committee is a Committee of the Trust Board and has been established in accordance with Corporate Policy CP105 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Committee has formal terms of reference and powers as delegated by the Trust Board.

2. Role

The Committee is responsible for seeking assurance on the planning and successful delivery of key performance measures both financial and operational, with a focus on sustained performance and future delivery.

The key performance measures which fall within the remit of the Performance and Finance Committee are the NHS Constitution standards relating to access and indicators relating to the delivery of the Trust's financial plan.

In line with the Trust's scheme of delegation the Committee is charged with reviewing and authorising business cases or recommending business cases to the Board for authorisation, if beyond the Committee's delegated limit.

3. Responsibilities

NHS Constitution standards (access)

3.1 To gain assurance that the organisation has, at all times, robust and effective operational planning systems in place (including demand and capacity) for delivering contract levels of activity

3.2 To gain assurance that the organisation has, at all times, robust and effective performance management systems in place relating to delivery of the access targets.

3.2 To seek assurance that controls are in place, and operating effectively to mitigate the risks to the successful delivery of access targets

3.3 Review the plans for winter and make recommendations to the Board for adoption. Monitor delivery of the plans.

3.4 To ensure that the Board is informed of significant issues, underperformance, deviation from plans and to provide assurance on action being taken

3.5 To seek assurance that agreed recovery plans are being implemented in a timely fashion and delivering the required outcomes

Financial Performance

3.6 To seek assurance that the organisation has a robust and effective financial planning and performance management systems in place.

3.7 To seek assurance on the production and implementation of long term financial plans (including capital) having regard to relevant national guidance,

commissioning plans, and resource availability both internally and within the local health economy in order to support the Board in its decision making.

3.8 To consider loan applications prior to recommending approval by the Trust Board

3.9 To seek assurance that controls are in place and operating effectively to mitigate the risks to the successful delivery of financial performance, including cash releasing efficiency schemes (CRES) and agency caps.

3.10 To ensure that the Board is informed of significant issues, underperformance, deviation from plans and to provide assurance on action being taken

3.11 To seek assurance that agreed recovery plans are implemented in a timely fashion and resulting in improved outcomes

3.12 To receive assurance that Service Line Management is in place and Patient level costing is being developed and used to support delivery of the Trust's financial objectives

3.14 To receive assurance on the work being undertaken in relation to the Lord Carter review

3.15 To receive regular assurance on the People Strategy, the Trust's current workforce figures and the Trust's agency spend position, to flag up any financial or delivery issues impacted by workforce

Overall Financial & Operational Planning

3.16 To provide overview and scrutiny to the development of the Trust's annual and longer term plans (as required by relevant National Guidance) for financial and operational performance and is line with the Trust Strategy, ensuring that the Trust's financial plan is consistent with the Trust's operational plan and reflective of the Trust's goals

3.17 Ensure that the annual plans (operations, revenue and capital) are consistent with, and supportive of, relevant Trust wide strategies - Clinical Services, IM&T and Estates

3.18 To recommend to the Trust Board the approval of the Annual Operating Plan in relation to operational performance and financial plans.

3.19 Review the risks on the Board Assurance Framework relevant to the remit of the Committee (NHS Constitution Standards and Finance) to ensure that controls are in place and mitigating action is effective

Investment

3.20 In line with the Trust's approved scheme of delegation scrutinise all business cases for proposed capital investment that require either Performance and Finance Committee or Trust Board approval, ensuring that outcomes and benefits are clearly defined, are measurable and support delivery of the Trust's goals

3.21 Evaluate, scrutinise and approve investment (and dis-investment) proposals within delegated limits, making recommendations to the Board in line with Standing Orders, Standing Financial Instructions

3.22 To receive assurance from the Capital Resource Allocation Committee that in-year capital investment is being spent as planned and delivering planned benefits.

4. Membership of the Committee

The Committee shall comprise:

Non-Executive Director (Chair)
2 Non-Executive Directors (one of whom will be designated as vice chair)
Chief Financial Officer
Chief Operating Officer

Other officers will be invited to attend the Committee to speak to specific agenda items:

- Director of Estates, Facilities and Development
- Director of Strategy and Planning

It is expected that all members will attend at least 10 out of 12 committee meetings per financial year. If Executive Directors are unable to attend a meeting they will be represented by a deputy who has the authority to make decisions on their behalf.

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

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

5. Chairman of the Committee

The Chairman and Vice Chairman of the committee shall be Non Executive Directors.

6. Quorum

The quorum shall be a minimum of 4 out of 6 members. Of these 2 must be Non Executive Directors, one Executive Director and one other officer.

7. Meetings

The Committee shall meet 12 times a year. The chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

8. Attendance at meetings

Other senior employees may be invited to attend by the chair, particularly when the Committee is discussing an issue that is the responsibility of that employee.

9. Notice of meetings

Meetings of the Committee shall be set at the start of the calendar year by the Corporate Affairs Manager. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the Committee not less than five working days before the date of the meeting.

10. Agenda and action points

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

11. Reporting Arrangements

The proceedings of each meeting of the Committee shall be reported to next meeting of the Board following production of the minutes. The Chair of the meeting shall draw

the attention of the Board to any issues that require disclosure or require Board action. The Chair is required to inform the Board on any exceptions to the annual work plan or strategy.

The committees reporting in to the Performance and Finance Committee are Capital Resource Allocation Committee and the Carter Steering Group.

12. Duties and Responsibilities of the Committee

The Committee is required to fulfil the following responsibilities:

12.1 Produce an annual work plan in the agreed Trust format, in line with the objectives set, for approval by the Trust Board.

12.2 Produce an annual report setting out the achievements of the committee and any gaps in control or effectiveness of reporting arrangements

12.3 Communicate and consult with the Health Groups and Directorates in achieving the objectives of the annual work plan, policy or strategy.

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

13. Scheme of Delegation

The Performance and Finance Committee will have delegated responsibility as follows:

Capital Cost	Approving Board / Committee
£5m+	Trust Board
£2m – Less than £5m	Performance and Finance Committee
£0.5m – Less than £2m	Executive Management Board
£5k – Less than £0.5m	Capital Resource Allocation Committee

Note: Any business case deemed to be a high financial risk per Trust Business Case Guidance will also require approval at the next level of authority.

Additional **external** approval is currently required for schemes with a capital cost above £5m as follows:

- NHS Improvement (NHSI) over £5m
- NHSI, Department of Health and Treasury over £50m

14. Authority

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

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

15. Relationship with Other Committees

The Committee receives information and assurances from the Trust's internal performance review processes and meetings The Committee will receive updates from the Capital Resource Allocation Committee.

The Committee works closely with the Trust's Quality Committee. The Trust Board is responsible for ensuring that clarity exists between the Performance & Finance Committee and the Quality Committee in terms of which measures each Committee is responsible for monitoring performance against. It is the responsibility of the respective Chairs of each Committee to ensure that issues of common interest or overlap are effectively communicated and managed between the Committees.

The Performance and Finance Committee may refer issues to the Audit Committee or be requested to consider issues raised by the Audit Committee.

16. Administration

The Committee is supported administratively by the Assistant Trust Secretary, who will agree the agenda with the Chairman, collate all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chairman and members of the Committee.

Date previously approved by Trust Board:	May 2019
Date updates received by Trust Board:	July 2022
Review date:	May 2023

PERFORMANCE & FINANCE WORKPLAN 2022/23

	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
PLANNING												
Financial Planning Process inc budgets									x			x
Operational Planning									x			x
Winter Planning Process					x							
Long Term Financial Planning	x										x	
Procurement Strategy				x							x	
IM&T inc. digital exemplar		x								x		
Capital Planning 202/23												x
Recovery Planning	x	x	x	x	x	x	x	x	x	x	x	x
CRES planning 2022/23		x						x				
CONTRACTING												
Demand, Capacity and Activity												
Contract negotiations/Update												
PERFORMANCE												
Performance Report / Elective Recovery	x	x	x	x	x	x	x	x	x	x	x	x
Screening Programme Update			x			x			x			x
Changes in Performance Standards		x										
FINANCE REPORTS												
Statement of Comprehensive Income 2022/23 (Monthly Finance Report)	x	x	x	x	x	x	x	x	x	x	x	x
CRES Delivery 2022/23	x	x	x	x	x	x	x	x	x	x	x	x
Statement of Financial Postion and Cash Flows (Balance Sheet)	x	x	x	x	x	x	x	x	x	x	x	x
Productivity including Model Hospital				x								
Productivity and Efficiency						x						
Patient Level Costing				x								
ASSURANCE AND GOVERNANCE												
Board Assurance Framework			x			x			x			x
Business Cases												
Investment and Disinvestment												
Capital Resource Allocation Committee	x	x	x	x	x	x	x	x	x	x	x	x
Scan4Safety	x						x					
Getting it right first time (GIRFT)									x			
Productivity and Efficiency Board minutes												
Contract Approval												
Review of Committee Effectiveness		x										

Hull University Teaching Hospitals NHS Trust

Agenda Item	10.1	**Meeting**	Performance and Finance Committee	**Meeting Date**	30.05.22
Title	Committee Effectiveness Review				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rachel Boulton, Quality Governance Officer				
Report previously considered by (date)	The effectiveness review is carried out 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 Committee is asked to review the attached report and mean average scores and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Hull University Teaching Hospitals NHS Trust

Performance and Finance Committee

Committee Effectiveness Review

1. Background

It is good governance practice to review the effectiveness of the Trust Board and its reporting committees periodically. The Trust undertakes this annually and has adapted a more detailed pro forma for this year's review to gain greater levels of feedback.

2. Process

Each Committee member has been asked to complete the pro forma overleaf. Responses are anonymous to give confidence in providing narrative comments as well as scores. The scores for each statement are from 1 (poor or never) to 5 (excellent or always).

The attached pro forma includes all questions asked and the mean average of the scores given by committee members in respect of these meetings.

The verbatim comments are taken directly from forms. Each sentence represent one person's individual view, where offered.

There were 5 responses submitted out of a possible 9. Each response gave a score to each question.

3. Summary of feedback

Of the members and attendees that responded the Committee scored a mixture of 4's and 5' across the review.

There are some narrative comments to draw the Committee's attention to, these are highlighted in the amalgamated report attached and are in connection to a range of areas.

Strategy
Understands alignment with BAF risks.

Managing Committee meetings and discussions
The meeting is well-chaired with members having the ability and opportunity to ask probing questions.

Consideration of Impact
Occasionally presented with a difficult balance between resources and amount of care available. Ensures that the patient's perspective is paramount.

Reaction to events
Pre meetings take place to ensure agenda is focused.

There are no surprises
There can be a danger of Committee updates lagging behind executive decisions.

Committee Chairman
Committee is consistently well chaired, particularly on levels of assurance gained from each agenda item.

Risk and control frameworks
The right balance is struck, looking for solutions rather than apportioning blame.

Meetings and administration
Assisted by pre-meet. Recent changes in construct of the reporting packs will be a real enabler.

Quantity and quality of information
Assisted by pre-meet. Recent changes in construct of the reporting packs will be a real enabler.

Quality is still improving.

Stakeholders
Now that some of the Covid restrictions have been reduced, Committee members should be able to re-start external verification and in turn, invite responsible parties to meetings to present on solutions.

4. Recommendation
The Committee is asked to review the attached report and mean average scores and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Rachel Boulton
Quality Governance Officer

May 2022

Hull University Teaching Hospitals NHS Trust

Trust Board Workforce, Education and Culture Committee

Terms of Reference

1. Formation of this Committee

The Workforce, Education and Culture Committee is a Committee of the Trust Board and has been established in accordance with Corporate Policy CP105 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Committee has formal terms of reference and powers as delegated by the Trust Board.

2. Role

The Committee is responsible for seeking assurance on the delivery of the Trust's People Strategy, the quality of teaching and education within the Trust and the ongoing work to improve staff engagement and the culture of the organisation.

3. Responsibilities

3.1 To gain regular assurance on the People Strategy, including key workforce metrics as well as the key objectives and strands within the Strategy

3.2 To gain regular assurance on the Trust's current workforce position as it relates to the People Strategy and plans for delivery, as well as the Trust's agency spend position, to flag up any financial or delivery issues impacted by workforce

3.3 To gain regular assurance on the results of the Trust's Staff Surveys, the annual staff survey and quarterly survey's and to link this to the delivery and outputs required of the People Strategy, particularly with regard to equality, inclusion and wellbeing

3.4 To support the Trust's organisational development and work on leadership, staff engagement, staff culture and becoming a learning organisation, through review, action planning and assurance processes

3.5 To gain regular assurance on the quality of medical and non-medical education and training within the organisation, including staff satisfaction, the delivery of action plans to address any gaps identified through feedback, and feedback on quality of placements.

3.6 To review items of workforce planning and statutory workforce compliance on behalf of the Board, including lessons learned and action plans, for recommendation to be approved at the Trust Board

3.7 To ensure that the Board is informed of significant issues, underperformance, and deviation from plans that would constitute a particular risk to the delivery of the Trust's People Strategy, and to provide assurance on action being taken

3.8 To seek assurance that agreed delivery plans are being implemented in a timely fashion and delivering the required outcomes

3.9 To provide oversight of progress against the Trust's Research and Innovation strategy, including key enablers and risks

3.10 Review the risks on the Board Assurance Framework relevant to the remit of the Committee ensure that controls are in place and mitigating action is effective, and that positive assurance is received where appropriate

4. Membership of the Committee

The Committee shall comprise:

- Non-Executive Director (Chair)
- 2 Non-Executive Directors (one of whom will be designated as vice chair)
- Director of Workforce & Organisational Development
- Chief Medical Officer
- Chief Nurse Officer
- Staff Side Representative

Of the Non-Executive Director members, one will be the Non-Executive Director appointed by the University of Hull.

Other officers will be invited to attend the Committee to speak to specific agenda items, which can include, amongst others:

- Director of Post Graduate Medical Education
- Director of Undergraduate Medical Education
- Guardian of Safe Working
- Freedom to Speak up Guardian

It is expected that all members will attend at least 4 out of 6 committee meetings per financial year. If Executive Directors are unable to attend a meeting they will be represented by a deputy who has the authority to make decisions on their behalf.

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

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

5. Chairman of the Committee

The Chairman and Vice Chairman of the committee shall be Non-Executive Directors.

6. Quorum

The quorum shall be a minimum of 3 out of 6 members. Of these, two must be Non-Executive Directors as well as one Executive Director. In the event of a vote being taken where an equal number of Non-Executive and Executive Directors are in attendance, the Non-Executive Chairman will have a casting vote.

7. Meetings

The Committee shall meet 6 times a year. The chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

8. Attendance at meetings

Other senior employees may be invited to attend by the chair, particularly when the Committee is discussing an issue that is the responsibility of that post-holder.

9. Notice of meetings

Meetings of the Committee shall be set in advance of the calendar year by the Corporate Affairs team. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the Committee not less than five working days before the date of the meeting.

10. Agenda and action points

The agenda and action points of all meetings of the Committee shall be produced in the standard agreed format of the Trust and kept by the Corporate Affairs team.

11. Reporting Arrangements

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

12. Duties and Responsibilities of the Committee

The Committee is required to fulfil the following responsibilities:

12.1 Produce an annual work plan in the agreed Trust format, in line with the objectives set, for approval by the Trust Board.

12.2 Produce an annual report setting out the achievements of the committee and any gaps in control or effectiveness of reporting arrangements

12.3 Communicate and consult with the Health Groups and Directorates in achieving the objectives of the annual work plan, policy or strategy.

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

13. Authority

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

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

14. Relationship with Other Committees

The Committee will work closely with the Trust's Quality Committee, for the link between workforce and high quality care. The Committee should work with the Performance and Finance Committee where any significant or growing risk exists around performance, service delivery and the People Strategy.

The Committee may refer issues to the Audit Committee or be requested to consider issues raised by the Audit Committee.

15. Administration

The Committee is supported administratively by the Corporate Affairs team, who will agree the agenda with the Chairman, collate all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chairman and members of the Committee.

Date last approved by Trust Board:	28 January 2020
Date updates received by Trust Board:	July 2022
Review date:	June 2023

Workforce Education and Culture Committee Workplan 2022								
AGENDA ITEM	**WHO**	**14-Feb**	**11-Apr**	**13-Jun**	**08-Aug**	**10-Oct**	**12-Dec**	**13-Feb**
People Strategy Performance Report	SN	**x**	x	**x**	x	**x**	x	**x**
RECRUITMENT AND RETENTION OF STAFF								
Variable Pay Report	SN	x	x		x			x
Nursing and Midwifery Staffing Report	BG	x	x	x	x	x	x	x
LEADERSHIP, CAPABILITY & CAPACITY								
Leadership Programme Update	LV					x		x
Talent Management	LV	x	x		x			x
INNOVATION, LEARNING AND CONTINOUS IMPROVEMENT								
Apprenticeship Programme	**SN**	x		x				x
Medical Undergraduate Progress Report	RD			x				x
Medical Education Progress Report	JK				x			x
Non-Medical Learning and Development Progress Report	LV	x		x		x		x
Organisational and Cultural Development (National Staff Survey)	SN		x					
EQUALITY, INCLUSION AND DIVERSITY								
Workforce Race Equality Standard (WRES)	HK				x			
Workforce Disability Equality Standard (WDES)	HK				x			
Modern Day Slavery Report	SN				x			
Gender Pay Report	SN						x	
LGBTQ+ Network	HK	x	x					
Trade Union Facility Time Publication Requirements	HK			x				
HEALTH AND WELLBEING								
Covid and Flu Vaccination Progress Report	SN	x	x				x	x
Health and Wellbeing Programme Report	SN					x		
Occupational Health Annual Report	CH				x			
Staff Support during Covid-19	LV		x			x		
EMPLOYEE ENGAGEMENT, COMMUNCATION AND RECOGNITION								
Freedom to Speak Up Guardian Report	SR			x		x		x
Guardian of Safe Working Report	ML		x		x			x
Employee Relations Progress Report	SN		x					
Responsible Officer Report	MP					x		
Quarterly Staff Survey	SN							
MODERNISING THE WAY WE WORK								
E-Rostering roll out and usage / Medical Bank Report	SN					x		
Consultant Job Planning	SN					x		
Governance								

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Workforce, Education and Culture Committee	**Meeting Date**	13.06.22
Title	Committee Effectiveness Review				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rachel Boulton, Quality Governance Officer				
Report previously considered by (date)	The effectiveness review is carried out 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 Committee is asked to review the attached report and mean average scores and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Hull University Teaching Hospitals NHS Trust

Performance and Finance Committee

Committee Effectiveness Review

1. Background

It is good governance practice to review the effectiveness of the Trust Board and its reporting committees periodically. The Trust undertakes this annually and has adapted a more detailed pro forma for this year's review to gain greater levels of feedback.

2. Process

Each Committee member has been asked to complete the pro forma overleaf. Responses are anonymous to give confidence in providing narrative comments as well as scores. The scores for each statement are from 1 (poor or never) to 5 (excellent or always).

The attached pro forma includes all questions asked and the mean average of the scores given by committee members in respect of these meetings.

The verbatim comments are taken directly from forms. Each sentence represent one person's individual view, where offered.

There were 7 responses submitted out of a possible 11. Each response gave a score to each question.

3. Summary of feedback

Of the members and attendees that responded the Committee scored a majority of 4's with a score of 5 for the committee's skills and the in relation to risk management.

There are some narrative comments to draw the Committee's attention to, these are highlighted below and in the amalgamated report attached and are in connection to a range of areas but mainly focus on the volume of papers and the meeting content.

Reaction to Events;

- The committee functioned well around staff wellbeing issues during the pandemic.

There are no surprises;

- Within reason the committee cannot know of every issue.

Decisions;

- The committee focuses on assurance from my perspective when in attendance.

Meetings and Administration;

- Perhaps an additional meeting would be beneficial.
- It is a massive agenda and sometimes the volume of issues is hard to stick to the time. Maybe presentations vs Formal papers might assist the board members on the committee to get a better overview.

Quality and Quantity of information;

- Sometime the papers can be overwhelming. Curious if assurance and call to action could be achieve in a different way?
- The quality is always good from all colleagues.

Timeliness of information

- Most papers arrive on time

Agenda Items

- EDI, Compassionate Culture work and Wellbeing could do with being standard items with a verbal update and more formal maybe 1-2 times per year.

4. Recommendation

The Committee is asked to review the attached report and mean average scores and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Rachel Boulton
Quality Governance Officer

June 2022

Hull University Teaching Hospitals NHS Trust

Remuneration Committee
Terms of Reference

1. Formation of this committee

The Board has established the Remuneration Committee, in accordance with Corporate Policy CP105 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Committee shall have terms of reference and powers and be subject to conditions that the Board decides, and shall act in accordance with any legislation, regulation or direction issued by the regulator.

The Remuneration Committee is a committee of the Board and has executive powers delegated specifically in these terms of reference.

2. Role

The role of the Remuneration Committee is set out below, subject to amendments at future Board meetings.

2.1 Remuneration

2.1.1 To approve the terms and conditions of the Chief Executive, Chief posts and Directors that report directly to the Chief Executive in accordance with Trust policies and following consultation with the Chief Executive, including;

- Salary, including any performance related pay or bonus
- Provision for other benefits, including pensions
- Allowances

2.1.2 To receive benchmarking information on the salaries of the posts in section 2.1.1 in order to determine the overall market positioning of the remuneration package

2.1.3 The Chief Executive is responsible for putting in place effective and fair appraisal arrangements for his/her direct reports and for reporting his/her decisions formally by a paper to the Committee at least annually. In making his/her decision on the level of overall performance, Committee Members will have had the opportunity to provide feedback on individuals to inform the Chief Executive's overall assessment.

2.1.4 To adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Chief/Directors (2.1.1) whilst remaining cost effective.

2.1.5 To approve any changes to the standard contract of employment for Chiefs/Directors in section 2.1.1

2.1.6 To agree and review the extent to which a full time Board Director takes on a Non-Executive Director or Chairman role of another organisation.

2.1.7 To approve any payments to staff which are outside of Trust policy.

2.1.8 To monitor the level and structure of remuneration for Very Senior Managers and note annually the remuneration trends across the Trust

2.1.9 To approve severance payments in line with NHS Improvement (NHSI) guidance

2.1.10 To approve MAR schemes and ensure that NHSI guidance is followed for individual staff applications.

2.1.11 To receive information on:

- Any Trust post where there is a termination clause of more than 6 months
- Highest paid employees in the Trust (20 individuals) - annually
- Staff earning over £100,000 - annually
- Any special pension arrangements for any employee
- All bonus schemes (i.e. Trust earnings not paid in to salary) in operation in the Trust

2.2 Nomination

2.2.1 To review the structure, size and composition of the Board and make recommendations for changes as appropriate

2.2.2 Before an appointment is made evaluate the balance of skills, knowledge and experience on the Board and its diversity and on the basis of the evaluation prepare a description of the role and capabilities required for appointment of Executive Directors.

2.2.3 To give full consideration to and make plans for succession planning for the Chief Executive and other Board Directors (Chiefs) taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

2.2.4 Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

2.2.5 Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise

2.2.6 Consider any matter relating to the continuation in office of any Executive Director (Chief Executive, Chief Financial Officer, Chief Nurse, Chief Medical Officer, and Chief Operating Officer) including the suspension and termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

2.2.7 To receive assurance on the succession plans for Vey Senior Managers.

3. Membership of the Committee

The Committee shall comprise:

- Trust Chairman
- All Non Executive Directors

Meetings of the Remuneration Committee may be attended by the invitation of the committee:

- The Chief Executive
- Director of Workforce and Organisational Development and any other Executive at the invitation of the Committee Chair
- Head of Corporate Affairs (minutes)

The Chief Executive and Director of Workforce and Organisational Development shall leave the meeting when their own terms and conditions or performance is discussed

4. Chairman of the committee

The Chairman of the Committee will be the Trust Chairman

5. Quorum

The quorum shall be three, one of whom must be the Trust Chair (or in their absence the Vice Chair)

6. Meetings

The Committee shall meet at least four times a year. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention. Members are expected to attend at least 75% of arranged meetings.

7. Notice of meetings

Meetings of the Committee shall be set at the start of the calendar year by the Head of Corporate Affairs, in liaison with the Committee Chair. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the Committee not less than five working days before the date of the meeting.

8. Agenda and action points

The agenda and action points of all meetings of the Committee shall be produced in the standard agreed format of the Trust and kept by the Trust Secretary's Office.

9. Reporting arrangements

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

To receive minutes for information from the Trust Pay, Terms and Conditions Group after each meeting

10. Duties and Responsibilities of the Committee

The Committee is required to fulfil the following responsibilities:

10.1 Produce an annual work plan in the agreed Trust format, in line with the objectives set, for approval by the Trust Board.

10.2 Give due consideration to the Public Sector Equality Duty and the NHS Constitution in undertaking its duties.

10.3 Identify and assess any risks that may prevent the achievement of the work plan.

10.4 Produce an annual report in the required format for the Trust's Annual report

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

11. Authority

The Remuneration Committee is authorised by the Board to instruct professional advisors and request attendance of individuals and authorities outside the Trust with relevant experience and expertise if it considers it necessary for or expedient to the exercise of its functions.

The Committee is authorised to obtain such internal information from any employee as is necessary and expedient to the fulfilment of its functions.

Approved by the Board: July 2022

Hull University Teaching Hospitals NHS Trust

Remuneration and Terms of Service Committee

Committee Work Plan 2021/22

Item	25 Feb 2021	27 May 2021	26 Aug 2021	25 Nov 2021	28 Feb 2022	26 May 2022	25 Aug 2022	24 Nov 2022
Workplan 2021/22	X	X	X	X	X	X	X	X
NHS Providers' salary benchmark information (taken at first meeting when new data available)		X (incl. in Cost of Living paper)				X		
Top 20 earners and gross pay over £100,000		X				X		
Annual pay gap audit	X							
Chief Executive direct reports' appraisals				X		X		
Committee review of effectiveness	X					X		
Chief Executive Appraisal		X		X			X	
Structure of Executive portfolios – strategic overview							X	
Pensions							X	
Succession planning (strategic/pipeline annual discussion)		X		X		X		X
Retention								X
Cost of Living – proposal for Execs for previous year	X			X				
Potential Redundancies (as and when required)								
Succession planning (as posts come available)								
Trust Pay, Terms and Conditions Group (as and when required)	X	X	X	X	X	X	X	X

Requirement to meet 4 times as a minimum per financial year

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Remuneration Committee	**Meeting Date**	26.05.22
Title	Committee Effectiveness Review				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The effectiveness review is carried out 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 Committee is asked to review the attached report and mean average scores and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Hull University Teaching Hospitals NHS Trust

Remuneration Committee

Committee Effectiveness Review

1. Background

It is good governance practice to review the effectiveness of the Trust Board and its reporting committees periodically. The Trust undertakes this annually and has adapted a more detailed pro forma for this year's review to gain greater levels of feedback.

2. Process

Each Committee member has been asked to complete the pro forma overleaf. Responses are anonymous to give confidence in providing narrative comments as well as scores. The scores for each statement are from 1 (poor or never) to 5 (excellent or always).

The attached pro forma includes all questions asked and the mean average of the scores given by committee members in respect of these meetings.

The verbatim comments are taken directly from forms. Each sentence represent one person's individual view, where offered.

There were 4 responses submitted out of a possible 9. Each response gave a score to each question.

3. Summary of feedback

Of the members and attendees that responded the Committee scored 3 and above in all areas of the review.

There are some narrative comments to draw the Committee's attention to. These are highlighted in the amalgamated report attached and relate to the frequency, assurance and complexity of the meetings.

4. Recommendation

The Committee is asked to review the attached report and mean average scores and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Rebecca Thompson
Head of Corporate Affairs
May 2022

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Remuneration

Key

1. Hardly ever / poor
2. Occasionally / below average
3. Some of the time / average
4. Most of the time / above average
5. All of the time / fully satisfactory

Please give each question a score or N/A by entering 'x' in the appropriate box. You can provide comments against any question to give examples, illustrate what improvement would look like or describe something that is done well, and you would want to see remain the same.

Behaviours

	Question	N/A	1	2	3	4	5	Comment
1.	**Strategy** All Committee members have a clear understanding of the orgainisation's strategy, and how the work of the Committee links to it.						X	
2.	**Managing Committee meetings and discussions** Committee meetings encourage a high quality of debate with robust and probing discussions.						X	
3.	**Managing internal relationships** Committee members make decisions objectively in the best interests of the organisation and feel collectively responsible for achieving organisational success.						X	
4.	**Consideration of impact** Consideration is given to the impact of decisions on stakeholders/patients.						X	
5.	**Committee members' own skills** Committee members recognise the role which they and each of their colleagues is expected to play and have the appropriate skills and experience for that role.						X	
6.	**Reaction to events** The Committee responds positively and constructively to events in order to enable effective decisions and implementation and to encourage transparency.						X	

	Question	N/A	1	2	3	4	5	Comment
7.	**There are no surprises** Committee members are kept fully informed of relevant sensitive and difficult issues.					x		Remuneration does not meet regularly so there are individual matters that are just dealt with
8.	**Committee Chairman** The Committee Chairman's leadership style and tone promotes effective decision-making constructive debate and ensures that the Committee works as a team.						x	
9.	**Decisions** After a decision has been made, it is clear who is responsible for implementing it, and by when.						x	
10.	**Attendance and contribution to meetings** All Committee members attend and actively contribute at meetings.						x	
11.	**Open channel of communications** The Committee has open channels of communication with the Board and others and is properly briefed.						x	
12.	**Risk and control frameworks** The Committee's approach to reviewing risk in the organisation is open and questioning, and looks to learning points from events, rather than blame.						x	

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.						X	
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.						x	The Committee is a mandatory one and its process of information, approval and assurance are usually dictated by the nature of the agenda items it receives.
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee..						x	
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.					x		The frequency of meetings are sufficient to ensure the appropriate business can be discharged
5.	**Quantity of information** The quantity of information received is appropriate and helps Committee members fulfil their role.						x	Often complex items are included, but with sufficient explanation
6.	**Quality of information** The quality of information received is appropriate and helps Committee members fulfil their role.						x	
7.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.					x		
8.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.						x	
9.	**Annual reporting** The Committee makes best use of its annual reporting.						x	

	Question	N/A	1	2	3	4	5	Comment
10.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.						x	
11.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.						x	

Hull University Teaching Hospitals NHS Trust

Charitable Funds Committee

Terms of Reference

1. Formation of this committee

In line with its role as a corporate trustee, the Board has established a committee known as Charitable Funds Committee reporting to the Board, in accordance with Corporate Policy CP105 Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

The Committee has Terms of Reference and powers and is subject to conditions such as reporting back to the Board, as the Board determines and will act in accordance with any legislation, regulation or direction issued by the regulator.

The Committee has delegated powers from the Trust Board, for the management (including investment) of funds held on trust by Hull University Teaching Hospitals NHS Trust.

2. Role

The Committee is responsible for providing information and making recommendations to the Trust Board on charitable fund issues and for providing assurance that these are being managed safely. The specific responsibilities are to:

2.1 To ensure that the Trust's charitable funds are established and operated in accordance with Charities Law.

2.2 To ensure that any fund raising activity carried out by or on behalf of the charity is properly undertaken and that all funds are properly accounted for in line with the Trust policy.

2.3 Recognising the changed responsibilities for both fundraising and funds management, with the creation of the Working Independently for Hull Hospitals charity (WISHH), ensure the efficient and effective management and application of residual funds.

2.4 To ensure that funds not needed for immediate expenditure are invested or deposited to earn interest to protect the real value of the asset whilst generating a reasonable level of income.

2.5 To ensure that audited accounts, as laid down in the 2011 Charities Act are submitted to the Trust Board and to the Charities Commission annually and made available for the public.

2.6 To manage and monitor expenditure from charitable funds in accordance with Standing Financial Instructions and the Scheme of Delegation

2.7 To receive information on grants against general funds which are less than £10,000. To approve bids of £10,000 or greater in line with the Scheme of Delegation.

2.8 To oversee the relationship and governance arrangements between the Trust's Charitable Funds and the Working Independently to Support Hull Hospitals (WISHH) Charity (registered charity no. 1162414 Hull and East Yorkshire Hospitals Health Charity). At least one meeting involving the Committee and WISHH trustees to be held annually.

2.8 To oversee the Trust's hospital arts strategy, specifically the use of charitable funds in the delivery of this strategy.

2.9 To oversee the Trust's broader Corporate Social Responsibility role, in particular the Trust's role to support the well-being of the local community, which may be supported through charitable funds.

3. Membership of the Committee

The committee shall comprise:

Chairman (Non Executive Director)
Non-Executive Director
Chief Financial Officer

In attendance:

Deputy Director of Finance (Finance and Business Management)
Project Director – Fundraising
Head of Corporate Affairs

It is expected that all members will attend three quarters of the meetings per financial year. If Executive Directors are unable to attend a meeting they will send a deputy.

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

The Trust Board will ensure that the Committee members have appropriate skills, knowledge and training to undertake the duties. The Board will also ensure that undue reliance is not placed on particular individuals when undertaking the responsibilities of the committee.

4. Chairman of the Committee

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

5. Quorum

The quorum shall be a minimum of 2 members, to include a Non-Executive Director and the Chief Financial Officer (or nominated deputy).

6. Meetings

The Committee shall meet a minimum of 3 times a year. The Chairman may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7. Attendance at meetings

Other senior employees may be invited to attend by the Chairman, particularly when the Committee is discussing an issue that is the responsibility of that employee.

8. Notice of meetings

Meetings of the Committee shall be set at the start of the financial year by the Governance Team. Notice of each meeting, including an agenda and supporting papers, shall be forwarded to each member of the Committee not less than five working days before the date of the meeting.

9. Agenda and action points

The agenda and action points of all meetings of the Committee shall be produced in the standard agreed format of the Trust and kept by the Governance Team.

10. Reporting arrangements

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

11. Duties and Responsibilities of the Committee

The Committee is required to fulfil the following responsibilities:

11.1 Produce an annual work plan.
11.2 Provide an annual report and accounts to the Trust Board.
11.3 Communicate and consult with the Health Groups and Directorates of the Trust in achieving the objectives of the annual work plan, policy or strategy.
11.4 Monitor, review and recommend any changes to the Terms of Reference annually to the Trust Board.

12. Authority

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

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

13. Relationships with other committees

This Committee does not receive minutes of other committees.

14. Administration

The Committee is supported administratively by the Deputy Director of Finance and the Corporate Affairs Team. The Corporate Affairs team will agree the agenda with the Chairman, collate all necessary papers, attend meetings to take minutes, keep a record of matters arising and issues to be carried forward and generally provide support to the Chairman and members of the committee.

Date revised by Committee: 20 May 2021

Date approved by the Trust Board:

Review date: May 2022

Hull University Teaching Hospitals NHS Trust
Charitable Funds Committee

Workplan 2021/22

	Nov 2021	Feb 2022	May 2022	Aug 2022	Nov 2022
Bids for general funds	✓	✓	✓	✓	✓
Fundraising Register	✓		✓		✓
Project Director's Report	✓	✓	✓	✓	✓
WISHH Progress Report		✓		✓	
Financial Report	✓	✓	✓	✓	✓
Fund balances	✓	✓	✓	✓	✓
Review of procedures & policies		✓			✓
Spending plans and Fund Balances review		✓		✓	
Legacy update		✓		✓	
Administration charge		✓			
Budget		✓			
COIF	✓		✓		✓
Year-end accounts and annual Governance report	✓				✓
Other current or technical Issues - as applicable	✓	✓	✓	✓	✓
Internal Audit Report (as applicable)	✓				✓
Committee Terms of Reference review		✓			

Requirement to meet a minimum of three times per year

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Charitable Funds	**Meeting Date**	19.08.21
Title	Committee Effectiveness Review				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The effectiveness review is carried out 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 Committee is asked to review the attached report and mean average scores and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Hull University Teaching Hospitals NHS Trust

Charitable Funds Committee

Committee Effectiveness Review

1. Background

It is good governance practice to review the effectiveness of the Trust Board and its reporting committees periodically. The Trust undertakes this annually and has adapted a more detailed pro forma for this year's review to gain greater levels of feedback.

2. Process

Each Committee member has been asked to complete the pro forma overleaf. Responses are anonymous to give confidence in providing narrative comments as well as scores. The scores for each statement are from 1 (poor or never) to 5 (excellent or always).

The attached pro forma includes all questions asked and the mean average of the scores given by committee members in respect of these meetings.

The verbatim comments are taken directly from forms. Each sentence represent one person's individual view, where offered.

There were 3 responses submitted out of a possible 5. Each response gave a score to each question.

3. Summary of feedback

The majority of the responses were scored at a 4 or a 5 suggesting that the Committee is effective in discharging its responsibilities.

The areas that scored 3 or below are:

- Committees of the Committee
- Risk and control frameworks
- Annual Reporting

The responses and verbatim comments are show at Appendix 1.

4. Recommendation

The Committee is asked to review the attached questionnaires and agree any relevant improvement actions that should be taken in response. The Committee is also asked if there are any recommendations to make to the Trust Board.

Rebecca Thompson
Head of Corporate Affairs

August 2021

Classification: Official

Publication approval reference: PAR994

Enhancing board oversight

A new approach to non-executive director champion roles

Version 1, December 2021

Contents

1. Summary

1.1 Introduction

This guidance sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director (NED) champion roles, through committee structures. It also describes which roles should be retained and provides further sources of information on each issue. For the purposes of this guidance the term NED champion includes ‘named NEDs’ and ‘NED leads’.

There are a range of issues which at various times have required additional board level focus to respond to and learn from high-profile failings in care or leadership. This has resulted in several reviews and reports establishing a requirement for trust boards to designate NED champions for specific issues to deliver change. This has led to an increasing number of roles spanning quality, finance and workforce.

The number of NED champion roles started to make it difficult for trusts to discharge them all effectively, particularly with a limited number of NEDs, and many do not have a role description, making it difficult to measure their impact on delivering change. Some roles have also been in place for over a decade without review.

Working with stakeholders, we have reviewed the issues the roles were originally established to address, to consider the most effective means of making progress now. There are a small number that are statutory requirements and some that still require an individual to drive change or fulfil a functional role. In these instances, the principle of the unitary trust board – with joint responsibility and decision making – remains. However, there are many issues where we now consider progress will be best made through existing trust committees rather than through individual NED champion roles.

This new approach will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by committees. The risk of false assurance among chairs and directors who are not designated ‘champions’ will also be reduced, as oversight of transformational change to

improve care and responsibility to constructively challenge on all issues using Appreciative Inquiry approaches, will rest with the whole committee and not just an individual. By reducing the risk of individual NEDs becoming too involved in operational detail, this approach may also help maintain their independence – something that NEDs are uniquely positioned to bring to a board.

1.2 Status of guidance

This new approach is recommended but not mandatory. If trusts consider NED champion roles an effective tool to provide assurance to their board on specific issues, then they have the flexibility to retain or implement that approach.

1.3 Co-developing the approach

The new approach has been co-developed with a working group of trust chairs and we have also held a series of workshops with a range of providers. This enabled us to identify current roles and test alternative approaches to enhancing board oversight of important issues. We have engaged with national policy teams on the issues requiring oversight at board level that have associated NED champion roles. Further detail on each issue is provided in annexes 1 and 2.

We have engaged with the Care Quality Commission (CQC) throughout the development of this approach. While there is a shared understanding that strong leadership and board oversight is critical for the provision of high-quality care, the governance arrangements that individual trusts use to achieve this is expected to vary according to local circumstances and priorities. CQC inspectors will be looking for evidence of strong leadership and governance, with effective oversight of important issues. Trusts will be expected to demonstrate how they provide this, including with reference to this guidance where appropriate.

1.4 New recommended approach

For each issue, we identified the original review or report that recommended the establishment of a NED champion role and worked with the relevant national policy team to consider the current status of the role and the best way of responding to the issue at this point in time. In many cases, it was agreed that board oversight would be enhanced through a change from NED champion roles to committee discharge. It was also noted that the new approach should sit alongside other effective governance tools such as walkarounds, for example.

The table below sets out the NED champion roles that were in scope for this review and their status under the new approach.

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management-violence and aggression		

It should be noted that the table above includes those issues for which a report or review has suggested a NED champion role should be established and does not include all important issues that trusts should have oversight of.

2. Implementation and support

To support the effective implementation of this new approach we recommend that trusts take the following steps:

2.1 Review current roles

Trusts should undertake a review to identify a list of their current NED champion roles. Annex 1 outlines roles that are statutory roles or that continue to require an individual to discharge those responsibilities. These roles should be retained. All other roles should be embedded in governance arrangements and aligned to committee structures where possible.

2.2 Align remaining roles to committee structures

Where we have recommended that issues are now discharged through a committee, we have grouped these issues by 'theme' to align with committee structures commonly used by trusts. However, this is not prescriptive, and trusts will want to align issues with the committee that they believe is the best fit and is aligned with their current governance arrangements.

Understandably some complex issues may fall under the remit of more than one committee structure – in these cases trust boards may wish to adopt a joint approach to ensure appropriate assurance.

2.3 Outline reporting structures

It will be up to trusts to decide how committees should report back on their assurance activities to the board, whether that is through existing reporting mechanisms or by establishing new periodic updates on issues that were previously the responsibility of a NED champion. Company secretaries may wish to ensure these issues are included on board/committee forward plans.

2.4 Update terms of reference

As trusts review their governance arrangements, they will want to ensure that committee terms of reference reflect any new responsibilities and respective reporting requirements because of these changes. Committee chairs and members

may wish to consider actions needed to discharge the roles effectively, such as regular engagement with an executive lead, background reading, visiting services and attending seminars or training as available and appropriate to the trust.

2.5 Ongoing support

While some trusts may already be working with similar arrangements, it is recognised that effective implementation may require cultural and behavioural shifts. To support implementation, it would be useful to receive trusts' feedback on where the proposed approach has worked well, to identify examples of best practice. We (NHS England and NHS Improvement) can then support in disseminating successful case studies and lessons learned with other trusts.

Existing platforms such as the NHS Providers Company Secretaries Network, existing care groups and regional forums will be used to share those learnings and collect feedback.

This guidance will be kept under review and updated as necessary.

Please send feedback and best practice examples to nhsi.providerpolicyengagement@nhs.net.

Annex 1: Retained NED champion roles

We have identified five NED champion roles which at this point should be retained. These are maternity board safety champion, wellbeing guardian, freedom to speak up guardian (FTSU), doctors disciplinary and security management. These should be retained because they are either a statutory requirement, the function requires a named individual to discharge or because we consider having an individual NED to be the most effective way of delivering the changes that are needed. This section provides further detail on these roles and additional sources of information are set out in the Resources section.

1. Maternity board safety champion

Applies to	All trusts providing maternity services
Type of role	Assurance
Legal basis	Recommended
Role description	Maternity NED role descriptor

In response to the Morecambe Bay Investigation (2015), this role was established through Safer Maternity Care 2016, which stated that “Senior trust managers will want to ensure unfettered communication from ‘floor-to-board’ by appointing a board level maternity champion”. The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended.

The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.

The named champion could be the chair of the quality and safety committee and the requirements of the role could be discharged through the appropriate committee provided trusts ensure that the clinical director and director of midwifery are integral

to these committee meetings. NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the board that the best quality maternity care is being provided by their trust. Trusts may also wish to note that the NSR maternity incentive scheme safety actions refer to the maternity board safety champion role under Safety Action 9.

Along with other recommendations contained in the Ockenden Review, this role will be reviewed nationally in 2-3 years' time to gauge its effectiveness.

2. Wellbeing guardian

Applies to	All trusts
Type of role	Assurance
Legal basis	Recommended
Role description	Guardian community website and role description

This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.

3. FTSU NED champion

Applies to	All trusts
Type of role	Functional
Legal basis	Recommended
Role description	FTSU supplementary information

The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation.

The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report).

All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the FTSU supplementary information.

4. Doctors disciplinary NED champion/independent member

Applies to	All trusts (advisory for foundation trusts)
Type of role	Functional
Legal basis	Statutory
Role description	None

Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as “the designated member” to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.

5. Security management NED champion

Applies to	All trusts, excluding NHS foundation trusts
Type of role	Assurance
Legal basis	Statutory
Role description	None

Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.

While promotion of security management in its broadest sense should be discharged through the designated NED, relevant committees may wish to oversee specific functions related to counter fraud and violence/aggression. We have included further guidance on these two functions in Annex 2. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.

Annex 2: Issues that can be overseen through committee structures

This section covers those issues which reports or reviews previously suggested should be overseen by a NED champion, but which we now consider are best overseen through committee structures. Trusts should use their discretion to determine the relevance of each issue to their trust. It should be noted that there will be many other important issues not included in this guidance that trusts should also have oversight of.

For the purposes of this guidance the issues are grouped into ‘themes’ aligned to committee structures commonly used by trusts. However, each trust will need to determine whether each issue is relevant to their trust and how best they should be allocated to their committee structures, especially since some issues will cut across several committees. These issues and themes are summarised in table format under the resources section.

Quality and Safety Committee

1. Hip fractures, falls and dementia

All trusts and health boards should have a director with responsibility for falls and the ‘National Audit of Inpatient Falls Audit (NAIF) Report 2020’ recommends a patient safety group which is overseen by a member of the executive and non-executive team. This could be fulfilled by an executive rather than a NED, provided there is committee and board oversight of safety, prevention and risk management and use of data to gauge the effectiveness of practice.

Hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. The board should consider the benefits of joint oversight and strategic planning across both agendas and implement where appropriate. Sufficient senior level support to enable systemic change is needed, including effecting change in partner external organisations and allocating resources as needed.

The Quality Committee may wish to ensure that the executive lead for dementia attends the Quality Committee and, in acute trusts, that they also attend the Dementia Steering Group, reporting issues into the Quality Committee. The NAIF audit has produced a useful information guide for healthcare champions which could be accessed to support this work.

2. Palliative and end of life care

The Ambitions for Palliative and End of Life Care National Framework 2021-26 set out six key ambitions for the improvement of Palliative and End of Life Care (PEoLC). Improving quality is one of the three strategic priorities of the national NHS England and NHS Improvement PEoLC programme, including high quality PEoLC, for all, irrespective of condition or diagnosis.

The impact of executive leadership on improving the quality of PEoLC is a theme that has been identified by the NHSE PEoLC team during visits to trusts. Having a NED as part of the PEoLC Executive committee, led to significant support at the Board and a focus on PEoLC. Board level oversight for PEoLC can be well supported through the Quality Committee, with reporting into the Board. The work of the Quality Committee might include:

- attendance of a NED from the Quality Committee at the PEoLC Executive Committee
- ensuring the board is aware of standards of care in PEoLC
- reviving PEoLC complaints to see where improvements could be made.

3. Resuscitation

Health Service Circular Series Number: HSC 2000/028 (Sept 2000) stipulates that chief executives of all NHS trusts should give a NED designated responsibility on behalf of the trust board for ensuring that a resuscitation policy is agreed, implemented, and regularly reviewed within the clinical governance framework.

This has been referred to more recently in the May 2020 Resuscitation Council Quality Standards in relation to acute, mental health and community trusts. The Quality Committee may wish to discharge this role, rather than an individual NED, and include this on the committee workplan, ensuring sign-off from the board.

4. Learning from deaths

Executive and non-executive directors have a key role in ensuring their provider is learning from issues such as incidents and complaints and identifying opportunities for improvement in healthcare identified through reviewing or investigating deaths. All NEDs play a crucial role in constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible.

In particular, they should familiarise themselves with the care provided to individuals with learning disabilities and those with mental health needs and should encourage meaningful engagement with bereaved families/carers. The Quality Committee in particular should understand the Learning from Deaths review process, champion quality improvement that leads to actions that improve patient safety, and assure published information on the organisation's approach, achievements and challenges. Implementing the Learning from Deaths Framework: Key requirements for trust boards includes some useful questions that NEDs may wish to ask in relation to these responsibilities.

5. Health and safety

Strong leadership at board level and a strong safety culture, combined with NED scrutiny, are essential. Health and safety should be viewed in its broadest sense to include patient safety, employee safety, public safety and system leadership. As such the remit will cut across committees including Quality, Workforce/People and Planning (estates). All committees need to help ensure their organisation gets the right direction and leadership on health and safety matters through performing a scrutinising role – ensuring the integrity of processes to support boards facing significant health and safety risks.

Committee members should have a sound understanding of the risks, the systems in place for managing them, an appreciation of the causes of any failures and an understanding of the legal responsibilities of employers and individual directors for ensuring the health and safety of workers and others affected by work activities. They should be familiar with the trust's health and safety policy – which should be an integral part of the organisation's culture, values and standards – and assure themselves that this is being followed.

6. Safeguarding

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that boards should consider the appointment of a NED to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people.

This role could be discharged through a committee but in ensuring appropriate scrutiny of their trust's safeguarding performance, all board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. In addition, board members should understand the statutory role of the board in safeguarding including partnership arrangements, policies, risks and performance indicators; staff roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding.

The CQC Trust-Level Well Led Framework does not reference a safeguarding NED; rather it notes that the inspection team should speak to the/any senior member of the organisation with safeguarding responsibility.

7. Safety and risk

The Trust-Level Well-Led Inspection Framework refers to interviewing a sample of NEDs with the NED for safety and risk being a priority. This is not intended to imply that a specific NED champion role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of these areas such as the chair of Quality and/or Audit committees as examples.

CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

8. Lead for children and young people

The Core Service Inspection Framework for Children and Young People (CYP) refers to an interview with the 'NED on the board with responsibility for CYP'. This is not intended to imply that a specific NED lead role should be in place. Moreover, it refers generally to a NED that would have suitable oversight of this area, such as the chair of quality for example. CQC have endorsed the new approach recommended in this guidance. However, should trusts wish to do so, then

allocating the role to an individual NED as one tool for ensuring strong leadership and governance is acceptable practice.

Audit and Risk Committee

9. Counter fraud

The role of fraud champion is one that is suited to a senior manager who is directly employed by the trust. This could also be an executive but is not intended to be a NED role. The 2004 Counter Fraud Directions included a requirement for NHS trusts to designate a NED to undertake specific responsibility for counter fraud. However, these were revoked by the 2017 Directions on Counter Fraud, so there is no longer a statutory requirement to designate a NED champion for counter fraud.

NHS funded services are required to provide the NHS Counter Fraud Authority (NHSCFA) details of their performance annually against the Government Functional Standard 013: Counter Fraud and NHSCFA ask that the audit committee chair (usually a NED) signs off the trust's submissions. The audit committee chair (and members) may also wish to review the local counter fraud specialist's (LCFS) final reports and consider any necessary improvements to controls, along with any recommendations contained within reports following NHSCFA's engagement through its quality assurance programme.

10. Emergency preparedness

The NHSE Emergency Preparedness, Resilience and Response (EPRR) Framework sets out the responsibilities of the accountable emergency officer (AEO), who is expected to be a board level director with executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements.

The Framework suggests that a NED or other appropriate board member should support the AEO and endorse assurance to the board that the organisation is complying with legal and policy requirements. This will include assurance that the organisation has allocated sufficient experienced and qualified resource to EPRR.

The independence that NEDs bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met. EPRR should be included on

appropriate committee forward plans and EPRR board reports, including EPRR annual assurance, should be taken to the board at least annually.

Given the synergies between the agenda for EPRR and other important issues such as security management and health and safety, triangulation between these areas through the Board and committees will be essential.

Finance, Performance and Planning Committee

11. Procurement

Procurement should be seen by the board as a value-adding function. The Finance, Performance and Planning Committee should help raise awareness of commercial matters at board and director levels and facilitate discussions that identify benefits to procurement activity and strategic development. The committee would need to understand the scope of procurement, the priorities (at national and at integrated care system level) and the challenges of delivering change. The Audit Committee should regularly review procurement.

Our Procurement Target Operating Model (PTOM) programme team is seeking ambassadors who can advocate and raise the profile of procurement at a local level. This role can also be carried out by an executive, provided there is committee and board oversight. NEDs should collectively provide assurance via these committees to the board that their trust is viewing procurement as a priority, engaging with the PTOM programme and aligning their procurement activity with national activity.

12. Cyber security

Board leadership is seen as essential to the success of this agenda so trusts may decide it is more appropriate for this function to be discharged by the board than a committee. NEDs should provide check and challenge, ensuring information governance has been considered in all decisions and that this can be evidenced.

Each trust should have a senior information risk owner (SIRO), who would usually be an executive, although trusts can appoint a NED to this role should they wish to do so. The SIRO should ensure on behalf of the board that the 10 minimum cyber-security standards are followed throughout their organisation.

The board/committee should regularly review cyber security risks, ensuring appropriate mitigation, and that regular maintenance of critical systems and equipment takes place, while minimising impact on clinical services during system downtime. This should include the following:

- Removal of unsupported systems from trust networks.
- Timely patching of systems and prompt action on high severity Alerts when they are issued.
- Ensuring robust and immutable backups are in place.

It is also recommended that boards undertake annual cyber awareness training, in addition to the mandatory and statutory information governance training that individual board members are required to complete.

Workforce/People Committee

13. Security management – violence and aggression

As set out in 'We are the NHS People Plan for 2020-21 – action for us all' and the NHS Violence Prevention and Reduction Standard 2020, the board may wish to ensure the following:

- The trust has committed to develop a violence prevention and reduction strategy and this commitment has been endorsed by the board, which is underpinned by relevant legislation (set out in the Violence Prevention and Reduction Standard 2020), ensuring the strategy is monitored and reviewed regularly – 'regularly' to be decided by the board.

- Inequality and disparity in the experience of any staff groups, including those with protected characteristics, has been addressed and clearly referenced in an equality impact assessment, which has been made available to all stakeholders.

- A senior management review is undertaken twice a year and as required or requested, to evaluate and assess the Violence Prevention and Reduction Programme, the findings of which are shared with the board.

The Workforce/People Committee may wish to align this with wider wellbeing work being undertaken by the committee, particularly in relation to wellbeing support after violence.

Resources

Summary of roles by suggested committee and further sources of information

The following is a list of further reading that NEDs and other board members may find useful in developing their knowledge and understanding of the issues highlighted in this document.

Role	Links to further reading
General	
Maternity board safety	• Morecambe Bay Investigation (2015) • Ockenden Review (2020) • NSR Maternity Incentive Scheme Safety Actions • Maternity and Neonatal Safety Champions Toolkit • Transforming Perinatal Safety Resource Pack • NHS England and NHS Improvement Maternity Safety Resources • Safer Maternity Care 2016
Wellbeing guardian	• Guardian Community website and role description • Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019)
Freedom to speak up	• Report template – NHS England and NHS Improvement website (england.nhs.uk) • Robert Francis Freedom to Speak Up report • FTSU supplementary information • FTSU Guidance and self-review tool
Doctors disciplinary	• Directions on Disciplinary Procedures 2005 • Maintaining High Professional Standards in the modern NHS
Security management	• Directions to NHS Bodies on Security Management Measures 2004

Role	Links to further reading
Quality and Safety Committee	
Hip fracture, falls and dementia	• Patient Information Resource National Audit of Inpatient Falls- Guide for Healthcare Champions • National Audit of Inpatient Falls (NAIF) 2020 Annual Report | RCP London • NICE Guidance - Falls in Older People: Assessing Risk and Prevention • Dementia Care Pathway- Full implementation guidance • Dementia wellbeing in the COVID pandemic • NHS England Dementia: Good Personalised Care and Support Planning Information for primary care providers and commissioners - Guidance
Palliative and end of life care	• Ambitions for Palliative and End of Life Care: a national framework for local action 2021-2026 • "What NHS England is doing to improve end of life care", NHS England and NHS Improvement webpage • "Resources on End of Life Care", NHS England and NHS Improvement webpage
Resuscitation	• Quality Standards: Acute Care, Resuscitation Council UK
Learning from deaths	• https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf
Safety and risk	• Inspection Framework – trust-wide well led, CQC
Lead for children and young people	• Inspection framework – NHS Hospitals services for children and young people, CQC
Safeguarding	• Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff
Health and safety	• "Leading Health and Safety at Work", HSE webpage • FAQs: Leading health and safety at work, HSE webpage • Leading health and safety at work: Actions for directors, board members, business owners and organisations of all sizes- Guidance, HSE

Role	Links to further reading
Audit and Risk Committee	
Counter fraud	• Refer to service condition 24 of the NHS standard contract: 2021/22 NHS Standard Contract, NHS England and NHS Improvement • "Information for Fraud Champions", Fraud Prevention, NHS Counter Fraud Authority webpage
Emergency preparedness	• NHS England and NHS Improvement Emergency Preparedness, Resilience and Response Framework – Guidance
Finance, Performance and Planning Committee	
Procurement	• NHS Procurement: Raising Our Game – Best Practice Guidance
Cyber security	• 2017/18 Data Security and Protection Requirements- Guidance • Data Security and Protection Toolkit, NHS Digital • The Minimum Cyber Security Standard- Guidance, Cabinet Office • Lessons learned review of the WannaCry Ransomware Cyber Attack – Independent report
Workforce/People Committee	
Security management - violence and aggression	• Violence prevention and reduction standard

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

Hull University Teaching Hospitals NHS Trust

Non-Executive Directors' Roles

Name	Title	Committee Membership	Other Trust Roles
Sean Lyons	Chair		Emergency Preparedness Lead
Stuart Hall	Vice Chair/ NED	Remuneration Quality Performance and Finance	Lead for RTT Deputy Lead ICS
Tracey Christmas	NED/SID	Remuneration Audit (Chair) Performance and Finance	Speaking Up/Whistleblowing Champion Transition child/adult lead Champion for Safeguarding
Tony Curry	A/NED NED	Remuneration Performance and Finance (Chair) Charitable Funds (Chair)	Lead for Digital & IT Non-Executive Champion for Scan4Safety
Mike Robson	NED	Remuneration Audit Performance and Finance Charitable Funds Committee	Non-Executive Champion for GIRFT
Una McLeod	NED	Remuneration Quality Workforce, Education and Culture Committee (Chair)	Lead for Hull University partnership Champion for End of Life Care
Linda Jackson	A/NED	Attends: Remuneration Quality	
Ashok Pathak	A/NED	Attends: Remuneration Quality	
David Hughes	NED	Quality (Chair) Remuneration	Patient Safety Champion Maternity Champion

MEETING	DATE 2022	PAPERS DUE 2022	TIME	LOCATION
Trust Board	11-Jan	04-Jan	9am - 12pm	The Boardroom, HRI
Trust Board	08-Mar	01-Mar	9am - 12pm	The Boardroom, HRI
Trust Board	10-May	03-May	9am - 12pm	The Boardroom, HRI
Trust Board	12-Jul	05-Jul	9am - 12pm	The Boardroom, HRI
Trust Board	13-Sep	06-Sep	9am - 12pm	The Boardroom, HRI
Trust Board	08-Nov	01-Nov	9am - 12pm	The Boardroom, HRI
Extra Ordinary Board Accounts approval	16-Jun	09-Jun	11am - 12pm	The Boardroom, HRI
AGM	11-Jul	08-Jul	12pm - 2pm	The Lecture Theatre, HRI
Board Development	08-Feb	01-Feb	9am - 12pm	The Boardroom, HRI
Board Development	12-Apr	05-Apr	9am - 12pm	The Boardroom, HRI
Board Development	14-Jun	07-Jun	9am - 12pm	The Boardroom, HRI
Board Development	09-Aug	02-Aug	9am - 12pm	The Boardroom, HRI
Board Development	11-Oct	04-Oct	9am - 12pm	The Boardroom, HRI
Board Development	13-Dec	06-Dec	9am - 12pm	The Boardroom, HRI
Performance and Finance	31-Jan	24-Jan	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	28-Feb	21-Feb	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	28-Mar	21-Mar	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	25-Apr	18-Apr	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	23-May	16-May	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	27-Jun	20-Jun	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	25-Jul	18-Jul	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	22-Aug	15-Aug	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	26-Sep	19-Sep	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	31-Oct	24-Oct	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	28-Nov	21-Nov	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	19-Dec	12-Dec	1.30pm - 4.30pm	The Committee Room, HRI
Quality	31-Jan	24-Jan	9am - 11am	The Committee Room, HRI
Quality	28-Feb	21-Feb	9am - 11am	The Committee Room, HRI
Quality	28-Mar	21-Mar	9am - 11am	The Committee Room, HRI
Quality	25-Apr	18-Apr	9am - 11am	The Committee Room, HRI
Quality	23-May	16-May	9am - 11am	The Committee Room, HRI
Quality	27-Jun	20-Jun	9am - 11am	The Committee Room, HRI
Quality	25-Jul	18-Jul	9am - 11am	The Committee Room, HRI
Quality	22-Aug	15-Aug	9am - 11am	The Committee Room, HRI
Quality	26-Sep	19-Sep	9am - 11am	The Committee Room, HRI
Quality	31-Oct	24-Oct	9am - 11am	The Committee Room, HRI
Quality	28-Nov	21-Nov	9am - 11am	The Committee Room, HRI
Quality	19-Dec	12-Dec	9am - 11am	The Committee Room, HRI
Remuneration	24-Feb	17-Feb	12pm - 1.30pm	The Committee Room, HRI
Remuneration	26-May	19-May	12pm - 1.30pm	The Committee Room, HRI
Remuneration	25-Aug	18-Aug	12pm - 1.30pm	The Committee Room, HRI
Remuneration	24-Nov	17-Nov	12pm - 1.30pm	The Committee Room, HRI
Audit	27-Jan	20-Jan	9am - 12pm	The Committee Room, HRI
Audit	28-Apr	21-Apr	9am - 12pm	The Committee Room, HRI
Audit Extra Ordinary Accounts	16-Jun	09-Jun	10am - 11am	The Committee Room, HRI
Audit	28-Jul	21-Jul	9am - 12pm	The Committee Room, HRI
Audit	24-Nov	17-Nov	9am - 12pm	The Committee Room, HRI
Charitable Funds Committee	17-Feb	10-Feb	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	19-May	12-May	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	18-Aug	11-Aug	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	17-Nov	10-Nov	2pm - 4pm	The Committee Room, HRI
NED	31-Jan	24-Jan	11.30am - 1pm	The Committee Room, HRI
NED	28-Feb	21-Feb	11.30am - 1pm	The Committee Room, HRI
NED	28-Mar	21-Mar	11.30am - 1pm	The Committee Room, HRI
NED	25-Apr	18-Apr	11.30am - 1pm	The Committee Room, HRI
NED	23-May	16-May	11.30am - 1pm	The Committee Room, HRI
NED	27-Jun	20-Jun	11.30am - 1pm	The Committee Room, HRI
NED	25-Jul	18-Jul	11.30am - 1pm	The Committee Room, HRI
NED	22-Aug	15-Aug	11.30am - 1pm	The Committee Room, HRI
NED	26-Sep	19-Sep	11.30am - 1pm	The Committee Room, HRI
NED	31-Oct	24-Oct	11.30am - 1pm	The Committee Room, HRI
NED	28-Nov	21-Nov	11.30am - 1pm	The Committee Room, HRI
NED	19-Dec	12-Dec	11.30am - 1pm	The Committee Room, HRI

Workforce Education and Culture Committee	14-Feb	07-Feb	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	11-Apr	04-Apr	10am - 12pm	The Boardroom, HRI

Workforce Education and Culture Committee	13-Jun	06-Jun	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	08-Aug	01-Aug	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	10-Oct	03-Oct	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	12-Dec	05-Dec	10am - 12pm	The Boardroom, HRI

Ethical Clinical Prioritisation Policy Committee	15-Feb	08-Feb	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	17-May	10-May	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	16-Aug	09-Aug	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	15-Nov	08-Nov	4pm - 5pm	The Committee Room, HRI

Operational Risk and Compliance Committee	12-Jan	05-Jan	10:45 - 12:15	The Committee Room, HRI
Operational Risk and Compliance Committee	09-Mar	02-Mar	10:45 - 12:15	The Committee Room, HRI
Operational Risk and Compliance Committee	11-May	04-May	10:45 - 12:15	The Committee Room, HRI
Operational Risk and Compliance Committee	13-Jul	06-Jul	10:45 - 12:15	The Committee Room, HRI
Operational Risk and Compliance Committee	14-Sep	07-Sep	10:45 - 12:15	The Committee Room, HRI
Operational Risk and Compliance Committee	09-Nov	02-Nov	10:45 - 12:15	The Committee Room, HRI

MEETING	DATE 2023	PAPERS DUE 2023	TIME	LOCATION
Trust Board	10-Jan	03-Jan	9am - 12pm	The Boardroom, HRI
Trust Board	14-Mar	07-Mar	9am - 12pm	The Boardroom, HRI
Trust Board	09-May	02-May	9am - 12pm	The Boardroom, HRI
Trust Board	11-Jul	04-Jul	9am - 12pm	The Boardroom, HRI
Trust Board	12-Sep	05-Sep	9am - 12pm	The Boardroom, HRI
Trust Board	14-Nov	07-Nov	9am - 12pm	The Boardroom, HRI
Extra Ordinary Board Accounts approval	25-May	19-May	11am - 12pm	The Boardroom, HRI
AGM	10-Jul	07-Jul	12pm - 2pm	The Lecture Theatre, HRI
Board Development	14-Feb	07-Feb	9am - 12pm	The Boardroom, HRI
Board Development	11-Apr	04-Apr	9am - 12pm	The Boardroom, HRI
Board Development	13-Jun	06-Jun	9am - 12pm	The Boardroom, HRI
Board Development	08-Aug	01-Aug	9am - 12pm	The Boardroom, HRI
Board Development	10-Oct	03-Oct	9am - 12pm	The Boardroom, HRI
Board Development	12-Dec	05-Dec	9am - 12pm	The Boardroom, HRI
Performance and Finance	30-Jan	23-Jan	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	27-Feb	20-Feb	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	27-Mar	20-Mar	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	24-Apr	17-Apr	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	22-May	15-May	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	26-Jun	19-Jun	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	31-Jul	24-Jul	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	21-Aug	21-Aug	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	25-Sep	18-Sep	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	30-Oct	23-Oct	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	27-Nov	20-Nov	1.30pm - 4.30pm	The Committee Room, HRI
Performance and Finance	18-Dec	11-Dec	1.30pm - 4.30pm	The Committee Room, HRI
Quality	30-Jan	23-Jan	9am - 11am	The Committee Room, HRI
Quality	27-Feb	20-Feb	9am - 11am	The Committee Room, HRI
Quality	27-Mar	20-Mar	9am - 11am	The Committee Room, HRI
Quality	24-Apr	17-Apr	9am - 11am	The Committee Room, HRI
Quality	22-May	15-May	9am - 11am	The Committee Room, HRI
Quality	26-Jun	19-Jun	9am - 11am	The Committee Room, HRI
Quality	31-Jul	24-Jul	9am - 11am	The Committee Room, HRI
Quality	21-Aug	21-Aug	9am - 11am	The Committee Room, HRI
Quality	25-Sep	18-Sep	9am - 11am	The Committee Room, HRI
Quality	30-Oct	23-Oct	9am - 11am	The Committee Room, HRI
Quality	27-Nov	20-Nov	9am - 11am	The Committee Room, HRI
Quality	18-Dec	11-Dec	9am - 11am	The Committee Room, HRI
Remuneration	23-Feb	18-Feb	12pm - 1.30pm	The Committee Room, HRI
Remuneration	25-May	18-May	12pm - 1.30pm	The Committee Room, HRI
Remuneration	24-Aug	17-Aug	12pm - 1.30pm	The Committee Room, HRI
Remuneration	23-Nov	16-Nov	12pm - 1.30pm	The Committee Room, HRI
Audit	24-Jan	17-Jan	9am - 12pm	The Committee Room, HRI
Audit	18-Apr	11-Apr	9am - 12pm	The Committee Room, HRI
Audit Extra Ordinary Accounts	25-May	19-May	9am - 10am	The Committee Room, HRI
Audit	20-Jul	13-Jul	9am - 12pm	The Committee Room, HRI
Audit	26-Oct	19-Oct	9am - 12pm	The Committee Room, HRI
Charitable Funds Committee	16-Feb	09-Feb	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	18-May	11-May	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	17-Aug	10-Aug	2pm - 4pm	The Committee Room, HRI
Charitable Funds Committee	16-Nov	09-Nov	2pm - 4pm	The Committee Room, HRI
NED	30-Jan	23-Jan	11.30am - 1pm	The Committee Room, HRI
NED	27-Feb	20-Feb	11.30am - 1pm	The Committee Room, HRI
NED	27-Mar	20-Mar	11.30am - 1pm	The Committee Room, HRI
NED	24-Apr	17-Apr	11.30am - 1pm	The Committee Room, HRI
NED	22-May	15-May	11.30am - 1pm	The Committee Room, HRI
NED	26-Jun	19-Jun	11.30am - 1pm	The Committee Room, HRI
NED	31-Jul	24-Jul	11.30am - 1pm	The Committee Room, HRI
NED	21-Aug	21-Aug	11.30am - 1pm	The Committee Room, HRI
NED	25-Sep	18-Sep	11.30am - 1pm	The Committee Room, HRI
NED	30-Oct	23-Oct	11.30am - 1pm	The Committee Room, HRI

NED	27-Nov	20-Nov	11.30am - 1pm	The Committee Room, HRI
NED	18-Dec	11-Dec	11.30am - 1pm	The Committee Room, HRI

Workforce Education and Culture Committee	13-Feb	06-Feb	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	10-Apr	03-Apr	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	12-Jun	05-Jun	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	14-Aug	07-Aug	10am - 12pm	The Boardroom, HRI
Workforce Education and Culture Committee	09-Oct	02-Oct	10am - 12pm	The Boardroom, HRI
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Ethical Clinical Prioritisation Policy Committee	15-Aug	08-Aug	4pm - 5pm	The Committee Room, HRI
Ethical Clinical Prioritisation Policy Committee	14-Nov	07-Nov	4pm - 5pm	The Committee Room, HRI

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.07.22
Title	Gifts Hospitality and Sponsorship, Declarations of Interest				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The report is received by the Audit Committee 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:

Recommendation:

The Trust Board is requested to:

- review the report and registers for gifts, hospitality and declarations received
- receive assurance that the governance processes are in place to ensure compliance with the Trust policy

Hull University Teaching Hospitals NHS Trust
Gifts, Hospitality and Sponsorship, Declarations of Interest

1. Purpose of the paper

The purpose of the report is to present the Register of Gifts, Hospitality and Sponsorship 2021/22 to the Trust Board.

2. Background

Systems are in place to proactively request from senior managers and other appropriate staff declarations regarding any gifts or hospitality and declarations of interest, on a quarterly basis. This includes all Health Group managers (triumvirate and divisional teams), senior pharmacists, senior supplies staff, medical education, finance and capital development. All responses are reviewed by the Head of Corporate Affairs against the Trust's policy, for appropriateness and to raise any queries on declarations.

The Trust's policy and processes on gifts, hospitality, sponsorship and declarations of interest have been subject to a recent internal audit. The Trust also works closely with the Counter Fraud Team regarding declarations received.

3. Declarations of Gifts, Hospitality and Sponsorship

Declarations of gifts, hospitality and sponsorship come under the Trust's Declarations Policy. This policy was updated in line with the new NHS England *Managing Conflicts of Interest* guidance, which was mandated from 1 June 2017. It was also updated in April 2018 following an internal audit report, to adopt further best practice. Further suggestions for best practice have been suggested by the Trust's Anti-fraud lead, and an updated version of the policy is presented on today's agenda for approval.

Staff are reminded on a regular basis via Pattie and corporate email to declare gifts and hospitality and the Corporate Affairs Team offer guidance to staff were necessary. Board members are periodically asked to provide an update on any gifts, hospitality and sponsorship, including making a nil return.

The full register of declarations of gifts, hospitality and sponsorship for 2021/22 is attached to this paper at Appendix A.

The full register is reviewed on a regular basis. This includes reviewing sources of sponsorship, gifts and hospitality and maintaining oversight of the levels of contribution being made from single sources. There are no particular queries or concerns to draw to the Committee's attention. The Audit Committee is asked for feedback against the attached register for any other queries to be followed up.

The Head of Corporate Affairs works closely with the Counter Fraud Team to review the registers as well as ensuring that any disclosures made by the Association of the British Pharmaceutical Industry match declarations made.

4. Declarations of Interests

Periodic reminders are also sent for declaration of interest forms to be reviewed and updated (see Appendix B for all declarations received for 2021/22 to). All new starters are required to declare any relevant interests. The annual Fit and Proper Persons check on Board members will take place in March and was reported at the May 2022 Trust Board meeting.

The Trust publishes on its website the business interests (or nil returns) and receipt of gifts, hospitality and sponsorship of all Board members as well as the declared interests of Deputy Directors/significant decision makers.

The register is reviewed on a regular basis. This includes checking whether Consultant colleagues are making declarations or nil returns on private practice and reviewing any company directorship declared for potential conflicts of interest.

The Audit Committee is asked for feedback against the attached registers for any other queries to be followed up.

5. Recommendation

The Trust Board is requested to:

- review the report and registers for gifts, hospitality and declarations received
- receive assurance that the governance processes are in place to ensure compliance with the Trust policy

Rebecca Thompson
Head of Corporate Affairs
July 2022

Notification of Gift/Hospitality/Sponsorship Offered 2021/22

Hull University Teaching Hospitals NHS Trust

Date of Declaration	Gift/Hospitality/Sponsorship	Name	Title	Offered by	Description	Value	Comment
21/04/2021	Gift	Sarah Addleshaw	HR Business Partner	Patient relative from DME	Patient Relative donated £1000 to be used specifically for Charity Ball. SA is responsible for the finances for the Ball. Ball was to take place in 2020 and therefore the money was transferred to SA bank account to ensure it could be used to pay for the tables for the DME staff as per the patient's relative wishes. Covid then prevented the Ball from taking place but the money remains with SA for when it takes place this year. Lee Bond, CFO and Simon Nearney, Director of Workforce are aware – see attached email (in Gifts Folder).	£1,000.00	Accepted
05/05/2021	Sponsorship	Anthony Maraveyas	Consultant Oncologist	Thrombosis UK (1 day) & Bayer (1 day)	Sponsorship and travel to London for National Thrombosis Week 21 (NTW21) 11/05/2021 - 12/05/2021 Charity and talking in sessions on both days one is company sponsored.	£100.00	Accepted

04/05/2021	Sponsorship	Dr Belinda Allan	Consultant in General Medicine and Endocrinology	Eli Lilly	Sponsorship for attendance (virtual) at Diabetes UK Annual Professional Conference 26/03/2021 - 08/04/2021.	£100.00	Accepted
11/05/2021	Sponsorship	Ruth Colville	Senior Project Manager	HSJ Workforce	Unpaid Sponsorship to speak at the HSJ Workforce Webinar Virtual Event on 26th May 2020 on the topic "Not just another tick-box: Delivering on equality and inclusion". This is an unpaid speaking engagement in which we will be sharing practical strategies which HUTH is implementing towards becoming a fairer more inclusive employer in line with the NHS People Plan. This work is in keeping with the EDI Our Voice Project which is commissioned with Trust structures.	£0.00	Accepted

13/05/2021	Sponsorship	Ruth Colville	Senior Project Manager	BBC Radio Humberside	Unpaid Sponsorship to speak on BBC Radio Humberside's Pause for Thought programme on 27th May 2021 at 6:40am. This is an unpaid speaking engagement and is a 90 second reflective slot. Ruth intends to reflect on the gift of inclusion and diversity within the hospital, the strength of our staff networks, how we care for one another to care for others and how it has made us more resilient in a time of crisis. This work is in keeping with the EDI Our Voices Project which is commissioned within Trust structures.	£0	Accepted
11/06/2021	Gift	Simon Nearney	Director of Workforce and OD	Medical Consultant	Gift of Brandy from Consultants home country was given on 10th June 2021.	£30.00	Accepted
20/07/2021	Gift	Rosie Featherstone	Sister / Charge Nurse	Tesco Manager	2 x fans gifted on 20/07/2021, see scanned document for evidence.	£39.98	Accepted
19/07/2021	Gift	Rosie Featherstone	Sister / Charge Nurse	B&Q Manager	10 x fans gifted on 19/07/2021, see scanned document for evidence.	£180.00	Accepted
19/07/2021	Gift	Rosie Featherstone	Sister / Charge Nurse	Previous patient	6 x fans gifted on 19/07/2021, see scanned receipt for evidence.	£84.00	Accepted
05/08/2021	Gift	Laura Maxwell	Sister	Jane Prutton	Tesco voucher given on 05/08/21, used to buy food for the team.	£75.00	Accepted
05/08/2021	Gift	Dan Pearce	Senior Physiotherapist	Jane Prutton	Tesco voucher given on 05/08/21, shared between physio team (roughly 15 staff members).	£50.00	Accepted

06/10/2021	Gift	Ruth Colville	Senior Project Manager	Grace McInnes Senior Editor, Health and Social Care Routledge (see form for address / email)	£80.00 or £160.00 in vouchers for Routledge Books. Accepted but to be donated to HUTH library.	£160.00	Accepted
17/11/2021	Gift	Nikki Croll	Clinical Nurse Speciliast	Patients relative	Bouquet of flowers.	£15.00	Accepted
28/04/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Novartis	Honorarium for podcast recording in free time.	£700.00	Accepted
18/05/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Novartis	Speakers fee for pre-recorded lecture undertaken in free time and played via webinar.	£925.00	Accepted
27/05/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Novartis	Honorarium speakers fee for pre-recorded lecture during free time.	£1,322.00	Accepted
29/06/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Novartis	Fee for being part of an advisory board for Beovu Injections during annual leave.	£1,000.00	Accepted
07/07/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Bayer	Honorarium fee for chairing an evening meeting done in free time.	£1,000.00	Accepted
24/06/2021 & 21/07/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Novartis	Fee for being part of an advisory board for Luxturna gel therapy during annual leave.	£2,700.00	Accepted
15/07/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Novartis	Fee for being part of an advisory board preparation of manuscript in free time.	£400.00	Accepted
24/11/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Bayer	Homorarium fee for presentation on DMO during free time.	£750.00	Accepted
20/10/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Novartis	Advisory board preparation fee - did not attend due to sick leave.	£600.00	Accepted
22/11/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Novartis	Advisory board fee for Beovu in DMO in free time.	£800.00	Accepted
18/11/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Bayer	Advisory board fee during free time.	£450.00	Accepted

09/12/2021	Sponsorship	Louise Downey	Consultant Ophthalmologist	Novartis	Advisory board work as part of retinal outcomes group contract during annual leave.	£1,000.00	Accepted
29/12/2021	Gift	Andrew Websdale	Senior Nurse	Patient - Kathleen O'Hanlon	£25 gift card received - shared between the team.	£25.00	Accepted
02/02/2022	Sponsorship	David May	Porter, Post and Switchboard Manager	Globalview (address details in evidence PDF)	Travel and food costs to attend MyPorter Awards London ceremony awards for NHS Porters across the UK on 24/02/22 at Dickens Inn, Marble Quay, City of London.	£100.00	Accepted
21/02/2022	Sponsorship	Thomas Mace	Consultant	Bial	Travel to Lisbon (plane return), accomodation for two nights and food costs covered for attendance to a Parkinson's conference on 22/10/2021.	£400.00	Accepted
07/03/2022	Gift	Ian Hutty	Head of IT Services	Dell	Meal on 07/03/2022.	< £25.00	Accepted
07/03/2022	Gift	Graham Annan	Client Systems Manager	Dell	Meal on 07/03/2022.	< £25.00	Accepted
07/03/2022	Gift	Mike Barnett	Technical Services Manager	Dell	Meal on 07/03/2022.	< £25.00	Accepted
01/03/2022	Gift	Graham Annan	Client Systems Manager	Imprivata	Meal at Rewired Executive Dinner on 14/03/2022.	Not stated	Accepted
25/02/2022	Other Paid Work	Claudia Myler	Principal Clinical Psychologist	University of Hull	0.2 WTE Academic Tutor Role - Clinical Psychology Doctoral Training Programme, University of Hull	Band 8a 0.2 WTE	Accepted
17/03/2022	Gift	David Wilkinson	Transport Manager	Drive Taxis	Meal and match ticket to watch Hull City offered, declined due to high value.	£125.00	Declined
31/03/2022	Gift	David Haire	Project Director - Fundraising	Dr Assem Allam	3 bottles of wine gifted on 17/12/2021. Accepted to be used for the benefit of the WISHH charity as raffle prizes.	£45.00	Accepted

31/03/2022	Gift	David Haire	Project Director - Fundraising	Hull York Medical School	Attendance to Allam Annual Lecture (UoH) on 03/09/2021 and evening meal at KCOM stadium on 15/09/2021.	£45.00	Accepted

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

DECLARATION OF EXTERNAL BUSINESS INTEREST(S) 2021/22

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Achal, Kulraj S.	Consultant Orthodonist	• Direc tor of a private Ltd. company (Chi Squared Limited) since 2020 • Undertakes private practice with BUPA Dental Care since 2019 • Will commence private practice as a Specialist Orthodontist in primary care in May 2022 • Wife works for HUTH as an Orthodontic Therapist	N	10/02/2022	Entered 28/03/2022		RT reviewed
Adedipe, Dr Tolu	Consultant Obstetrician and Gynaecologist	• Trustee and Trust Board Member of Wakefield Women's Centre	N	19/07/2021	Entered 20/07/2021		RT reviewed
Arif, Mariyam	GPST-1	• Husband Ammar Shafiq works at HUTH as a IMT Year 2	N	21/03/2022	Entered 30/03/22		RT reviewed
Bateman, Julie	Cognitive Behavioural Therapist	• Undertakes private practice as a CBT Therapist	N	23/08/2021	Entered 24/08/2021		RT reviewed
Beavis, Professor Andrew	Head of Medical Physics	• Director of Vertual Ltd, a company that provides Virtual Reality / Computer Simulation products for Radiotherapy Training (internationally) since 2007 customers include NHS hospitals • Co-Investor on grant(s) relating to work performed in the trust as part of collaborative work with the University. Vertual Ltd may received 'Innovate' type grants to find part(s) of it's business development work	N	21/02/2022	Entered 21/02/2022		RT reviewed
Beddoes, Gowan	Highly Specialist Cardiac Physiologist	• Undertakes private practice at Spire Hospitals supporting Electrophysiology / Ablation procedures as a Bank Cardiac Physiologist • Wife Belinda Beddoes works as a Echocardiographer at CHH since 2005	N	15/04/2021	Entered 28/04/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Beddows, Ellen	Optomestrist Consultant	• Occasional locum Optometry work as an Optician in a High Street Opticians Practice on days off / weekends. This has amounted to one day in the last year (very infrequent).	N	21/07/2021	Entered 27/07/2021		RT reviewed
Bhandari, Prof Sunil	Consultant Nephrologist	• Trustee for Kidney Research UK, promoting research and health in Renal Medicine (Voluntary) • Vice President of Royal College of Physicians of Edinburgh to promote delivery of high quality health care and training (Voluntary) • Undertakes private practice at Spire Hospitals once a month doing outpatient consultations • Advisor to Pharma Companies - Pharmacosmos, Astellas and GSK • Received Research Funding from Pharmacosmos • Budget Holder for Renal Research - No control over it's administration, this is decided by R&D and HUTH	N	08/11/2021	Entered 10/11/2021		RT reviewed
Blenkin, Helen	PPA	• Husband David Blenkin works for HUTH • Sister Annette Sharp (?) works for CHCP since date of employment	N	23/07/2021	Entered 26/07/2021		RT reviewed
Bourne, Andrew	Optometrist Specialist	• Director of own locum Optometry company • Provides locum Optometry services to primary care and private settings	N	22/07/2021	Entered 26/07/2021		RT reviewed
Brigham, Jessica	Staff Nurse	• Nil Return	N	24/04/2021	Entered 27/04/2021		RT reviewed
Bryan-Smith, William	Bank Chaplain	• Directorship of Eborland and Development Company since date of employment	N	19/07/2021	Entered 20/07/2021		RT reviewed
Burns, Kim	Head of Costing	• Husband is Director/Owner of T.B.Steel Detailing	N	01/03/2022	Entered 21/03/2022		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Butcher, Kim	Assistant Hotel Services Manager	• Son, Lee Gavin Butcher is a Systems Developer at HUTH	N	14/04/2021	Entered 21/04/2021		RT reviewed
Buttle, Debbie	Senior Administrator	• Employed by Spire Healthcare (typing for Prof Ahmed only) started September 2015, ad-hoc hours.	N	28/04/2021	Entered 05/05/2021		RT reviewed
Cady, Michelle	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.	N	24/03/2022	Entered 28/03/2022		RT reviewed
Cady, Michelle	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	N	14/03/2022	Entered 21/03/2022		RT reviewed
Caldwell, Jane	Consultant Cardiologist	• Managing Director of CK Arrhythmics Ltd. A company through which private practice at the Spire Hospital is operated • Chair of Hull East Riding Cardiac Trust Fund, this charity provides funding to support pilot research in HUTH/HYMS and does not give services or supply goods • Provides private Cardiology consults and occasional procedures in Spire Hospital under CK Arrhythmics Ltd.	N	20/07/2021	Entered 20/07/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Carling, Angela	Laboratory Manager	• Husband is Director of Bloodfast EVS who supply transport services to HUTH, commenced in post 01/09/18	N	19/07/2021	Entered 20/07/2021		RT reviewed
Carr, Melissa	Nurse Director	• Holds a Directorship for a non-profit making company - Beck Close Management LTD, which is a company to manage the private land/road where house is situated • Budget holder	N	06/08/2021	Entered 10/08/2021		RT reviewed
Cast, Dr James	Consultant Radiologist	• Undertakes private practice at Hull and East Riding Spire Hospital	N	26/07/2021	Entered 26/07/2021		RT reviewed
Cattermole, Helen	Consultant Orthopaedic Surgeon/Director of Medical Education	• Director of Envelope Productions • Husband Jonathan Tilsed, Consultant Surgeon • Daughter Katherine Tilsed, ESC Assistant	N	16/04/2021	Entered 21/04/2021		RT reviewed
Chapman, Thomas	Bariatric Dietitian	• From date of employment has private work from Streamlink Surgical and Spire Hospitals	N	16/04/2021	Entered 20/04/2021		RT reviewed
Choo, Stephanie Mei Yann	ST4 Renal Medicine	• Partner Prabhsimran Singh will be working as a Gastroenterology Registrar at HUTH from September 2021	N	19/07/2021	Entered 20/07/2021		RT reviewed
Christmas, Tracey	Non-Executive Director	• Is a budget holder and/or Trust Board Member	N	23/02/2022	Entered 07/03/2022		RT reviewed
Christmas, Tracey	Non-Executive Director	• Is a budget holder and/or Trust Board Member	N	13/04/2021	Entered 13/04/2021		RT reviewed
Coggan, Allison	Communications Manager	• Son Patrick Coggan joined the Trust as a Business Admin Apprentice in 2019 and has worked as an Administrator in the Emergency Department at HRI since April 2020	N	02/02/2022	Entered 08/02/2022		RT reviewed
Coggan, Patrick	Administrator	• Mother Allison Coggan works as Communications Manager at the Trust	N	02/02/2022	Entered 08/02/2022		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Collins, Michael	Senior Information Manager	• In a relationship with Lucy Haire, Information Services • Budget Holder	N	01/02/2022	Entered 21/03/2022		RT reviewed
Colville, Ruth	Senior Continuous Improvement and Organisational Development Practitioner	• Speaker on BBC Radio Humberside "Pause for Thought" programme on 14/12/21 at 6.40am. This is an unpaid speaking engagement and is a 90 second reflective slot reflecting on the role of leaders in effecting a positive experience of change. Pam Hallett, Researcher/Producer of Pause for Thought/ a producer of Make a Difference at BBC Radio Humberside has also asked for Ruth to come back in January 2022.	N	13/12/2021	Entered 15/12/2021		RT reviewed
Colville, Ruth	Senior Project Manager	• Speaker on BBC Radio Humberside "Pause for Thought" programme on 17/08/21 at 6.40am. This is an unpaid speaking engagement and is a 90 second slot reflecting on the concepts of leadership. This reflection has arisen as a result of reading done in developing the Supervisor's Course for Internal Medicine Trainee Year 3s for the region for Health Education England the Improvement Capability and Capacity Programme of work which has been commissioned within Trust structures.	N	15/08/2021	Entered 17/08/2021		RT reviewed
Crowther, Nicola	Senior Biomedical Scientist	• Husband Michael Crowther is a Phlebotomist at HUTH	N	22/07/2021	Entered 27/07/2021		RT reviewed
Cunningham, Thomas Keith	Consultant Obstetrician and Gynaecologist	• Undertakes private practice at the Hull IVF Unit	N	23/07/2021	Entered 27/07/2021		RT reviewed
Curry, Tony	Non-Executive Director	• Budget Holder	N	22/02/2022	Entered 22/02/2022		RT reviewed
Deshpande, Dr Pradeep	Consultant in Rehabilitation Medicine	• Nil Return	N	04/08/2021	Entered 09/08/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Dixon, Wendy	Accommodation Manager	• Partner Mark Green works for HUTH	N	08/11/2021	Entered 10/11/2021		RT reviewed
Dixon, Wendy	Accommodation Manager	• Partner Mark Green works for HUTH	N	19/07/2021	Entered 20/07/2021		RT reviewed
Downey, Louise	Consultant Opthalmologist	• Has Directorship in a Ltd company to receive payments from private practice (Spire) and pharma work • Undertakes private practice at Spire Hospitals one afternoon per week • Research funding from Novatis / Roche for global and national RCT work	N	02/05/2021	Entered 11/05/2021		RT reviewed
Draper, Hannah	Clinical Research Fellow	• Husband Stuart Haywood is a Sales Controller for Hospital Solutions for Phoenix Healthcare Distribution since February 2021 • Has been a Non-Executive Director and has shares in Enuma Consulting Limited since May 2020	N	21/02/2022	Entered 22/02/2022		RT reviewed
Elstob, Julia	Operational Improvement Lead - Elective Recovery	• Husband Sean Elstob - Materials Management Assistant based at HRI	N	03/03/2022	07/03/2022		RT reviewed
Foulds, Tom	Bsuiness Manager	• Personal Interest and Director of MY D3N Ltd. Established in November 2018. Company interest in “Buying and selling of own real estate”	N	14/04/2021	Entered 21/04/2021		RT reviewed
Fretter, Rachael	Charity Officer	• Charity Offier - WISHH Charity • Auntie Amanda Nickolay is a Patient Admin Offier at HUTH	N	15/04/2021	Entered 21/04/2021		RT reviewed
Gallager, John	Clinical Scientist	• Undertakes private practice at York Teaching Hospitals NHS Foundation Trust as a Honorary Visiting Specialist (GI Physiology) one clinic a fortnight to start in February 2022 • Partner Chloe McDonnell is a Staff Nurse at York Hospital	N	24/01/2022	Entered 01/02/2022		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Gandhi, Jay	Physiotherapist	• BAME Hub Lead for Yorkshire and Humber Clinical Research Network (CRN) National Institute of Health and Research start date Jan 2021 • Pro-bono consultancy ad-hoc to support local restaurants during the pandemic (started Feb 2020)	N	14/04/2021	Entered 21/04/2021		RT reviewed
Geary, Beverley	Chief Nurse	• Nil Return	N	21/02/2022	Entered 22/02/2022		RT reviewed
Gibby, Alice	Staff Nurse	• Personal relationship (not stated what kind) with Christian Carr since 01/04/2021	N	23/07/2021	Entered 26/07/2021		RT reviewed
Gibson, Stephen	Section Manager Radiographer	• Married to Louise Gibson Sonographer in Radiology HUTH since 2000	N	15/04/2021	Entered 21/04/2021		RT reviewed
Goel, Siddhartha	Opthalmology Consultant	• Director / Shareholder in the following companies: Eye Correction Centre Ltd, Eye Correction Centre UK East, Mr S Goel Ltd, View Eye Care Ltd. • Director only at AOO Specialist Indemnity Scheme Ltd • View Eye Care Ltd (Director / Shareholder) are considering NHS Contracts in the Manchester area. None undertaken as yet. • Undertakes private practice	N	19/07/2021	Entered 26/07/2021		RT reviewed
Goode, Joanne	Chief Pharmacist	• Husband works for Xerox, unaware of Trust using this company but they do work with the NHS • Sister Sarah Goode works as a nurse at Haxby Medical Group • Budget Holder	N	03/03/2022	Entered 09/03/2022		RT reviewed
Goode, Joanne	Chief Pharmacist	• Husband works for Xerox • Sister is a Nurse at Haxby Group Hull and is on a secondment with HEE	N	09/11/2021	Entered 08/12/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Grover, Kartikae	Consultant Breast Surgeon and Clinical Lead for Breast Surgery	• Undertakes private practice at Spire Hospitals	N	24/02/2022	Entered 07/03/2022		RT reviewed
Haeney, James	Consultant Plastic Surgeon, Plastic Surgery Training programme director Yorks & Humber HEE	• Trustee and council member British Association of Plastic, Reconstructive & Aesthetic surgeons (BAPRAS) • Private practice admitting rights at Spire Hospital, Clifton Park Hospital (York), Trent Cliffs Hospital (Scunthorpe) • Training programme director Plastic Surgery Yorks & Humber (HEE)	N	14/04/2021	Entered 21/04/2021		RT reviewed
Haire, David	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	N	31/03/2022	Entered 11/04/2022		RT reviewed
Haire, Gemma	Quality and Safety Manager	• Husband Damian Haire, Brother-in-law Greg Haire and Father-in-law David Haire all work for HUTH	N	28/02/2022	Entered 07/03/2022		RT reviewed
Haire, Gemma	Quality and Safety Manager	• Husband Damien Haire (DGM in Family and Women's Health) Father-in-law David Haire (Director of Fundraising) and Brother-in-law Greg Haire (DGM in Surgery Health Group) all work for HUTH	N	19/07/2021	Entered 26/07/2021		RT reviewed
Haire, Greg	Deputy Operations Director	• Father, Brother and other family members work within the Trust	N	15/04/2021	Entered 21/04/2021		RT reviewed
Haire, Lucy	Information Analyst	• Greg Haire Ex-Husband, David Haire Father-in-law, Damien Haire Brother-in-law, Gemma Haire Sister-in-law and in a relationship with Michael Collins	N	27/07/2021	Entered 09/08/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Hargraves, Claire	Dietetic Team Leader (Intestinal Failure)	• Undertook one off questionnaire for research company about experience of home care services. This included payment of £100.	N	16/07/2021	Entered 26/07/2021		RT reviewed
Harley, Dr James	Neurology Consultant	• Undertakes private practice at a weekly outpatient clinical at Spire Hospital	N	19/07/2021	Entered 20/07/2021		RT reviewed
Harman, Daniel	Elderley Medicine Consultant	• Employed by CHCP • Has Shareholder status as an employee of CHCP • Is on the Board of Trustees at Dove House Hospice, Hull	N	19/07/2021	Entered 20/07/2021		RT reviewed
Haslam, Nicola Clare	Band 7 WH Physio	• Works for CHCP providing Community Services • Works for a private practice in an emplyed role in Consortium Physiotherapy • Husband is a specialist nurse in Hepatitis	N	25/11/2021	Entered 08/12/2021		RT reviewed
Hauff, Corinna	Consultant Radiologist	• Undertakes private practice at Spire Hospital Hull	N	19/07/2021	Entered 20/07/2021		RT reviewed
Hawkes, Barry	Student Nurse Apprentice	• Wife Jenny Hawkes is employed by HUTH as an Occupational Therapist based at CHH	N	25/07/2021	Entered 10/08/2021		RT reviewed
Hawkes, Jenny	Clinical Lead Occupational Therapist	• Husband Barry Hawkes employed by HUTH as Student Nurse Apprentice on AMU, HRI	N	27/07/2021	Entered 10/08/2021		RT reviewed
Horner, Rachel	Specialist Orthoptist	• Nil Return	N	15/02/2022	Entered 21/02/2022		RT reviewed
Horton, David	Radiology Consultant	• Nil Return	N	19/07/2021	Entered 20/07/2021		RT reviewed
Hughes, David	Non-Executive Director	• Employed as a Consultant Histopathologist at Sheffield Teaching Hospitals NHS Foundation Trust • Daughter is a nurse at Sheffield Teaching Hospitals	N	23/02/2022	Entered 07/03/2022		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Hughes, Mark	Programme Nurse Clinical Director	• Wife is a Midwife at Women and Children's Hospital, HUTH	N	20/07/2021	Entered 20/07/2021		RT reviewed
Jackson, Warren	GI Physiology Manager	• Undertakes private practice at York Teaching Hospitals NHS Foundation Trust, Honorary Visiting Specialist (GI Physiology) every two weeks starting in February 2022 • Wife Helen Jackson works at HUTH as an Ophthalmic Technician • Is a budget holder for GI Physiology	N	21/01/2022	Entered 24/01/2022		RT reviewed
Jarvis, Martin Amadee	Consultant Cardiothoracic Surgeon	• Wife Karen Jarvis is an ACP in Cardiothoracic Surgery and Lead for Advanced Practice at HUTH	N	21/02/2022	Entered 21/02/2022		RT reviewed
Jarvis, Martin Amadee	Consultant Cardiothoracic Surgeon	• Married to Karen Jarvis, Lead for Advanced Clinical Practice at HUTH	N	19/07/2021	Entered 20/07/2021		RT reviewed
Johnson, Rachel	Head of Communications	• Partner Danny Storr is Deputy Chief Finance Officer at Hull CCG • Aunt Pam Bell is a Pre-Assessment Nurse at CHH	N	01/03/2022	Entered 07/03/2022		RT reviewed
Johnson, Rachel	Head of Communications	• Partner Daniel Storr is Deputy Chief Finance Officer at Hull CCG • Auntie Pam Bell is Pre-Assessment Nurse at CHH	N	12/11/2021	Entered 08/12/2021		RT reviewed
Johnson, Rachel	Head of Communications	• Partner is Daniel Storr, Deputy Director of Finance at NHS Hull CCG • Auntie is Pam Bell, Pre-Assessment Nurse at CHH	N	22/07/2021	Entered 26/07/2021		RT reviewed
Johnson, Rachel	Head of Communications	• Partner is Daniel Storr, Deputy Director of Finance at NHS Hull CCG • Auntie is Pam Bell, Pre-Assessment Nurse at CHH	N	16/04/2021	Entered 20/04/2021		RT reviewed
Johnston, Cassia	Senior Administrator	• Partner Alexander Jewitt works for HUTH as a Clinical Administator	N	28/04/2021	Entered 05/05/2021		RT reviewed
Jones, Wren (legal name Cooper)	Ward Clerk	• Nil Return	N	23/07/2021	Entered 26/07/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Kapur, Rakesh	Consultant Vascular Surgeon	• Nil Return	N	13/03/2022	Entered 21/03/2022		RT reviewed
Kapur, Rakesh	Consultant Vascular Surgeon	• Nil Return	N	01/05/2021	Entered 11/05/2021		RT reviewed
Kay, Kathryn	Consultant Biomedical Scientist	• Executive Director of MSK Consultancy Ltd. Started 08/2013 since date of employment in September 2020. Not currently trading.	N	15/04/2021	Entered 20/04/2021		RT reviewed
Kaye, Andrea	Mortuary and Bereavement Service Manager	• Husband Neil Kaye and Step-son Toby Costa work for HUTH	N	19/07/2021	Entered 20/07/2021		RT reviewed
Kenney, Vicky	Business Manager	• Mother is a Housekeeper on Ward 100	N	14/04/2021	Entered 21/04/2021		RT reviewed
Ketley, Jo-Anne	Senior Administrator (Hull Day Surgery Unit)	• Nil Return	N	19/07/2021	Entered 20/07/2021		RT reviewed
Khalil, Modar	Consultant Neurologist	• Has a Directorship in a Ltd company through which private clinic is ran at the Spire Hospital • Undertakes private practice at the Spire Hospital	N	26/07/2021	Entered 27/07/2021		RT reviewed
Khan, Sujoy	Consultant Immunologist	• Nil Return	N	15/04/2021	Entered 21/04/2021		RT reviewed
Kolodziej, Magdalena	Research Nurse	• In a personal relationship with another staff member (Adam Wolstencroft) since June 2020	N	14/04/2021	Entered 20/04/2021		RT reviewed
Krebs, Helen	Clerical Officer	• Holds a Directorship for a company that has no interest in the NHS (no other details provided)	N	19/07/2021	Entered 20/07/2021		RT reviewed
Kumar, Maneesh	ST3 Neonates	• Budget Holder	N	29/09/2021	Entered 29/09/2021		RT reviewed
Kumar, Navit	Consultant Radiologist	• Undertakes private practice at Spire Hospitals	N	14/04/2021	Entered 21/04/2021		RT reviewed

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Lindstrom, Alexandra	Orthoptist	• Undertakes private practice perfoming Colorimetry Assessments for adult patients • Partner Aftab Magsud works for the Trust as an Orthoptist	N	17/11/2021	Entered 08/12/2021		RT reviewed
Lyons, Sean	Chairman	• Chair at West Nottinghamshire Further Education College, Mansfield • Daughter is a Student Nurse at Sheffield Hallam University since September 2021 • Trust Board member	N	24/11/2021	Entered 22/03/2022		RT reviewed
Mace, Thomas	Consultant Physician	• Parkinson's UK Excellence Network co-lead • Sits on the Parkinson's UK MDT Steering Group • Member of local governors for St John of Beverley Catholic Primary School	N	21/02/2022	Entered 21/02/2022		RT reviewed
Mace, Thomas	Consultant Physician	• Co-Clinical Lead for Parkinson's Excellence Network Yorkshire (Parkinson's UK) • Medical Representative for MDT Site Oversite Group for Parkinson's Excellence Network (Parkinson's UK)	N	15/08/2021	Entered 17/08/2021		RT reviewed
Macleod, Una	Non-Executive Director	• Is a Dean at Hull York Medical School - employed by University of Hull • Holds grants from Yorkshire Cancer Research and NIHR	N	01/03/2022	Entered 07/03/2022		RT reviewed
Maliakal, Paul	Consultant Neuroradiologist	• Director of Maliakal Ltd. used for private work done at the Spire • Honorarium paid by Medical Device Manufacturers for providing consultancy & proctoring work and lectures given in private time. These are mostly single event consultancies. • Undertakes private practice at the Spire Hospital	N	19/07/2021	Entered 20/07/2021		RT reviewed
Martine, Dr Dujardin	Consultant Radiologist	• Nil Return	N	29/07/2021	Entered 09/08/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Mason, Ann	Senior Project Manager	• Budget Holder	N	19/07/2021	Entered 20/07/2021		RT reviewed
Mathew, Verghese	Consultant Paediatrician	• Undertakes private practice at Spire Hospital on a weekly basis • Budget holder for Paediatric Research	N	10/11/2021	Entered 15/11/2021		RT reviewed
Melia, Brian	Head of Optometry	• Undertakes private practice as Locum Optometrist infrequently (one day last year)	N	19/07/2021	Entered 20/07/2021		RT reviewed
Messingham, Ellen	Optometrist Principle	• Undertakes private practice on adhoc basis providing locum cover in various primary care opticians since before starting in employment at HUTH	N	21/02/2022	Entered 21/02/2022		RT reviewed
Messingham, Ellen	Optometrist	• Undertakes private practice as a Locum	N	19/07/2021	Entered 20/07/2021		RT reviewed
Mizon, Julia	Deputy Chief Operating Officer (Elective Recovery and Cancer)	• Is a budget holder and/or Trust Board Member	N	01/03/2022	Entered 07/03/2022		RT reviewed
Morgan, Matthew	Honorary Consultant Nephrologist	• Non-executive director of York and Scarborough Teaching Hospitals NHS Foundation Trust since July 2020 • Deputy Dean of Hull York Medical School since February 2020	N	09/11/2021	Entered 28/03/2022		RT reviewed
Morgan, Matthew	Honorary Consultant Nephrologist	• Non-executive director of York and Scarborough Teaching Hospitals NHS Foundation Trust • Deputy Dean Hull York Medical School (membership of executive team, strategic planning group and management board)	N	14/04/2021	Entered 21/04/2021		RT reviewed
Morice, Professor Alyn	Profressor of Respiratory Medicine	• Holds a Directorship in Tussogenics Ltd - Company number 12237679 Incorporated on 01/10/19 • Receives multiple Grants & Sponsorship via the University of Hull	N	02/09/2021	Entered 13/09/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Morris, Kevin	Trauma and Orthopaedic Consultant	• Nil Return	N	09/11/2021	Entered 10/11/2021		RT reviewed
Moverley, Frances	Head of Freedom to Speak Up	• Sister Jennifer Moverley is Head of Compliance and Assurance at NLAG since July 2021, was previously a member of staff at HUTH (interest previously declared)	N	19/07/2021	Entered 20/07/2021		RT reviewed
Muddada, Dr Hinranmayi	Obs & Gynae Consultant	• Ownership in Trentcliff Private Clinics since 30/03/2021 • Planning to undertake private practice in the future	N	12/04/2021	Entered 20/04/2021		RT reviewed
Mumdzjans, Androniks	Consultant in Obstetrics and Gynaecology	• Undertakes private practice at the Spire Hospital • Wife Eviia Mumdzjans works at HUTH as Claims/Coroner inquest officer	N	19/07/2021	Entered 20/07/2021		RT reviewed
Murphy-Pittock, Daniel	Project Support Manager	• Married to Andrew Murphy-Pittock Head of Undergraduate Medical Education at HUTH	N	19/07/2021	Entered 20/07/2021		RT reviewed
Murtagh, Fliss	Honorary Consultant in Palliative Medicine	• NIHR Senior Investigator. Funding from NIHR grant HTA 15/57/39, from the European Commission (C-POS project 772635), and from Yorkshire Cancer Research (RESOLVE and TRANSFORM projects). Also from MRC (CovPall project MRC ref MR/V012908/1).	N	31/07/2021	Entered 09/08/2021		RT reviewed
Muthukumar, Nagarajan	Trauma and Orthopaedic Consultant	• Director of Limited Company (Muthukumar Limited) - incorporated in 2012. This company is mainly used for private practice with Spire Hospitals • Hold shares in Muthukumar Limited • Undertakes private practice at Spire Hull & East Riding Hospital for both private and Choose and Book appointments	N	09/11/2021	Entered 10/11/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Nearney, Simon	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	N	28/02/2022	Entered 22/03/2022		RT reviewed
Newman, Emilie	Senior Staff Nurse Haemostasis and Paediatric Immunology and Allergy	• Works at Pioneer Healthcare covering Paediatric Allergy Clinics on a weekend at Wilberforce House. This has been arranged through HUTH in an attempt to address and reduce the long waiting times for Allergy patients within the Trust.	N	30/04/2021	Entered 05/05/2021		RT reviewed
O'Brien, Paul	Deputy Chief Pharmacist	• Is a budget holder and/or Trust Board member	N	07/03/2022	Entered 07/03/2022		RT reviewed
Painter, Carron	Head of Cardiac Physiology	• Budget Holder	N	15/04/2021	Entered 28/04/2021		RT reviewed
Parker, Pamela	Consultant Sonographer	• President of the British Medical Ultrasound Society • Married to Mr Trevor Parker, Sonographer and Clinical Governance Radiographer at HUTH • Budget Holder	N	08/11/2021	Entered 10/11/2021		RT reviewed
Parker, Pamela	Consultant Sonographer	• President of the British Medical Ultrasound Society • Married to Mr Trevor Parker, Clinical Governance Radiographer at HUTH	N	19/07/2021	Entered 20/07/2021		RT reviewed
Pathak, Ashok	Non-Executive Director	• Is a budget holder and/or Trust Board Member • Is a Trustee of Cricket Beyond Boundaries	N	26/02/2022	Entered 07/03/2022		RT reviewed
Patmore, Jane	Consultant Physician in Diabetes and Endocrinology	• Husband Professor Russell Patmore works at HUTH	N	19/07/2021	Entered 20/07/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Patmore, Russell	Medical Director - Clinical Support Health Group	• Member of professional advisory board for Roche Pharmaceuticals, this involvement has been discussed with the Trust's CEO who has approved it • Wife is a Consultant in Diabetes at HUTH • Receives grants for research role at York University from charitable bodies such as CRUK, Bloodwise and Marie Curie as well as multiple grants for projects from pharmaceutical companies. These grants purely support the research activity of the Haematological Malignancy Research Network and do not conflict with role at the Trust • Is a budget holder	N	22/02/2022	Entered 22/02/2022		RT reviewed
Perkins, Daryl	Paediatric Respiratory Specialist Nurse	• District Manager for St John Ambulance Humber and East Riding District	N	19/04/2021	Entered 20/04/2021		RT reviewed
Purva, Dr Makani	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	N	21/02/2022	Entered 22/02/2022		RT reviewed
Railton, Jackie	Assistant Director of Strategy and Planning	• Daughter Emma Railton commenced as Bank Physiotherpist at HUTH 12/07/2021 • Budget Holder	N	19/07/2021	Entered 20/07/2021		RT reviewed
Ramirez Jimenez, Antonio Jose	Deputy Chief Pharmacist	• Nil Return	N	08/03/2022	Entered 09/03/2022		RT reviewed
Ramsay, Carla	Director of Operations - Emergency Medicine Health Group	• Civil Partner is employed by the Environment Agency (EA has a regulatory role for the Trust) • Trustee of The Warren Hull - youth work charity in Hull	N	15/11/2021	Entered 15/11/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Rayner, Ben	Consultant in Emergency Medicine Clinical Director of Emergency Medicine	• Occasional medical cover for Hull FC or at MKM Stadium • Paid work as Medical Incident Advisor for Yorkshire Ambulance Service	N	24/02/2022	Entered 07/03/2022		RT reviewed
Rayner, Ben	Consultant in Emergency Medicine Clinical Director of Emergency Medicine	• Undertakes private practice as a Medical Incident Advisor for YAS and also provides medical cover for Hull FC	N	19/07/2021	Entered 20/07/2021		RT reviewed
Robinson, Helen	Trainee Anatomical Pathology Technologist	• Daughter Jessica Robinson works full time at Blood Sciences HUTH since October 2021, previously worked as a Pathology Support Worker	N	09/11/2021	Entered 15/11/2021		RT reviewed
Robson, Mike	Non-Executive Director	• Non-Executive Director and Trustee of Hull Truck Theatre from September 2018 to present • Trust Board member	N	22/02/2022	Entered 22/02/2022		RT reviewed
Rostron, Suzanne	Director of Quality Governance	• Daughter works at HUTH as a HCA	N	04/03/2022	Entered 07/03/2022		RT reviewed
Ryabov, Ellen	Chief Operating Offier	• Budget holder and/or Trust Board Member	N	21/02/2022	Entered 21/02/2022		RT reviewed
Salvage, Dr David	Consultant Radiologist	• Undertakes 1-2 hours of private practice per week at Spire Hull & East Riding Hospital • Wife works for HUTH	N	22/02/2022	Entered 22/02/2022		RT reviewed
Salvage, Dr David	Consultant Radiologist	• Undertakes 1-2 hours of private practice per week at Spire Hull & East Riding Hospital • Wife works for HUTH	N	10/11/2021	Entered 15/11/2021		RT reviewed
Salvage, Dr David	Consultant Radiologist	• Undertakes 1-2 hours of private practice per week at Spire Hull & East Riding Hospital • Wife works for HUTH	N	28/07/2021	Entered 10/08/2021		RT reviewed
Salvage, Dr David	Consultant Radiologist	• Married to Mrs Salvage	N	14/04/2021	Entered 20/04/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Sauderson, John	Consultant Physicist	• Director of St John's (Drypool) Community Project, company number 05922835 • NHS Hull CCG awarded a grant of £23,600 to St John's Community Project spread over 5 quarters (01/01/20 - 31/03/2021) for a project entitled "Shedheads" for the benefit of "Lone Parents, Long Term Unemployed and Elderly in HU9 and surrounding area" • Brother works for Macmillan Cancer Support	N	10/11/2021	Entered 15/11/2021		RT reviewed
Sebok, Katalin	Lead Medicines Management Technician	• Director at Husbands company Cherry Brickwork Ltd since 20/03/16	N	22/02/2022	Entered 22/03/2022		RT reviewed
Sebok, Katalin	Senior Pharmacy Technician	• Co-director of Cherry Brickwork Ltd. Company number 10086847 founded 29/03/16	N	17/04/2021	Entered 05/05/2021		RT reviewed
Sellens, Stuart	Optometrist Specialist	• Undertakes two days a week in a community optometry practice providing sight tests under General Ophthalmic Services contract (Specsavers Beverley from 21/08/2016 until 03/09/2021; Onlookers Opticians, Driffield 04/09/2021 onwards) • Wife works as a Physician Associate for Priory Medical Group, York since October 2018	N	21/07/2021	Entered 26/07/2021		RT reviewed
Shariq, Ammar	IMT - Year 2	• Wife Mariyam Arif works at HUTH as a GPST-1	N	21/03/2022	Entered 30/03/2022		RT reviewed
Sharlotte, Scott	Biomedical Scientist	• Mother works in the Virology Department since 2011	N	26/07/2021	Entered 27/07/2021		RT reviewed
Smith, George	Vascular Consultant	• Provides Consulting and Lecturing work for Essity Medical	N	02/08/2021	Entered 01/09/2021		RT reviewed
Smithson, Jacquelyn	Consultant Gastroenterologist	• Nil Return	N	20/08/2021	Entered 24/08/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Smyth, Roger	Optometrist	• Director of Andrew & Rogers Optomestrists Beverley since 01/07/1998 • Undertakes private Optometry practice	N	22/02/2022	Entered 23/02/2022		RT reviewed
Smyth, Stephen	Acting Director of Operations, Medicine Health Group	• Budget Holder • Undertaking a one hour consultation with Merck Serono Ltd on 24/11/2021, this will be done on annual leave time	N	14/11/2021	Entered 15/11/2021		RT reviewed
Starr, Donald	Consultant Maxillofacial Surgeon	• Undertakes private practice at the Spire Hospital • Wife is a Practice Nurse with Ridings Medical Group	N	20/07/2021	Entered 20/07/2021		RT reviewed
Stephens, Andrew	CT Speciality Manager	• Bank Radiographer with Cobalt Healthcare • Married to Radiographer employed in general x-ray	N	03/08/2021	Entered 09/08/2021		RT reviewed
Stephenson, Shaun	Optomestrist Specialist	• Undertakes private practice as an Optomestrist at Specsavers, Kingswood, Hull • Specialist Optometrist for the York and Scarborough Teaching Hospital Trust	N	03/08/2021	Entered 04/08/2021		RT reviewed
Stones, Ben	Band 5 Biomedical Scientist	• Brother to commence employment in Biomedical Science at HUTH in August 2021	N	22/07/2021	Entered 26/07/2021		RT reviewed
Taylor, Amy	Senior Staff Nurse NICU	• Owns small Aesthetics Business, is a personal interest and not NHS linked. Opened business in January 2021.	N	24/10/2021	Entered 08/11/2021		RT reviewed
Taylor, Duncan	Director of Estates, Facilities & Development	• Director of Taywel Engineering Ltd and Hull Profile Cutting Ltd. Both businesses are run by son and family • Son is Band 5 Technician in Estates based at Sterile Services Unit	N	03/09/2021	Entered 13/09/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Thackray, Simon	Associate Medical Director for Cardiology	• Director of East Riding Cardiology, a Ltd company through which private practice is ran through • Undertakes private pratice at Spire Hospital and Medico-legal work • Wife is an employee of Boston Scientific but does not cover the geography of HUTH • Receives speaker fees from Boehringer Ingelheim, Astra Zeneca and Bayer PLC. These are payments for delivering CPD events to primary and secondary care.	N	14/01/2022	Entered 17/01/2022		RT reviewed
Thackray, Simon	Associate Medical Director for Cardiology	• Owner of East Riding Cardiology Ltd. through which private practice and medico-legal practice is processed. • Undertakes private practice at the Spire Hospital • Wife Melanie Thackray works for Boston Scientific who in turn supply catheter lab consumables to HUTH. Melanie has no interaction with the team who work with HUTH, no direct or indirect involvement and her remuneration is not linked to commercial activity with HUTH.	N	19/07/2021	Entered 20/07/2021		RT reviewed
Thomas, Craig	Senior Administrator	• Brother Jamie Watkin works for HUTH since January 2021	N	19/07/2021	Entered 20/07/2021		RT reviewed
Turner, Chris	Communications Officer	• Has ownership at Alexkatt Photography (Photographer) • Wife Kaye Turner, Auntie Ann Spence and Sister-in-law Carly Anderson all work for HUTH	N	20/07/2021	Entered 20/07/2021		RT reviewed
Vissamsetti, Bharat	Consultant Urologist	• Is planning to undertake private practice in the future • Wife Dr Muddada works for HUTH	N	20/08/2021	Entered 01/09/2021		RT reviewed
Vijayakumar, Oditta	Consultant Anaesthetist	• Undertakes private practice at Spire Hospitals and Pioneer Group	N	16/11/2021	Entered 08/12/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Ware, Kerry	Housekeeper	• Nil Return	N	23/07/2021	Entered 26/07/2021		RT reviewed
Watkins, Angela	Staff Nurse	• Undertakes private practice as Bank Staff at The Spire Hull & East Riding since 2016	N	21/02/2022	Entered 22/02/2022		RT reviewed
Webster, Nicola	Contract and Commissioning Manager	• Nadine Smith (Sister-in-law) accountant at University of Hull involved with Medical Department (HYMS)	N	12/04/2021	Entered 13/04/2021		RT reviewed
Whitton, Lisa	WISHH Charity Manager and Fundraiser	• WISHH Charity Manager – Hull Hospitals Official Charity • WISHH Charity operational cost budget holder	N	14/04/2021	Entered 21/04/2021		RT reviewed
Williams, Jennifer	Acting Lab Manager, Haematology & Blood Transfusion	• Husband Gareth Williams works for HUTH as a Clerical Officer in Central Pathology	N	14/04/2021	Entered 21/04/2021		RT reviewed
Wilmot, Rachel	Consultant Clinical Biochemist and Clinical Lead for Blood Sciences	• Is the Equality, Diversity & Inclusion Champion and therefore defacto Non Voting Board Member of the Association for Clinical Biochemistry & Laboratory Medicine	N	14/04/2021	Entered 20/04/2021		RT reviewed
Wood, Tim	Principal Physicist	• Undertakes private practice providing Scientific Consultancy and Software Development for Leeds Test Objects Ltd. since February 2016 • Wife works for York and Scarborough Teaching Hospitals as Occupational Therapist, soon to move to City Healthcare Partnership	N	06/01/2022	Entered 10/01/2022		RT reviewed
Wooler, Brendan	Consultant Surgeon	• Director of BPWMedical Ltd. since 2017 through which private practice is provided at Spire Hospital Hull and East Riding • Undertakes private practice at Spire Hospital	N	10/11/2021	Entered 15/11/2021		RT reviewed

Name	Title	Declaration	Conflict of interest or no conflict of interest?	Date declared	Comments	Date register reviewed	Action taken
Wright, Graham	Consultant Clinical Scientist/Head of Nuclear Medicine	• Wife Sallyann Wright is employed by HUTH as the Production Manager within the Molecular Imaging Research (MIRC) facility/radiopharmacy	N	23/07/2021	Entered 26/07/2021		RT reviewed
Wright, Sallyann	Production Manager MIRC	• Married to Graham Wright Head of Nuclear Medicine since 02/04/2019	N	09/11/2021	Entered 15/11/2021		RT reviewed
Wrightson, Rachel	Head of Finance	• Husband works for HUTH in Hdigital • Son works for HUTH in Clinical Admin	N	28/02/2022	Entered 07/03/2022		RT reviewed
Wrightson, Rachel	Head of Finance	• Trustee / Treasurer of local Scout Group • Husband Derek Wrightson works in H Digital at HUTH • Son Alex Wrightson works in Clinical Admin at HUTH • Brother-in-law Michael Brennan is a Mental Health Spec. Nurse at HUTH	N	08/11/2021	Entered 15/11/2021		RT reviewed
Yeap, Lay Leng	Consultant Obstetrician and Gynaecologist	• Nil Return	N	25/04/2021	Entered 27/04/2021		RT reviewed

Report to the Board in Public
Charitable Funds Committee May 2022

Item: Financial Report including Fund Balances	Level of assurance gained: Reasonable
The Committee agreed reasonable assurance. The committee received a comprehensive update the charities funds including the balance sheet. The committee discussed the legacy's and the ongoing work in health groups to identify the spending for the larger funds.	
Item: Project Director's Report	Level of assurance gained: Reasonable
The Committee agreed reasonable assurance. The committee received a comprehensive overview of the fundraising and the projects that it is supporting. The Project Director of Fundraising also provided an update on existing benefactor funded developments.	
The committee approved the following; • Pancreatic Research Project/Clinical Fellowship • Running Costs Budget	

Agenda Item		Meeting	Trust Board	Meeting Date	12.07.22
Title	Board Assurance Framework 2022/23 Q1				
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: • Agree the risks and ratings for 22/23

Hull University Teaching Hospitals NHS Trust
Trust Board
Board Assurance Framework 2022/23 Q1

1. Purpose of the Report

The purpose of the report is to present the 2022/23 Q1 Board Assurance Framework to the Trust Board.

2. Background

The Board Development session in April 2022 included a Board Assurance Framework workshop to review the current strategic risks and shape the 2022/23 risks in line with the Trust's strategic objectives.

The Board discussed and approved, in principle, the risks for 2022/23 at its May 2022 meeting.

In June 2022 each of the risks were discussed at the relevant Board Committee, for example BAF risks 4, 7.1, 7.2 and 7.3 which are the performance and finance risks were discussed at the Performance and Finance Committee.

3. Current Status of the Board Assurance Framework

An overview of the finalised 2022/23 Q1 Board Assurance Framework risks is provided in Table 1 below:

Table 1

Risk	Inherent Risk (L x I)	Current Risk (L x I)	Target Risk (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	4x5=20	4x4=16	3x4=12	Low
3.1 - Quality There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its 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 due to actions within the Trust's control. Crowding in ED, Patients with No Criteria to Reside and Mental Health patients require partnership working to determine improvement plans.	5x5=25	4x4=16	3x3=9	Low

Risk	Inherent Risk (L x I)	Current Risk (L x I)	Target Risk (L x I)	Risk Appetite
4 - Performance There is a risk to access Trust Services following the residual impact of Covid	5x5=25	4x5=20	4x4=16	Low
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	Moderate
6 – Research and Innovation There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment	4x4=16	3x4=12	2x4=8	Moderate
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 over the next 3 years of failure ofcritical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability	4x5=20	3x5=15	2x5=10	Moderate

Risk Appetite Matrix
The risk appetite matrix is included for information.

Appetite	None	Low	Moderate	High	Significant
Tolerance	Minimal – risks will not be taken	Low – very limited risks with no significant impact	Low/Medium – will take some risks but only with high probability of predicting the outcome	Medium – willing to take risks, innovate, invest to achieve the strategic objective	High – actively seeks out risks/opportunities, pursues innovation, invests
Target Risk Rating	Reduction planned/expected	Reduction planned/expected	Reduction planned/expected	Rating likely to stay the same in year	Rating may increase during the year

Table 2 shows the quarterly risk rating positions and will be updated after each quarter.

Table 2

BAF Risk	Inherent Risk	Q1 Position	Q2 Position	Q3 Position	Q4 Target Position	Target Risk Achieved
1	5x4=20	4x4=16			3x4=12	
2	4x5=20	4x4=16			3x4=12	
3.1	4x4=16	3x4=12			2x4=8	
3.2	5x5=25	4x4=16			3x3=9	
4	5x5=25	5x4=20			4x4=16	
5	3x4=12	3x4=12			2x3=6	
6	4x4=16	3x4=12			2x4=8	
7.1	5x4=20	5x4=20			3x4=12	
7.2	4x5=20	4x5=20			3x5=15	
7.3	4x5=20	3x5=15			2x5=10	

Each of the BAF risks excluding BAF risk 5 have been discussed at the relevant Board Committees. The following updates are for information:

BAF 1 – Culture
The risk ratings have increased due to the staff survey results and the Trust being in a worse position at the end of 2021/22.

BAF 2 – Workforce
The risk rating reflects the concerns around ward staffing and staff re-deployments The shortages of Midwives and Obstetricians was also a concern. There were also still a number of vacancies in hard to recruit areas such as Acute, Oncology,

Hematology and Radiology.

BAF 3.1 – High Quality Care
There will be a continuation of Quality Improvement programmes in 2022/23 such as; assurance visits, a Well-Led review at the Board Development in August and QSIR training (now the Trust is a faculty). Quality Improvement programmes will align with the Nursing Strategy and include collaborative working were possible.

BAF 3.2 – Harm Free Care
The risk has been re-scoped to include the management of Mental Health patients and patients with 'no criteria to reside'. Work is ongoing to agree the end of the enhanced surveillance measures in 2022.

BAF 4 – Performance
The risk has been re-scoped to include system wide capacity, patients with no criteria to reside as part of the recovery planning.

BAF 5 – Partnerships
The risk has been re-scoped to include development and support of the Integrated Care System and collaborative working. Programmes 2 and 3 are underway, as is the expression of interest to be included in the National Hospital Programme.

BAF 6 – Research and Innovation
The risk has been re-scoped to include the issue relating to the lack of investment which would mean that the Research and Innovation support service is not delivered to its full potential.

BAF 7.1 – Finance
The finance risk relating to achieving the financial plan for 2022/23 has been added to the BAF. The plan assumes a break-even position at year-end.

BAF 7.2 – Underlying Financial Position
The risk is the same as the previous year and system wide financial objectives and shortfalls in CRES will be considered. Although system wide objectives will be considered the risk is linked to the Trust's underlying financial position only.

BAF 7.3 - Capital
The capital risk has been re-scoped to cover the longer term plans to replace the core infrastructure, linking it to the Integrated Care System and the risk of not being placed on the National Hospital Programme.

The in-year capital planning risk will be placed on the Corporate Risk Register for review.

4. Timetable for reporting
Each BAF risk will be reviewed monthly following the Committee meetings by the Head of Corporate Affairs. Q2 updates will be presented to the Committees at the end of October and to the Board in November 2022, Q3 updates will be presented to the December Committees and the Board in January 2023 and Q4 updates will be presented to the March Committees and the May Board.

5. Recommendation
The Board is asked to:

- Approve or amend the risks and ratings included in the BAF for 2022/23.
- Decide if any further assurance is required.

Rebecca Thompson
Head of Corporate Affairs
July 2022

Strategic risk: Culture
Risk Appetite: Low
Risk: Failure to improve a positive working culture

Strategic Objective: Honest Caring and Accountable Culture
Executive Lead: Chris Long
CQC Domain: Well Led

Assurance Committee: Workforce, Education and Culture

Enabling Plan: People Strategy

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: Improving Culture **Condition:** The Trust does not make progress towards further improving a positive working culture this year. **Cause:** Staff behaviours Low staff engagement Workforce engagement with ICS/HASR **Consequence:** Trust unable to achieve Outstanding CQC rating and Well Led domain	Trust People Plan 2019/22 approved and in place Work being carried out around recruitment and retention 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	Delays in delivering the People Plan due to the pandemic Staff survey – engagement scores have reduced	**Management assurance:** Workforce, Education and Culture Committee Workforce Transformation Committee Rise and Shine programme – emerging leaders to commence 2021/22	**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 2022	1.Series of virtual exec-led focus groups x 10 (March/April) 2.Staff survey results presented at HG business meetings (March) 3.Launch bi-monthly staff forum (Link Listeners – from April) 4.Run Barrett Values survey (late March) 5.Exec-led manager briefing/feedback sessions (May/June) BAME networking event (June) Zero tolerance policy launch (Q1)	Q1 Barratt Values Survey rolled out Executive-led manager briefing sessions held Staff Survey Board Development Session in June 2022
Risks from Risk Register:			**Metrics** Performance against People Strategy Quarterly and National Staff Survey Results People Report monitoring/ Board and Workforce committees	**Outcomes:** Established BAME network Diversity in recruitment implemented		
			Independent / semi-independent: NHSE/I CQC Internal Audits			

Inherent risk			Risk as at 30.06.22 (Q1)			Planned target risk position by 31/3/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	4	4	16	3	4	12

Strategic theme: Workforce Risk Appetite: Low Risk: Failure to manage 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, both quantitative and quality of staff, across the Trust Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand **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 Freedom to speak up	Medical staffing levels including Junior Doctors Variable (agency and overtime) pay Absence of WiFi in educational buildings Maintenance of time for training for both trainees and trainers in the light of service recovery Sickness/absence levels	**Management assurance:** Monitoring of Workforce assurances through the Workforce Transformation Committee and Workforce Education and Culture Committee Vacancy position reported in every Board meeting Obstetric workforce risk – 3 consultants recruited	**Gaps:** Certain medical specialities struggle to recruit due to national/international shortages Managers thinking innovatively about new roles to new ways of working (ACP/PA)	People Plan People Strategy Refresh Q2	There are currently 43 Trainee Nursing Associates (TNA), with 19 due to finish the programme in May July 2022, and a further 3 who will finish in September 2022. The Trust has recently appointed a RNA Nurse Educator who is providing pastoral support and gaining an understanding of what is working well and where improvements need to be made for this group of Staff. Work has commenced in developing a mechanism to triangulate the actual and required CHPPD, (which is determined through identification of the patient acuity and dependency levels using the SNCT), for all inpatient areas and ED in conjunction with the harm rates, red flags, staff training and engagement for all areas where the required CHPPD is greater than the actual. It is envisaged that this information will support the Nurse Directors to proactively identify `High Risks` areas and required action. This information will be presented in future reports in conjunction with the following factors/mitigation implemented to mitigate the identified risk.
	Risks from Risk Register: 3990 - Shortage of staff is a serious issue in the			**Metrics** Staff Survey People Performance Report	**Outcomes:** Vacancy rates reduced – 4.4%		

	department of cardiothoracic surgery 3044 – Consultant Pathologist shortages (Breast Pathology)			**Independent / semi-independent:** CQC NHS England/Improvement Internal Audits	Sickness levels reduced 3.96% Improved Staff Survey results		

Inherent risk			**Risk position as at 30.06.22 (Q1)**			**Planned target risk position by 31/3/2023**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	4	16	3	4	12

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 quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its 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 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 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	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	**Management assurance:** Reports to Quality Committee Quality/outcome data Self-assessments Infection Control Annual Report Quality Accounts Associate Director of Quality appointed Operational Risk and Compliance Committee Learning from Deaths Reports	**Gaps:** Quality Risk Profile – Patient flow and the Trust's waiting list **Assurance:** Structured framework for the assessment of Dementia patients in relation to falls is now in place	Q1 Trust to become Accredited QSIR Faculty Quality Strategy Launch Aim to be in a stable position, with agreed tolerance limits by July 2022. This would mean a sustainable case load of 35 open Serious Incidents at any time 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 To continue to review patient harms at the Weekly Patient Safety Summit Implementation of the Patient Safety Incident Response Plan	Q1 QSIR Faculty established Learning from Deaths – Mortality and Morbidity review in Oncology– a number of actions now in place following lessons learned Sepsis Quality Improvement plan in place – June 2022 Implementation of Purpose T and individualising the skin integrity plan of care Quality Strategy Launched Falls task and finish group established
Risks from Risk Register: 3460 - Availability of Radiology Support for Paediatric & Neonatal Services. 3282 - Failure in the Trust systems to ensure requested test results, pathology and radiology, are reviewed &			**Metrics** National Audit Benchmarking Harm Free Care Patient Experience Survey **Independent / semi-independent:**	**Outcomes:** 2 Never Events reported in Q1 No Regulation 28 reports in Q1 Reduction in Serious Incidents backlog =75 in June 2022		

	actioned by the requester 3450 - There is a risk of increased pressure damage to patients due to failing or lack of pressure relieving mattresses			CQC inspections Internal audits External reviews (e.g. NHSEI)	Falls harm Pressure Ulcers			

Inherent risk			**Risk position as at 30.06.22 (Q1)**			**Planned target risk position by 31/3/2023**		
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: QualityCommittee
Enabling Strategies/Plans: Recovery Plan & Work-streams, PatientSafety

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 due to actions within the Trust's control. Crowding in ED, Ambulance handovers, Patients with No Criteria to Reside and Mental Health patients require partnership working to determine improvement plans. **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 CHCP Community Beds Patient Access Team Weekly Patient Safety Summit Quality Strategy Integrated Performance Report Mental Health Strategy Cardiology staffing Falls adherence to NICE guidance CG161	Clinical Harm Reviews – not possible to review every patient Crowding in ED/Flow Radiology capacity issues 104 week waits performance 52 week waits performance Ophthalmology experiencing a delay in meeting outpatient appointments Cardiology staffing – plan for 4 wte HUTH and 4wte NLAG Obstetrics staffing The ED targets and the ambulance handover times Patients with no criteria to reside CHCP Bed model still being agreed Mental Health Strategy to be approved	**Management assurance:** Reports to Quality Committee Clinical harm data and reports Performance Reports to the Performance and Finance Committee CHCP Community Beds Source Group PTL validation Patient Access Team in place to support Mutual Aid and Concierge service Text validation to commence end of June 22 Choice letters / offers of alternative provider Performance and Activity meeting with the Health Groups to review patient harm. ED – Intentional rounding, EPIC reviewing ambulance handovers, safety briefings	**Gaps:** Diagnostic waiting times GP Capacity and increased referrals The RTT trajectory	Q1 Mental Health Strategy Quality Strategy Increase in CHH elective capacity – NCTR ward reconfiguration Mutual aid in place with NLAG, York, Scarborough, Rotherham, South Tees, HCA London and Mid-Yorks Independent sector activity – One Health, Spire, St Hugh's Insourcing capacity in place with Pioneer and Medinet CHCP contract to secure home care packages to enable patients to be discharged Quality Strategy ambition – increase harm-free care in the following areas: hospital, acquired pressure ulcers, Catheter associated UTI, avoidable VTE, reduction harm from falls, medication errors Roll out of PSIRP and patient safety improvement programmes Implement QI Programme to listen, learn and act from patients' perspectives – patients and staff feedback forum Always Events to be developed Falls task and finish group – organisational strategic action plan National Falls Prevention week 19th-24th September 2022	Q1 Quality Strategy Launched Access Policy updated and ratified Quality Strategy milestones year 1 – Increase proportion of harm-free incidents, become accredited QSIR faculty/academy

	Risks from Risk Register: 2675 - Insufficient capacity within Radiology to accommodate increasing demand		**Metrics** Patient Safety incidents Waiting list numbers Reduction in Trust preventable infections and complications	**Outcomes:** 12 hour Trolley Breaches daily average in June 2022 = 18 ED Breaches average June = 66 (admitted), 116 (discharged) RTT list size 69556 (May 2022) Slight increase in the number of Incidents, PALS and Complaints received in response to delays in treatment	
			Independent / semi-independent: CQC inspections Internal audits – Waiting lists, recovery included in schedule Positive feedback from ECIST visit May 2022		

Inherent risk			**Risk position as at 30.06.22 (Q1)**			**Target risk position by 31/3/2023**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	4	4	16	3	3	9

Strategic Theme: Performance
Risk Appetite: Low
Risk: access to Trust services

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

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 **Condition:** 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** **Risks from Risk Register** Crowding in the Emergency Department Insufficient capacity within Radiology to accommodate increasing demand	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 Patients with NCTR Ambulance handovers Cancer performance deteriorating – June 2022 (diagnostics) 12 hour trolley wait standard changed to 12 hours from arrival in ED leading to an increase in breaches.	**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 **<u>Metrics</u>** Health Group recovery plan trajectories **<u>Independent / semi-independent:</u>** 1. NHSE/I 2. CQC 3. Internal Audit 4. External Audit	104 week wait performance improving – June 2022 Revised Trust trajectory agreed with NHSE on 19th May 2022: 30/06/2022 no worse than 127 31 July 2022 x 36 (was 56) 31 August 2022 x 25 (was 32) 30 September 2022 x 9 (was 13) 31 December 2022 x 0 (was 0) Waiting list increasing 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 Orthodontic Quarter 1 referral information sent to Regional Clinical Lead for triage and assessment of appropriateness of secondary care intervention **<u>Outcomes:</u>** Waiting list increasing 69556 (May 2022) 104 week wait expected	May 2022 - Paediatric pathway reviewed – action plan in place to reduce the time to entry via an alternative route. A further test of change in initial assessment will begin in June with Crews 'pinning out' in the cubicle rather than having to go to a separate screen this will act as the intermediary step while awaiting the EPR interface to automate the data capture. Work with partners continues to reduce the level of 'no criteria to reside' patients and improve flow Increased focus and support to reduce the 104-week risks to zero and to ensure a position which is no worse than 127 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 specialties in regards to cancer, P2 and 104-week risks from May 2022 – supported by focused changes to the theatre programme Targeted specialty 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 6-7%; 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	Q1 Single Point of Access for discharge operational – to reduce the number of rejected/diverted referrals Increased focus on compliance with Safer to enable effective tracking of discharges Pathway 0 patients now escalated to HG NDs ECIST Visit May – positive feedback received Full validation of risks to end of June 2022 complete – small number of removals Progressing mutual aid support from providers within and without of H&NY ED workshop to review processes took place in June 2022 Multi-disciplinary ESDEC pilot to be carried out in July – similar to 'Perfect 10'

					performance no worse than 127 (June 2022)	primarily involved with pathway management A process of text validation on 31,000 pathways will commence at the end of June 2022 delivered by Healthcare Communications. This process will focus on patients confirming whether they still require treatment. Elective Intensive Support Team (IST) visit on 26th and 27th May 2022	

Inherent risk			**Year-end risk position as at 30.06.22 (Q1)**			**Planned target risk position by 31/3/2023**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	5	5	20	4	4	16

Strategic Theme: Strategy
Risk Appetite: Moderate
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 and Humber Acute Services programme 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	Acute Workforce Maternity models Models delivering improvements for Constitutional and Clinical standards Assurance Reviews Digital enablers	Delays and timing of implementation of services/deliverability of models Impact of Ockenden Out of hospital programme at various stages of development Do not get on NHP shortlist for capital funding The funding earmarked for NHP Pathfinder schemes has been reduced since they were announced, the approach to design and construction has changed (more standardisation) and funding allocation for Business Cases reduced to £1m Timescales for delivery are increasing – new NHP schemes may not be able to complete until 20230-35	**Management assurance:** Bi-monthly reports detailing progress to the Committees in Common Joint Board meeting in July 2022	**Gaps:** Out of hospital care Impact of displacement to neighbouring areas/systems Travel and accessibility of services Cost and resourcing of multiple business cases Cost of external support e.g financial and legal Political challenge Lack of ability to influence	Humber Acute Services Review/ICS System wide workforce modelling Links with Universities/training and development Rotational Posts/new skills Work streams being established Mapping of dependencies/re-scoping of capital plans Alternative sources of funding being reviewed Development of project level OBCs and FBCs EOI submitted to National Hospitals programme (Sept 2021)	Wide ranging engagement programme in place including: models of care design, travel and access, workforce, out of hours and digital
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 National Hospitals Programme		

Inherent risk			Year-end risk position as at 30.06.22 (Q1)			Planned target risk position by 31/3/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
3	4	12	3	4	12	2	3	6

Strategic theme: Research and Innovation
Risk Appetite: Moderate
Risk: Lack of investment in R&I leading to delivery issues

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

Executive Lead: Prof M Purva | **Enabling Plan: Research and Innovation Strategy**

CQC Domain: Safe

Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales
Strategic risk: Research and Innovation There is a risk that R&I support service is not delivered operationally to its full potential due to lack of investment **Cause:** Funding is unavailable Consequence: Impact on R&I Investment Impact on R&I capacity Risks from Risk Register: No risks highlighted	Strengthened partnership with the University of Hull Infection Research Group ICS Research Strategy	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 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.	**Management assurance:** Successful portfolio of Covid studies managed in 2020/21 2316 patients involved in clinical research as at August 2021 Continuing working with HYMS and the ICS **Metrics** Recovery Activity R&I Capacity **Independent / semi-independent:** NHS E/I HASR CQC ICS	**Gaps:** Scale of ambition vs deliverability Current research capacity hampered due to the recovery plan Funding availability 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. **Outcomes:** Number of consultants with protected R&I time	(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. Additional investment is a priority for 2022/23	Q1 – continue to risk-assess the balance of investment in R&I capacity and other competing priorities. Continue to support research Collaborations as a leading partner in the Humber and North Yorkshire Health and Care Partnership

Inherent risk			Risk position as at 30.06.22 (Q1)			Planned target risk position by 31/3/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

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

Strategic Objective: Financial Sustainability — **Assurance Committee: Performance and Finance Committee**
Executive Lead: Chief Financial Officer
CQC Domain: Effective — **Enabling Strategy: Financial Plan 2022/23**

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 Funding for a further NCTR ward from May onwards	Ongoing development of accountability of Health Groups – further improvements required Gap in identified CRES schemes and required level Month 2 £3.4m deficit due to non-delivery of the Elective Recovery Fund and unidentified CRES EF&D have shortfalls on catering and car parking income which have not returned to pre-Covid levels MHG financial pressure due to NCTR wards remaining open in Q1	**Management assurance:** Performance Committee and Boards Finance Performance Reviews with Health Groups	**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 Junior Doctor operational pressures Continuity of Care Locums in Clinical Support (Oncology and Haematology) Lung Health check	ICS balanced plan in place – June 2022	No national reporting at month 1 due to the plans being finalised Mon 2 - £3.4m deficit due to the non-delivery of the ERF and unidentified CRES
Risks from Risk Register:			**Metrics** 1. Run rate 2. I&E position 3. CRES position 4. Activity performance against plan 5. Cash flow	**Outcomes:** 1. Achieve Board approved financial plan 2. Achieve financial control total at Trust and system level		
			Independent / semi-independent: 1. NHSE/I 2. CQC 3. Internal Audit 4. External Audit 5. Local Counter Fraud Specialist			

Inherent risk			Year-end risk position as at 30.06.22 (Q1)			Planned target risk position by 31/3/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	5	4	20	3	4	12

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

Strategic Objective: Financial Sustainability **Executive Lead: Lee Bond** **CQC Domain: Effective**			**Assurance Committee: Performance and Finance** **Enabling Plan: Financial Plan 2022/23**			
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 Impact of Covid-19 finances and recovery planning **Consequence:** The Trust does not achieve its Financial Plan or make efficiency savings	Financial Plan NHS Finance sees performance being measured at a system (ICS) level CRES Schemes Balanced Financial plan	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 CRES delivery HNY ICB financial position of £56.2m deficit - Trust deficit £14.2m	**Management assurance:** Regular update reports to the Performance and Finance Committee NHSEI review of the NHS financial position includes £1,605m for additional inflation funding, ambulance funding, commissioner side pressures and specific issues to be targeted.	**Gaps:** Expenditure pressures of £0.5m, mainly driven by the CRES shortfall in all HGs EF&D shortfall includes energy CRES of £218k	Ongoing development of accountability of Health Groups	Q1 Deficit of £0.4m at month 2 mainly driven by unidentified CRES System to deliver a balanced financial plan after extra NHS Funding – smoothing adjustments to be made HNY ICB has an indicative share of the additional NHS funding, reducing the planned deficit to £24.5m
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:** Risk on elective recovery income CRES delivery		

Inherent risk			**Year-end risk position as at 30.06.22 (Q1)**			**Planned target risk position by 31/3/2023**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	3	5	15

Strategic Objective: Financial Sustainability
Executive Lead: Lee Bond
CQC Domain: Effective

Assurance Committee: Performance and Finance

Enabling Plan: Capital Plan 2022-2025

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

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 over the next 3 years 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. Partially dependent on HASR Capital EOI funding No additional capital allocation outside of ICS CDEL 2022/23 assumes 'do minimum' position **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	Supplier price increases and delays to building works to be managed Energy and Decarbonisation funding not yet secured Schemes that sit outside of the capital programme - 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.	**Management assurance:** Monthly updates to the Performance and Finance Committee Regular updates to the Board	**Gaps:** Building works impacting on patients and staff Delays in Day Surgery Unit Impact of IFRS 16 – expected CDEL cover totaling £0.97m	Capital Plan Digestive Suite, Phase 1 Theatres Updgrade at CHH completing Phase 1 of Day Surgery Scheme Backlog maintenance target set at £5.3m Planned capital expenditure for 2022/23 is £33.9m	Q1 Month 2 Capital expenditure position is £0.96m against a plan of £1.91m
Risks from Risk Register: In year achievement of the Capital plan			**Metrics** Capital performance and expenditure against the plan **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:** Front Entrance Build Day Surgery Theatres CHH		

Inherent risk			Year-end risk position as at 30.06.22 (Q1)			Planned target risk position by 31/3/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	3	5	15	2	5	10

Appendix 2 – Actions taken, planned and draft assurance ratings

BAF Risk 1	**Honest Caring and Accountable Culture** The Trust does not make progress towards further improving a positive working culture this year. **Inherent 5x4=20** **Current 4x4=16** **Target 3x4=12**			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
1.Series of virtual exec-led focus groups x 10 (March/April) 2.Staff survey results presented at HG business meetings (March) 3.Launch bi-monthly staff forum (Link Listeners – from April) 4.Run Barrett Values survey (late March) 5.Exec-led manager briefing/feedback sessions (May/June) BAME networking event (June) Zero tolerance policy launch (Q1)				

BAF Risk 2	**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 4x5=20** **Current 4x4=16** **Target 3x4=12**

Q1 Actions	Q2 Actions	Q3 Actions	Q4 Actions	Year End Position
There are currently 43 Trainee Nursing Associates (TNA), with 19 due to finish the programme in May July 2022, and a further 3 who will finish in September 2022. The Trust has recently appointed a RNA Nurse Educator who is providing pastoral support and gaining an understanding of what is working well and where improvements need to be made for this group of Staff. Work has commenced in developing a mechanism to triangulate the actual and required CHPPD, (which is determined through identification of the patient acuity and dependency levels using the SNCT), for all inpatient areas and ED in conjunction with the harm rates, red flags, staff training and engagement for all areas where the required CHPPD is greater than the actual. It is envisaged that this information will support the Nurse Directors to proactively identify `High Risks` areas and required action. This information will be presented in				

future reports in conjunction with the following factors/mitigation implemented to mitigate the identified risk.				

BAF Risk 3.1	**High Quality Care** There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of an 'outstanding' rating. Inherent Risk: 4x4=16 Current Risk: 3x4=12 Target Risk: 2x4=8

Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
Q1 QSIR Faculty established Learning from Deaths – Mortality and Morbidity review in Oncology– a number of actions now in place following lessons learned Sepsis Quality Improvement plan in place – June 2022 Implementation of Purpose T and individualising the skin integrity plan of care Quality Strategy Launched				

BAF Risk 3.2	**High Quality Care** There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED, Ambulance handovers, Patients with No Criteria to Reside and Mental Health patients require partnership working to determine improvement plans. Inherent Risk: 5x5=25 Current Risk: 4x4=16 Target Risk: 3x3=9			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
Q1 Quality Strategy Launched Access Policy updated and ratified Quality Strategy milestones year 1 – Increase proportion of harm-free incidents, become accredited QSIR faculty/academy Dementia and Delirium Strategy approved Falls Task and Finish Group established Backlog of Serious Incidents reduced to 75				

BAF Risk 4	**Great Clinical Services** There is a risk to access to Trust services 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**
Q1 Single Point of Access for discharge operational – to reduce the number of rejected/diverted referrals Increased focus on compliance with Safer to enable effective tracking of discharges Pathway 0 patients now escalated to HG NDs ECIST Visit May – positive feedback received Full validation of risks to end of June 2022 complete – small number of removals Progressing mutual aid support from providers within and without of H&NY				

BAF Risk 5	**Partnerships** There is a risk to the development of the ICS and HACR due to recovery constraints Inherent Risk: 3 x 4 = 12 Current Risk: 3 x 4 = 12 Target Risk: 2 x 3 = 12			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
Wide ranging engagement programme in place including: models of care design, travel and access, workforce, out of hours and digital System wide workforce modelling Links with Universities/training and development Rotational Posts/new skills Work streams being established Mapping of dependencies/re-scoping of capital plans Alternative sources of funding being reviewed Development of project level OBCs and FBCs EOI submitted to National Hospitals programme (Sept 2021)				

BAF Risk 6	**Research and Innovation** There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment Inherent Risk: 4x4=16 Current Risk: 3x4=12 Target Risk: 2x4=8			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
Q1 – continue to risk-assess the balance of investment in R&I capacity and other competing priorities. Continue to support research Collaborations as a leading partner in the Humber and North Yorkshire Health and Care Partnership				

BAF Risk 7.1	**Financial Sustainability** Expenditure incurred exceeds income by greater than agreed control total Inherent Risk: 5 x 4 = 20 Current Risk: 5 x 4 = 20 Target Risk: 3 x 4 = 12			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
No national reporting at month 1 due to the plans being finalised Mon 2 - £3.4m deficit due to the non-delivery of the ERF and unidentified CRES ICS balanced plan in place – June 2022				

BAF Risk 7.2	**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**
Deficit of £0.4m at month 2 mainly driven by unidentified CRES work ongoing with HGs System to deliver a balanced financial plan after extra NHS Funding – smoothing adjustments to be made HNY ICB has an indicative share of the additional NHS funding, reducing the planned deficit to £24.5m				

BAF Risk 7.3	**Financial Sustainability** Failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability Inherent Risk: 4 x 5 = 20 Current Risk: 3 x 5 = 15 Target Risk: 2 x 5 = 10			
Q1 Actions	**Q2 Actions**	**Q3 Actions**	**Q4 Actions**	**Year End Position**
Capital Plan Digestive Suite, Phase 1 Theatres Updgrade at CHH completing Phase 1 of Day Surgery Scheme Backlog maintenance target set at £5.3m Planned capital expenditure for 2022/23 is £33.9m				

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

Appendix 3

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

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

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

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

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

Agenda Item	8	Meeting	Trust Board	Meeting Date	12 July 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:

- Review the quality data provided and decide if sufficient assurance has been received
- Decide if any additional information would be useful at Board level in terms of quality indicators and information

1. QUALITY ACCOUNTS

Following final approval at the Quality Committee, the Quality Accounts were published in line with legal requirements by 30 June 2022. The quality priorities for 22/23, which are all aligned to the Quality Strategy 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 Continuous Quality Improvement Team will work with and support the project leads in delivery of the priorities, providing quarterly reports to the Patient Safety and Clinical Effectiveness Committee for information, escalation and action and to the Quality Committee for assurance.

2. CQC

2.1 IR(ME)R Inspection

The CQC Ionising Radiation (Medical Exposure) Regulations (IRMER) inspection team conducted a routine inspection of the Neurointerventional Department at Hull Royal Infirmary on 14 June 2022 and the Radiotherapy Department at Castle Hill Hospital on 15 June 2022. Immediate feedback from the inspection confirmed that there were no enforcement actions required and no major concerns were identified. The CQC identified some areas of good practice for sharing with other organisations via its annual report. This was a positive inspection for the team.

On 01 July 2022, the Trust received the draft IR(ME)R inspection reports to be checked for factual accuracy and any inaccuracies identified within 10 working days. This will then inform the release of the final report for wider dissemination. The draft reports also confirm that the Trust has received no regulatory or enforcement action; however as with every inspection, there are always areas to improve on, these are highlighted in the report and the service have 6 weeks to provide the improvement plan to the CQC IR(ME)R team. The service are in the process of developing the plan as required.

2.2 Internal Assurance Programme

An internal assurance schedule of peer reviews, well-led assessments, staff focus groups and lead presentations has been established to provide the Trust with a continuous assurance and improvement programme for all core services and key fundamental standards. This mirrors aspects of the CQC methodology and includes external peer review members for each visit. In addition to providing assurance and identifying areas that could be improved, these visits also provide staff with experience of the process and helps to determine if the Trust is providing services that are safe, effective, caring, responsive and are well-led to achieve the best possible outcomes for our patients, their relatives/carers and our staff. The assurance work focuses on identifying the good practices/what is working well to celebrate success and inform learning, highlight the areas of improvement and apply a quality improvement approach to making the required sustainable changes where appropriate.

There are a number of streams to achieving full assurance for the Trust as part of the plan; these have been broken down into three categories, as detailed below:

- Fundamental Standard Presentations and Reviews – This part of the assurance plan focuses on all the key areas of Safe, Effective, Responsive and Well-led (Governance) e.g. Safeguarding, Incident Management, Nutrition and Staffing etc. It is conducted via

desk-top reviews of intelligence gathered against the key lines of enquiries and with presentations from the relevant leads with improvement work undertaken as agreed.
- Core Service Assurance Visits and Well-led Assessments – This focuses on undertaking unannounced visits to the clinical areas within the core services, e.g. Maternity, ED, Critical Care etc. to observe practice in the ward areas, undertake documentation reviews and speak with staff and patients regarding their experiences of the service. This also include desk-top reviews of intelligence gathered against the key lines of enquiries, focus groups with staff and a well-led assessment and interviews with the Triumvirates and other key leaders of the services.
- Trust-level Assurance Assessments – This part of the plan focuses on the overall Trust-level Well-led assessment and Board sessions, regulatory reviews, learning from others, registration and compliance with the statutory notifications to the CQC.

The assurance plan was piloted in November and December 2021 with full roll out from April 2022. There was a delay rolling the full programme out due to COVID-19 and the redployment of staff. However, the plan is still on track to be delivered during 2022 as set out. A significant amount of assurance work has already been undertaken as detailed below:

Assurance visits and well-led assessments:

- Maternity
- Children and Young People
- Medicine
- Surgery
- Outpatients
- ED

Fundamental Standard presentations have also been provided from:

- Safeguarding adults and children (two presentations; initial and then a follow up)
- Infection, prevention and control
- Falls
- Dementia
- Patient Experience
- Deteriorating Patient
- Nurse staffing
- Committee functioning
- Freedom to speak up
- Managemrnt of risks, issues and performance
- Policies and procedures
- National and Local Audit – clincial audit and effectiveness
- Information management
- Claims
- HR and Organisational Development
- Nurse Revalidation
- Medicine Management
- Nutrition and hydration

There has been a good level of assurance and feedback received from all key areas so far with some good practices highlighted (what is working well) along with areas for improvement (even better if) identified. All services have received initial feeabck following the visits and full feedback will be provided following the completion of all the well-led activities. Some key high level highlights are detailed as follows for the Board's information:

What is working well:

- Patients have provided very positive feedback regarding the staff caring from them, staff are very
- Safeguarding practices
- The Birthing Centre was described as 'inspirational' by our external assessor
- Excellent multi-disciplinary team working
- Compliance with IPC practices across all areas
- Outstanding work been undertaken regarding Nutrition and hydration led by Nutrition Nurse Specialist
- Dementia Boards implemented in DME
- Staff were very patient focussed with some examples of staff going above and beyond for their patients

Even better if:

- Improved staff morale - staff morale was variable across the areas with staff feeling low and burnt out
- Improved learning from events – not all staff were aware of incidents/SIs/Complaints and the learning from these
- In date information – Most areas had out of date leaflets, posters, inconsistent IPC messages and were displaying the old Trust logo
- Feeling listened to – staff felt they were able to raise concerns but didn't always feel listened to or that action was taken
- Completed Health and Safety checks and risk assessments

2.3 Well-led Self-Assessment

In August 2021, a Board Development Session was undertaken to complete the Trust well-led self-assesment. The KLOE were reviewed with the evidence and assurance available with areas for improvement and overall ratings. Overall ratings are as follows.

KLOE	Rating
KLOE W1 - Is there the leadership capacity and capability to deliver high quality, sustainable care?	Amber/Green
KLOE W2 - is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?	Amber/Green
KLOE W3 – Is there a culture of high-quality, sustainable care?	Was not rated
KLOE W4 – Are there clear responsibilities, roles and systems of accountability to support good governance and management?	Amber/Green
KLOE W5 – Are there clear and effective processes for managing risks, issues and performance	Green
KLOE W6 – Is appropriate and accurate information being effectively processed, challenged and acted on?	Green
KLOE W7 - Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?	Amber/Green
KLOE W8 – Are there robust system and processes for learning, continuous improvement and innovation?	Amber/Green

As part of the ongoing internal assurance work the next Trust well-led self assessment as part of the Board Development session in August 2022.

3. SERIOUS INCIDENTS

A total of 19 serious incidents were reported in May and June 2022; 11 in May and 8 in June.

There was 1 Never Events recorded in May 2022 which was a repeat event concerning administration of local anaesthetic to an incorrect digit. The investigation is still being

undertaken but will focus on the learning from the actions from the previous similar Never Event. The Never Event did not cause harm to the patient.

The categories of each serious incident reported are shown below:

Diagnostic incident *(including delayed diagnosis)*	4
Slips,trips,falls	4
Sub-optimal care of the deteriorating patient	4
Treatment delay	3
Maternity/obstetric incident	2
NEVER EVENT: Wrong site surgery	1
Category 4 Pressure ulcer	1

44 serious incident investigations were completed during May and June 2022.

A thematic review of inpatient falls resulting in a fractured neck of femur consisting of 11 serious incidents was completed. Themes included; lack of close observation of patients at risk of falls, contributory factors included staffing pressures from increased numbers of patients and increased acuity. Failure to recognise medications which contribute to risk of falls was also a factor. The majority of patients were from the medical elderly wards.

11 of the completed investigations were de-logged from serious incident status with agreement from the Clinical Commissioning Group; this was due to the investigation concluding that the patient did not come to harm as a result of the incident. 4 of the serious incidents found that although the patient had experienced delays within the Emergency Department, the delays were because their condition had deteriorated and their care plan changed which meant they were cared for and treated in the most appropriate setting.

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.

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. CONTINUOUS QUALITY IMPROVEMENT (CQI)

The CQI team launched its CQI Academy at the beginning of May 2022 after successfully becoming an accredited Quality, Service Improvement and Redesign (QSIR) Faculty. The Trust was granted accredited faculty status after candidates completed an intensive assessment process lead by NHS England & Improvement. To date the CQI Academy hosts ten accredited associates who can each support the delivery of our QSIR training programme with a further eight candidates due to complete their assessments by September 2022.

The CQI Academy aims to support the development of CQI within the Trust by delivering support and training to colleagues through the following programme:

- **QSIR Fundamentals –** A one day introduction to CQI course which provides delegates with a basic understanding of the tools and techniques required to lead small scale change provides within the organisations.
- **QSIR Virtual –** An eight module course split into hourly or two hourly virtual teaching sessions designed to support delegates who are unable to attend our one day Fundamentals course.
- **QSIR Practitioner –** A five day intensive CQI programme delivered over a two to three month period developed to give delegates an in-depth knowledge base on the tools and techniques for continuous quality improvement. This programme is designed for delegates who wish to lead large scale change projects or support the CQI Academy coaching functions.

For all of our courses delegates are asked to attend the sessions with a change idea in mind and following completion of the course delegates will be required to progress their projects while being supported by CQI coaching and drop-in sessions. Once delegates have completed their CQI projects they will have the opportunity to present their work in a poster which will be shared at one of our CQI Celebration Events.

Our CQI Academy Associates

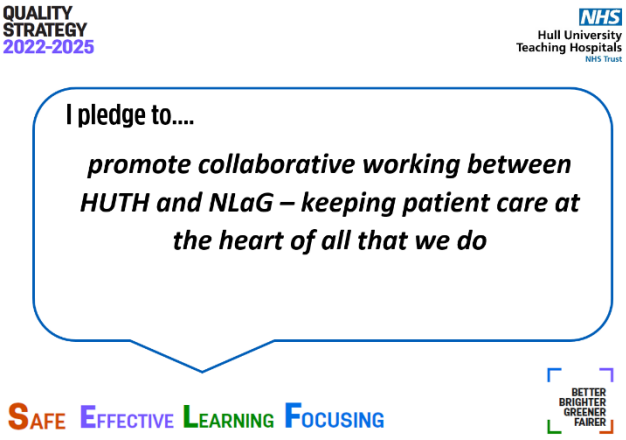
Nathaniel Steadman
Julia Elstob
Noemi Keleman
April Montoya
Sarah Meadows

Austin Smithies
Jamie Bradbury
Andy Hunter
Frances Moverley
Ruth Colville

5.1 Quality Strategy

One June 6th 2022 the Trust launched its 2022-2025 Quality Strategy which outlines the Trusts quest to become a regional centre of excellence and to be an overall CQC rated 'Outstanding' organisation by 2026.

During the launch week the Quality Strategy 'roadshow' visited different locations throughout the Trust to share knowledge of the strategy and ask colleagues to provide their Quality Pledge. We received over 150 Quality Pledges within the first week of the launch and continue to ask staff to keep on pledging!



Our milestone 100th pledge came from Chief Executive Chris Long who pledged to *"help people turn ideas into action"*

Colleagues who were unable to attend one of our Quality Strategy roadshow events are able to complete a digital pledge via Pattie and there will be many more opportunities to pledge as we launch our walking roadshow.

All of our current Quality Pledges can be viewed on our Quality Strategy Wall located in the Quality Governance Office.

6. RECOMMENDATIONS

The Trust Board is recommended to:

- Review the quality data provided and decide if sufficient assurance has been received
- Decide if any additional information would be useful at Board level in terms of quality indicators and information

QUALITY INDICATOR REPORT
JUNE 2022 PERFORMANCE
PRODUCED JULY 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

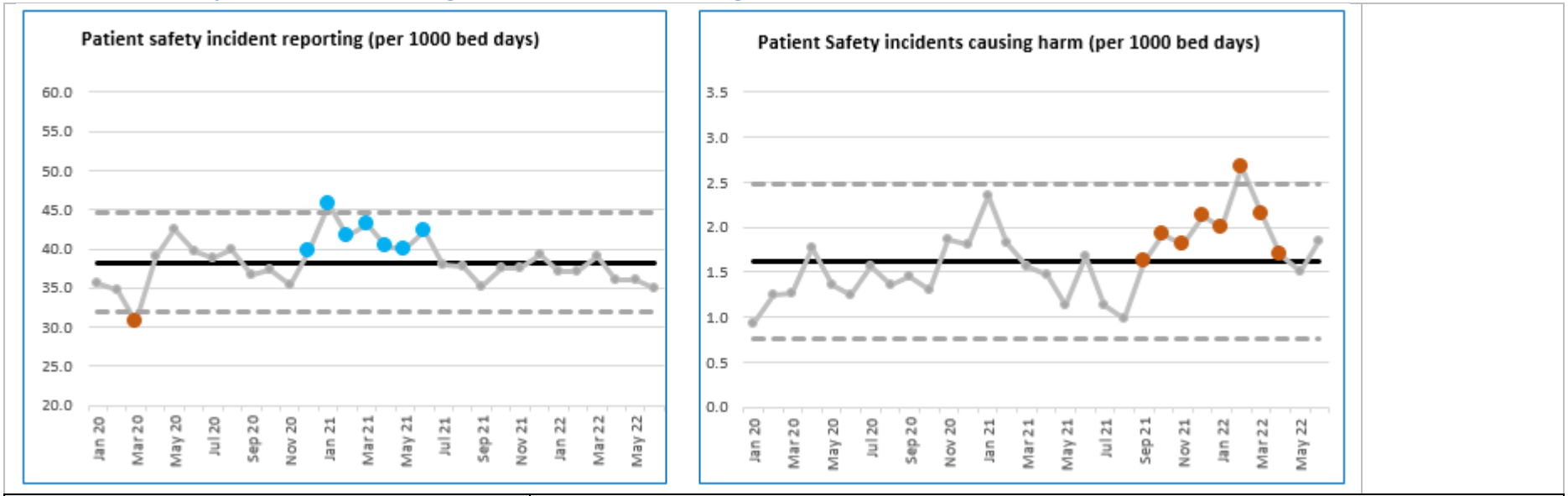
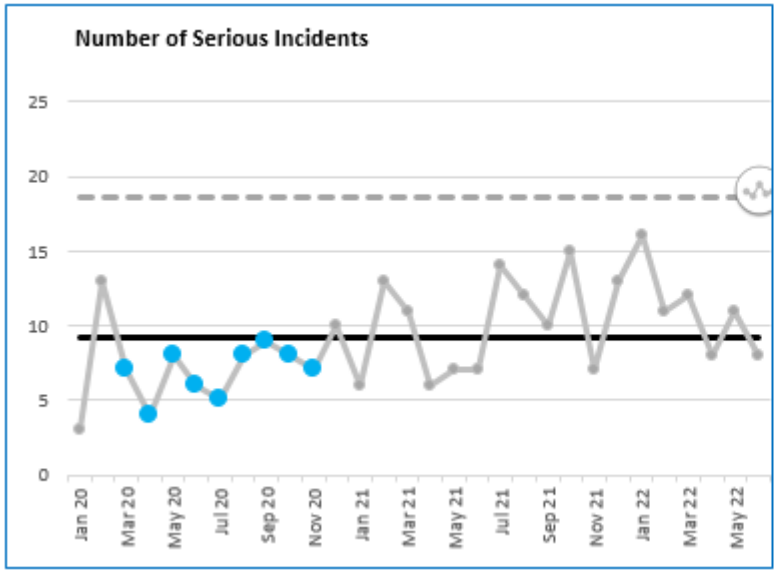


Chart Says:	• There were 35 patient safety incidents per 1000 bed days recorded in June 2022 (n=1420); 1.85 (per 1000 bed days) incidents resulted in moderate, severe or catastrophic harm to the patient. • There has been a shift in the data for incidents causing harm to patients • The Trust has a positive 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
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. • The Trust Quality Strategy has an aim to see a reduction in harm to patients measured against 6 strategic ambitions • 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



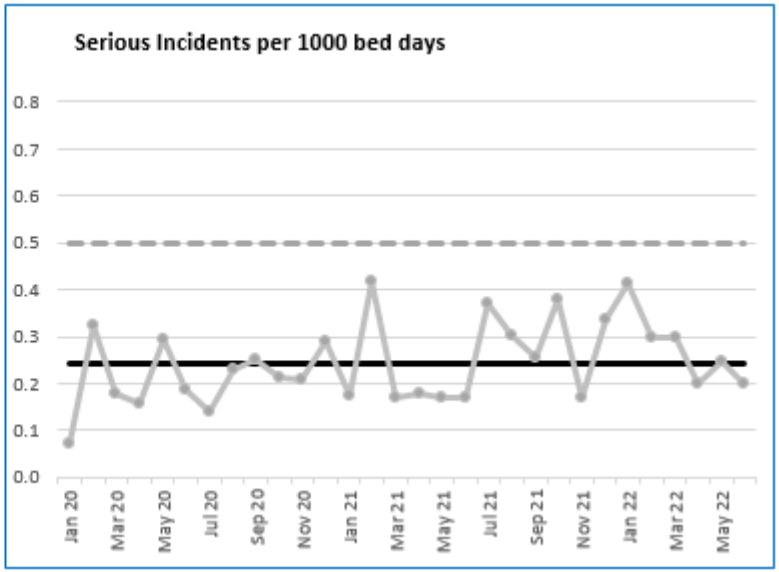
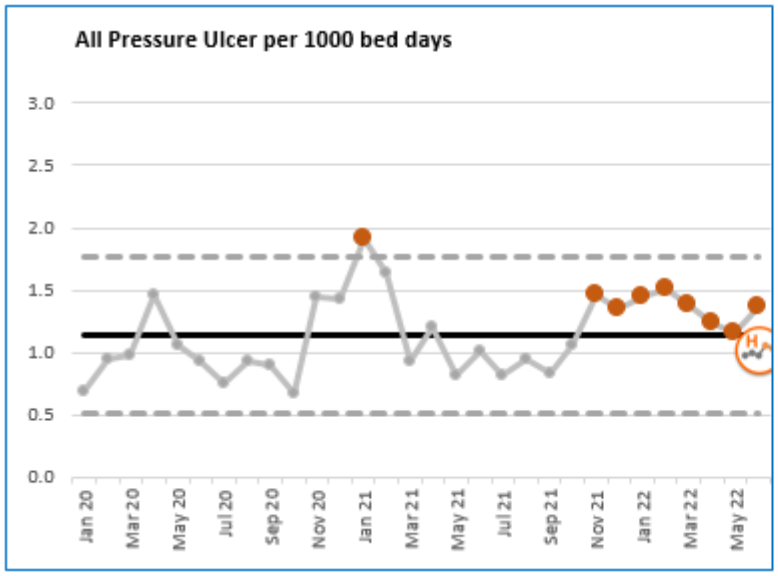


Chart Says:	• The Trust declared 8 serious incidents in June 2022 equating to 0.20 serious incidents per 1000 bed days • The graphs above show common cause variation with no cause for concern.
Issues:	• The Trust continues to declare an average of 3 serious incidents per week • Agreement with commissioners in March 2020 to stop monitoring 60 day investigation completion compliance for the duration of the pandemic • In June the Trust had 65 serious incidents under investigation with 28 that had been open for investigation for more than 100 days • The number of open investigation has greatly reduced from 100 at the beginning of March 2022. • The number of serious incidents being closed week on week is slightly higher than the proposed number but is following the proposal trajectory.
Actions:	• Aim be in a stable position, within agreed tolerance limits, by September 2022 with a sustainable case load of 35 open SIs at any time • For no serious incident investigation to take more than 100 days to complete • Utilise the wider Governance team members to facilitate investigations • Where possible thematic reviews are being undertaken as opposed to individual investigations
Mitigations:	• Implementation of the Patient Safety incident Response Plan (PSIRP) • Focus on immediate learning and actions taken within 72 hours of an incident occurring

2.4 Hospital Acquired Pressure Ulcers causing harm



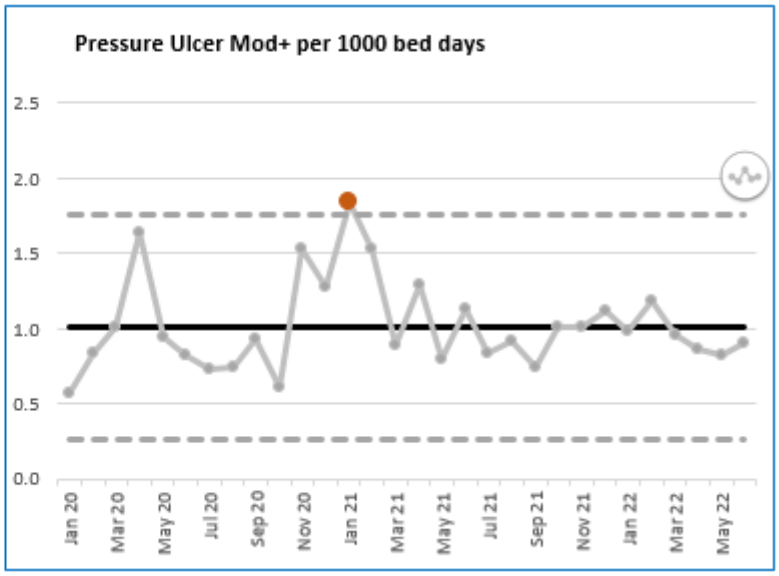
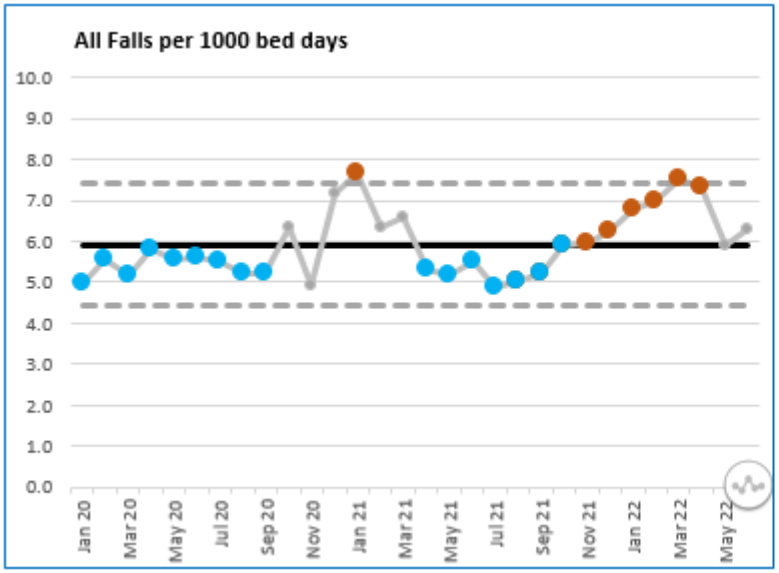


Chart Says:	• There were 1.37 hospital acquired pressure ulcers per 1000 bed days recorded in June 2022 (n=55). • 0.90 (per 1000 bed days) hospital acquired pressure ulcers resulted in moderate, severe or catastrophic harm to the patient.
Issues:	• There were 26 Category 2 pressure ulcers reported (5 as device related); 16 Deep Tissue Injuries (DTI) and 5 unstageable pressure injuries (2 device related) • 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 • The Tissue viability link nurse and High 5 ward rounds have recommenced. There is a plan to have Tissue Viability drop-in sessions for all grades of staff. • The TV news letter is published quarterly and there is collaborative work with the Clinical Nurse educators to deliver the TV QIPP. • There is a plan to establish a TV task and finish group with the aim to reduce the number of hospital acquired pressure ulcers.

2.5 Inpatient falls causing harm



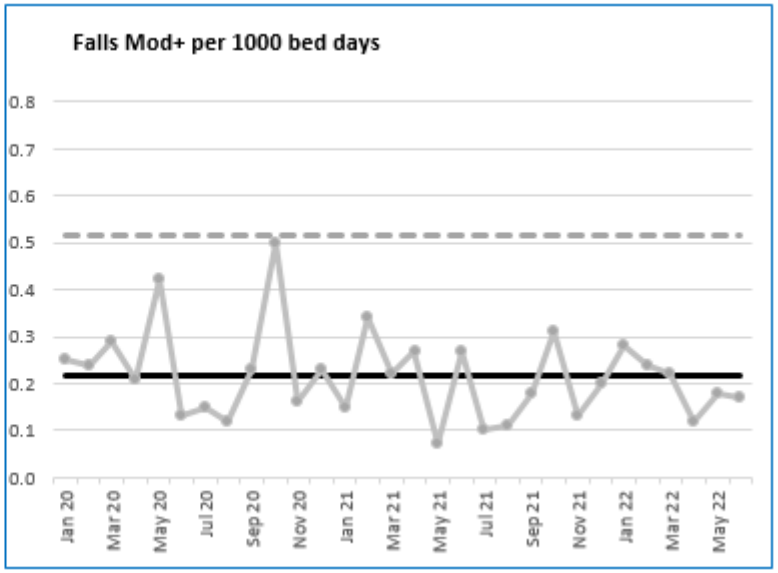


Chart Says:	• There were 6.3 inpatient falls per 1000 bed days recorded in June 2022 (n=251). • 0.17 (per 1000 bed days) inpatient falls resulted in moderate, severe or catastrophic harm to the patient. • There has been an upward trend in the number of falls being reported although this remains within control limits.
Issues:	• The Trust is reporting a high number of inpatient falls however the number of falls resulting in harm remains low within control limits. • 1 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:	• The Trust Quality Strategy has a strategic ambition to reduce the number of inpatient falls that result in harm; Quality Improvement initiatives will identify the key risks to patient safety and required actions to implement change to support the delivery of this strategic aim
Mitigations:	• The Trust Multi-Disciplinary Falls Committee continues to meet bi-monthly to review SID for that have not been declared as a SI and the Task and Finish group meet fortnightly to move the strategic action plan forward

2.6 Duty of Candour

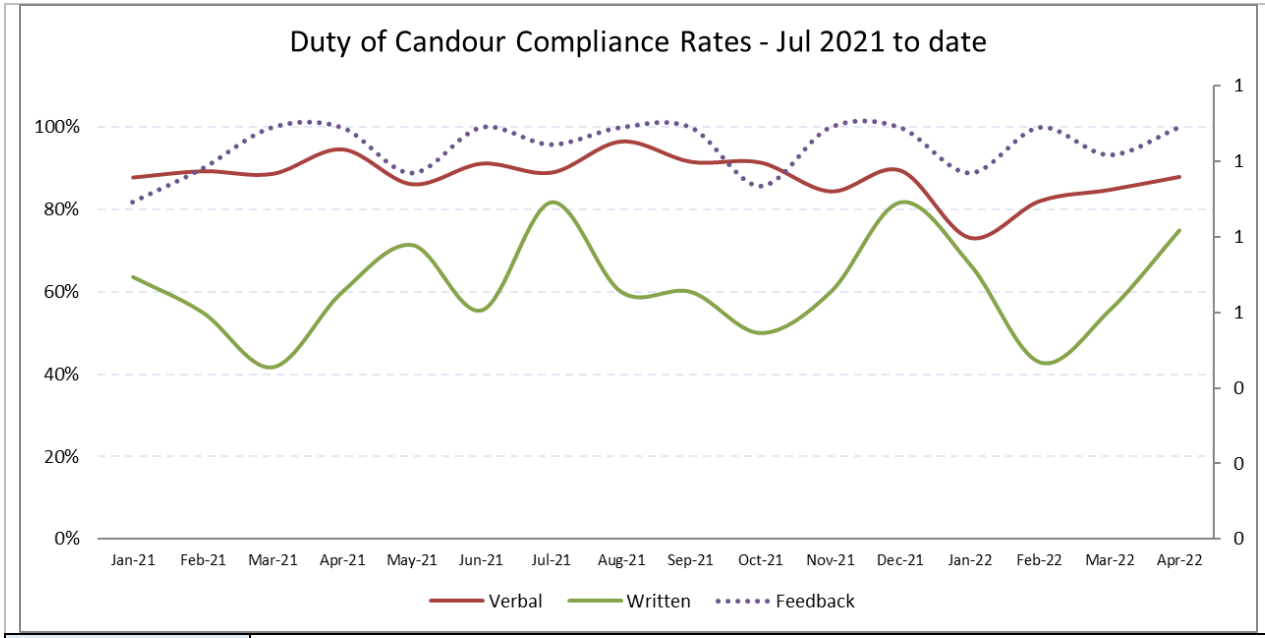


Chart Says:	• 74 incident investigations were completed that required Duty of Candour when the incident was reported. • A verbal apology was offered for 87.8% incidents within 10 working days of the incident. • 75.6% of written apologies were sent within 10 working days. • 100% of written feedback letters following an investigation were sent within 10 working days.
Issues:	• The month of April 2022 saw a continued non-compliance in the verbal and written elements of the Duty of Candour process. • One current obstacle to meeting the timeframe for providing a written apology is the time taken to 'verify' each incident that reports moderate and above harm. Incidents are 'verified' to establish the harm that has occurred. • Each Health Group has a different approach to this verification and the review will establish areas for improvement.
Actions:	• An in-depth review of the current arrangements of Duty of Candour processes will be undertaken by the Patient Safety Team, to identify areas for improvement to increase compliance against the delivery of the Duty of Candour. • The review will be completed by the end of September 2022 with the findings and recommendations to be presented at the October Patient Safety & Effectiveness Committee.
Mitigations:	• The Patient Safety and Patient Experience Teams will work closely to establish a more consistent approach to the delivery of Duty of Candour on patients who experience harm and then follow the complaints process.

3. Performance Review – Effective

3.1 Mortality; HSMR and SHMI

Hospital Standardised Mortality Ratio - monthly position

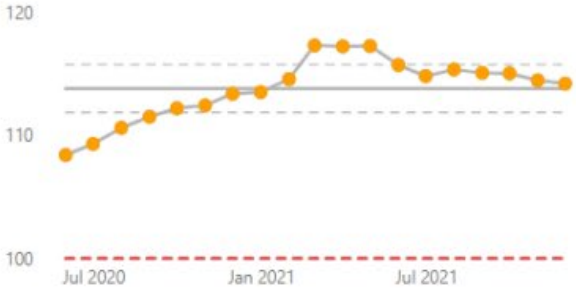
Mar-22: 100.29 Target: 100.00

Hospital Standardised Mortality Ratio - Weekend

Mar-22: 156.57 Target: 100.00

Summary Hospital Mortality Indicator (HSCIC)

Dec-21: 114.22 Target: 100



Crude Mortality (non-elective admissions)

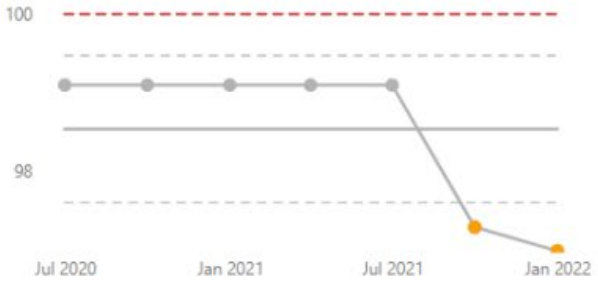
May-22: 3.1% Baseline: 3.4%

Chart Says	Summary Hospital Mortality Indicator (HSCIC) - From Feb-21 to Dec-21, performance has been above the mean of 113.8 and is flagging as a high concern. The expected performance range is between 111.9 and 115.8. As the target of 100 falls below the expected range, we are not capable of achieving this target. As such, process change within the service is required to achieve this target.
Issues	Summary Hospital Mortality Indicator (HSCIC) - The Trust continues to be highlighted as one of the top 10 Trusts to have a 'higher than expected' SHMI and reported as an outlier in the CQC Insight Report.
Actions	Summary Hospital Mortality Indicator (HSCIC) - The Mortality Task and Finish Group continues to meet every two weeks to undertake in-depth discussions and analysis of the factors impacting on the Trust's SHMI and HSMR status. Focused work has commenced on the key areas outlining including Sepsis, Pneumonia, Stroke and Lung Cancer
Mitigations	Summary Hospital Mortality Indicator (HSCIC) - Sepsis Improvement Project continues to meet monthly which is including focussed work on correct identification, management and coding of sepsis and sepsis deaths. This has also included a meeting with Liverpool University Teaching Hospitals NHS Trust who have a similar demographic and population to Hull and have an improved SHMI status. A follow up site visit is being arranged. An audit on the pneumonia deaths that occurred in May 2022 has commenced and provisional data was presented to the June Mortality Task and Finish Group with some additional analysis work agreed to follow. The SJR reviews continue to be completed; however, the task and finish group has also agreed some further development work regarding the completion and learning from SJRS including some more criteria for focussed reviews in targeted areas. The mortality dashboard continues to be monitored.

3.2 NICE and National Audit

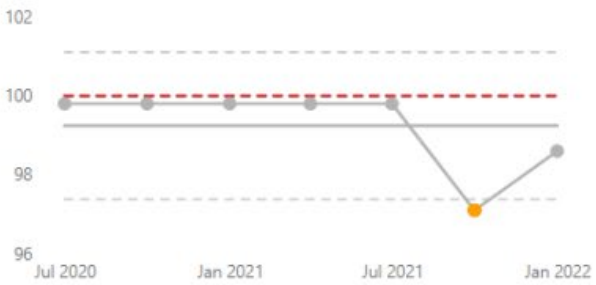
% of NICE technology appraisals that the Trust is compliant with

Jan-22: 97.0% Baseline: 100.0%



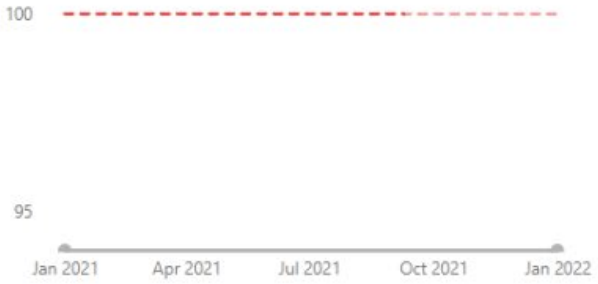
% of NICE interventional procedures that the Trust is compliant with

Jan-22: 98.6% Baseline: 100.0%



% Trust participation in national audits

Jan-22: 94.0% Baseline: 100.0%



National audit outlier alerts

Jan-22: 6 Baseline: 0

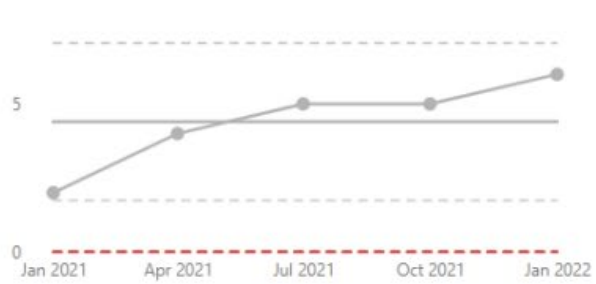
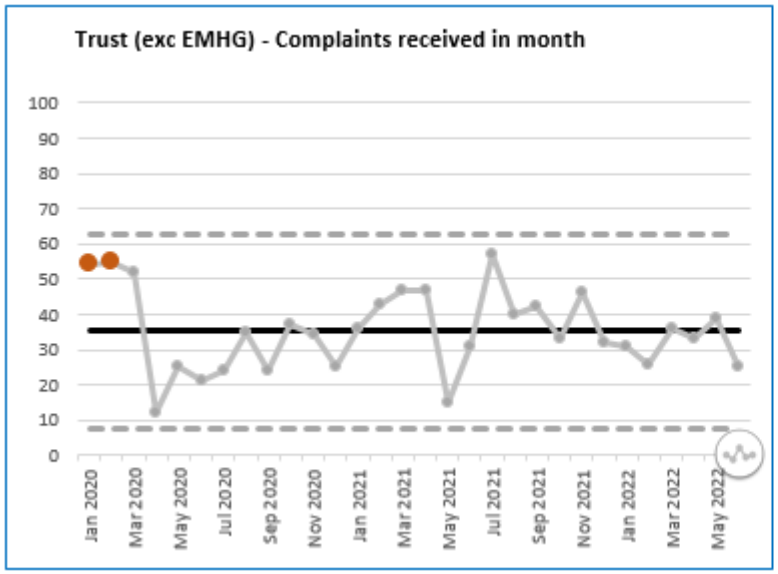


Chart Says	% Trust participation in national audits - The Trust performance was 94% participation; % of NICE technology appraisals that the Trust is compliant with - In the last 7 points of quarterly performance there have been 5 points of common cause not outside the limits and 2 points of concern implying areas of service change. Current performance is below the lower control limit of 97.61 at 97. The charts demonstrate a slight reduction in the number of NICE guidelines the Trust is demonstrating compliance with.
Issues	% Trust participation in national audits - The Trust currently do not take part in National Ophthalmology Database audit or IBD Registry audit, hence the result of 94% for this indicator.; % of NICE technology appraisals that the Trust is compliant with - 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	% Trust participation in national audits - The software for both is currently being purchased and it is expected that the Trust will take part in these audits in 2022/23.; % of NICE technology appraisals that the Trust is compliant with - 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	% Trust participation in national audits - ; % of NICE technology appraisals that the Trust is compliant with - There are no risks associated with these assessments in progress.

4. Performance Review – Responsive/Experience

3.1 Number of Complaints received (excluding Emergency Medicine Health Group)



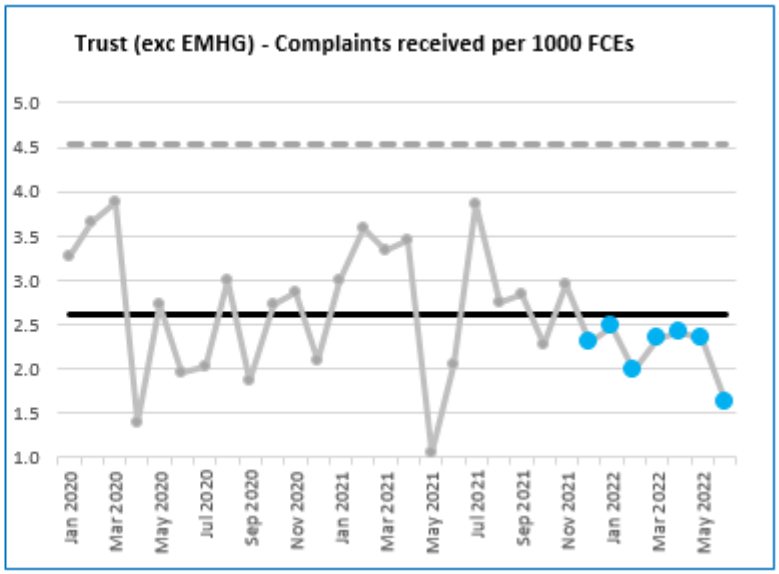
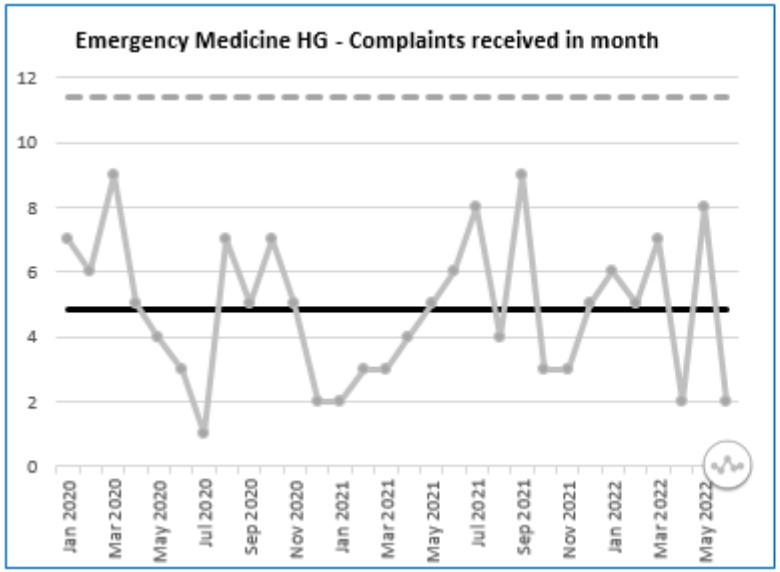


Chart Says:	• There were 25 complaints received (excluding those against the ED) in June 2022, this equates to 1.6 complaints per 1000 Finished Consultant Episodes (FCEs). • The graphs for the total numbers received per month show common cause variation with no cause for concern. • The graph against the FCEs shows that there has been improvement with fewer complaints received over a 7 month period
Issues:	• In the month of June the specialty with the highest number of complaints (3) was elderly medicine with concerns regarding care and comfort including assistance with nursing care • Treatment concerns accounted for the highest number of complaints received across the Trust (13) with un-satisfaction with treatment plans the common theme
Actions:	• Development of a public and patient engagement strategy • Learning from experience and themes arising from complaints • The work in partnership with the patients and public to develop and improve services • To see a reduction in formal complaints particularly across the Trust top categories e.g. staff attitude and communication
Mitigations:	• Introduction of the Role of Patient Safety Partners • Learning from 'lived experience' across a number of different platforms including the Patient Councils
Learning:	• Review and tracking of access plans for all patients awaiting further follow up or diagnostic tests has been initiated • Continence policy reviewed and updated • Respiratory service to review provision for thoracoscopy service and develop business case • Prostatectomy Leaflets to be reviewed to check that they highlight concerning side effects and what actions patients need to take if they have concerns. • Parent Education Midwife to review Healthy Lifestyles content

	• New process to be investigated for doctors/consultants to return calls to patients who have been discharged home and are telephoning the ward with queries within Vascular service. • Process for referring oncology patients for dental treatment who cannot access NHS dentist to be reviewed and formalised • The process of prescribing chemotherapy to be reviewed • Breaking bad news will be taken forward as a teaching session for junior doctors within Elderly Medicine.

3.2 Number of Complaints received (Emergency Medicine Health Group)



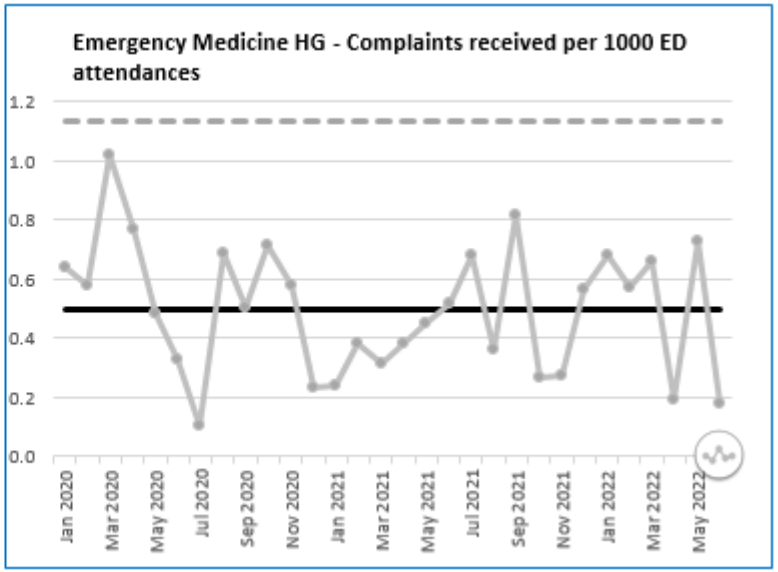
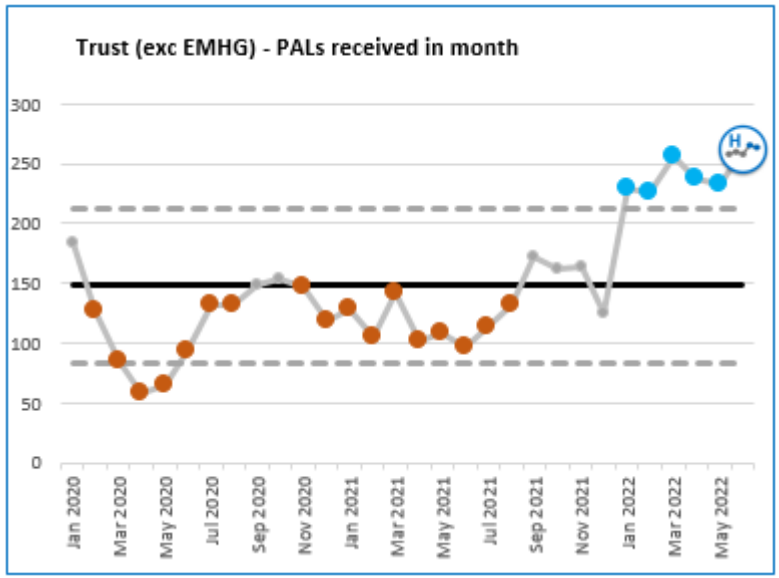


Chart Says:	• There were 2 complaints received in the Emergency Medicine Health Group (ED) in June 2022, this equates to 0.2 complaints per 1000 ED attendances • The graphs for the total numbers received per month show common cause variation with no cause for concern.
Issues:	• The 2 complaints received were in relation to the care and comfort received by a patient and a complaint regarding delays and waiting times. • The ED is seeing an increasing number of patients visiting the department with 4hr performance targets not being met. • The average time a patient spends in the department has risen by more than 50% compared to the same month in the previous year
Actions:	• Development of a public and patient engagement strategy • Learning from experience and themes arising from complaints • The work in partnership with the patients and public to develop and improve services • To see a reduction in formal complaints particularly across the Trust top categories e.g. staff attitude and communication
Mitigations:	• Introduction of the Role of Patient Safety Partners • Learning from 'lived experience' across a number of different platforms including the Patient Councils
Learning:	• Food and drink now available for patients who are in the department waiting for treatment • Reinforcement of the process for the handling of referral letters • Issues with discharge letter to be discussed with the Clinical Lead as a potential learning opportunity

3.2 Number of PALs received (excluding Emergency Medicine Health Group)



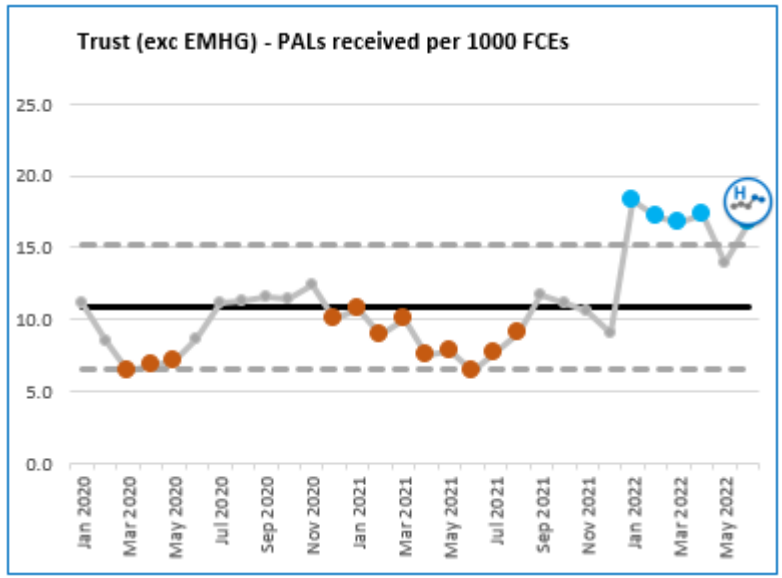


Chart Says:	• There were 260 concerns raised with the PALs Team (excluding those against the ED) in June 2022, this equates to 16.8 concerns per 1000 Finished Consultant Episodes (FCEs). • The graphs show that there has been an increase in the numbers of concerns raised since January 2022 • PALs are not formal complaints but allows the Trust focus on resolving issues as well as dealing with questions, suggestions and concerns. • The Trust view this as a positive way of responding to patients in a timely way and for identifying areas for learning and improvement.
Issues:	• In the month of June the highest number of concerns raised was in regards to delays and waiting times (92) particularly within the outpatients service for follow up and the next highest were concerns regarding communication and telephone enquiries not being responded to • The specialties with the highest number of PALs concerns received was the ED (see separate chart) and gynaecology with delays and waiting times again being the theme
Actions:	• Development of a public and patient engagement strategy • Learning from experience and themes arising from complaints • The work in partnership with the patients and public to develop and improve services • To see a reduction in formal complaints particularly across the Trust top categories e.g. staff attitude and communication
Mitigations:	• Introduction of the Role of Patient Safety Partners • Learning from 'lived experience' across a number of different platforms including the Patient Councils
Learning:	• Eye clinic telephone system being reviewed • Staff to communicate more with patients throughout a procedure under conscious sedation

3.2 Number of PALs received (Emergency Medicine Health Group)

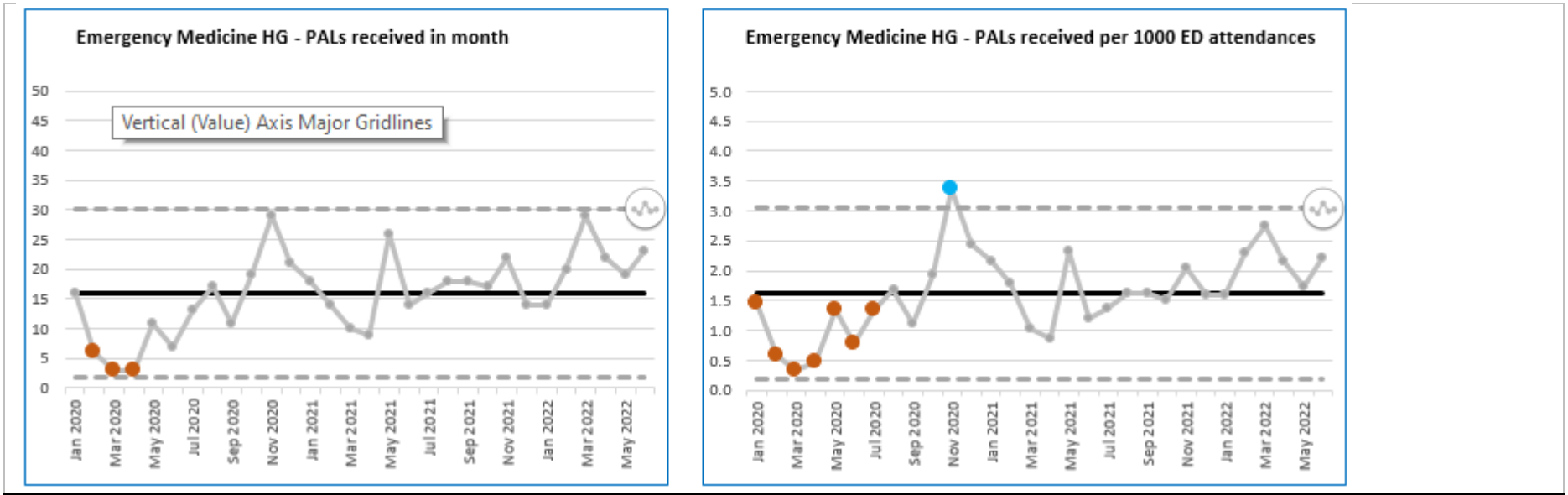
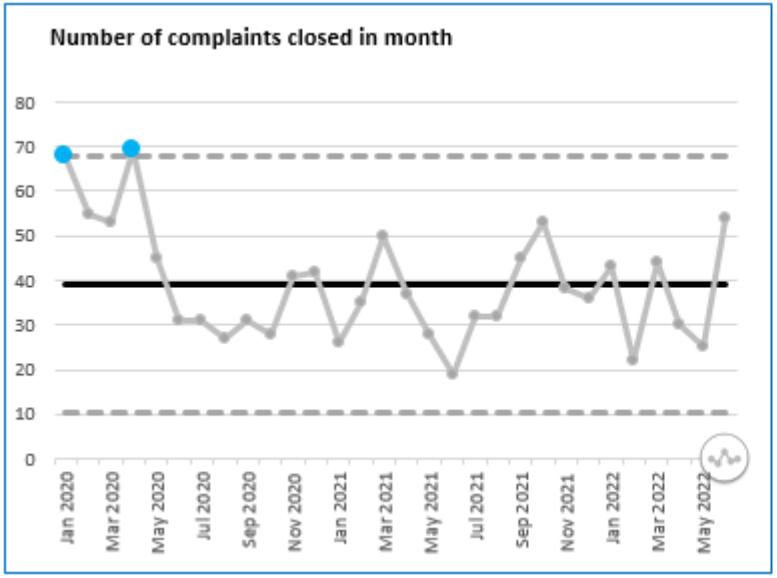


Chart Says:	• There were 23 complaints received in the Emergency Medicine Health Group (ED) in June 2022, this equates to 0.2 complaints per 1000 ED attendances • The graphs for the total numbers received per month show common cause variation with no cause for concern. • PALs are not formal complaints but allows the Trust focus on resolving issues as well as dealing with questions, suggestions and concerns. • The Trust view this as a positive way of responding to patients in a timely way and for identifying areas for learning and improvement
Issues:	• In the month of June the highest number of concerns raised was in regards to staff attitude (9) followed by concerns regarding delays and waiting times (6) • In addition to the concerns regarding to staff attitude there were 7 compliments received praising the staff within the ED
Actions:	• Development of a public and patient engagement strategy • Learning from experience and themes arising from complaints • The work in partnership with the patients and public to develop and improve services • To see a reduction in formal complaints particularly across the Trust top categories e.g. staff attitude and communication
Mitigations:	• Introduction of the Role of Patient Safety Partners • Learning from 'lived experience' across a number of different platforms including the Patient Councils
Learning:	• Consultant reviewed concerns raised with the educational supervisor of the clinician involved so that reflective learning can take place

3.3 Number of Complaints closed against the 40 working day timeframe



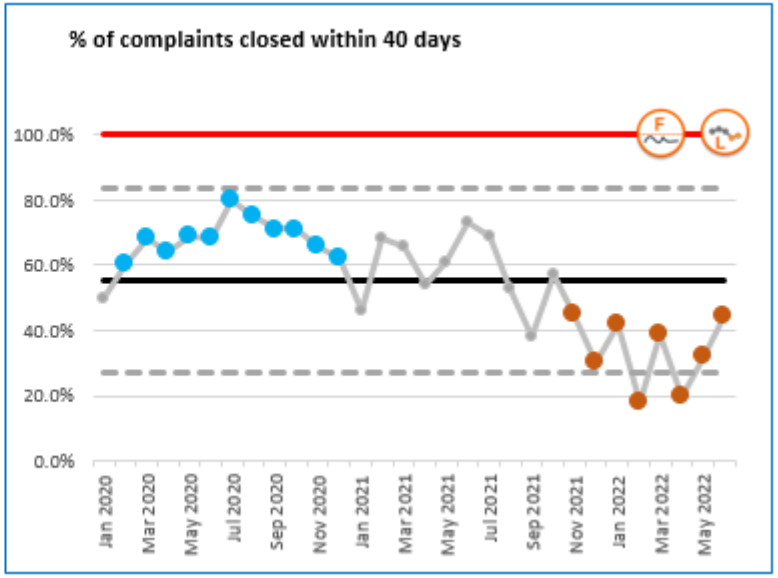


Chart Says:	• 54 Complaints were closed in the month of June with 44% closed within the PHSO recommended 40 day response deadline. • 15 Complaints were upheld and 27 partly upheld. 12 complaints were not upheld. • The timescales to close within 40 days has been lower than the mean for 8 months
Issues:	• There are a total of 86 complaints that are currently breaching the deadline and have been open for investigation for more than 40 days • The complaint response workload is not always distributed across all investigatory managers who investigate within their own Health Groups • The Health Group with the highest number of complaints investigations overdue is Surgery Health Group with 51 open
Actions:	• To increase the monthly closure rate per month to eliminate the backlog of open complaints investigations • Monthly meetings between the Head of Patient Experience and Engagement with Health Group representative to review open complaints • Escalation of variations to the Health Group Triumvirates and PESC
Mitigations:	•

Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee

Agenda Item		**Meeting**	Trust Board Meeting	**Meeting Date**	12/7/2022
Title	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4				
Lead Director	Joanne Ledger Interim 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 Trust Board is requested to:

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

Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee

CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)
MATERNITY INCENTIVE SCHEME – YEAR 4
June 2022

1. PURPOSE OF THE REPORT

The purpose of this report is to provide information following a review of the impact of Covid-19, and readiness to apply for a 10% reduction in the Clinical Negligence Scheme for Trusts (CNST) Maternity premium in 2021/22.

This report presents the following:

- Background
- Covid-19 impact on reporting
- Review of the year four CNST safety actions

2. BACKGROUND

As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the Clinical Negligence Scheme for Trusts (CNST), administered by NHS Resolution. The Maternity CNST rebate in 2019 was £470k with a further £21k allocation from Trusts who were not compliant with all ten-safety actions.

3. COVID-19 IMPACT ON REPORTING –

The 10 maternity safety actions are, as follows:

1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care (TC) services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? (ATAIN)
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2 (SBLCBv2)?
7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification (NHSEN) scheme

Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee

Pause in reporting procedure regarding the maternity incentive scheme

In recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme (MIS) 10 safety actions are paused with immediate effect for a minimum of 3 months.

This will be kept under review. Trusts are asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care. Examples of continuing to apply the principles include: undertaking midwifery workforce reviews, ensuring that as far as possible the oversight provided by the maternity, neonatal and board level safety champions continue, as well as using available on line training resources.

Trusts are asked to continue to report to MBRRACE-UK and report eligible cases to the Health Safety Investigation Branch (HSIB). In addition, every reasonable effort should be made to make the Maternity Services Data Set submissions to NHS Digital.

In the current challenging circumstances, in descending order of priority for reporting to MBRRACE-UK as follows:

- Notify all perinatal and maternal deaths;
- Complete the surveillance information for COVID-19 related perinatal deaths where either the mother and or baby is infected with SARS-CoV-2;
- Continue to complete the perinatal surveillance information for all other deaths, whilst there is capacity to do so;
- Continue to complete reviews using the Perinatal Mortality Review Tool, whilst there is capacity to do so.

The reporting period for MIS year 4 will also be kept under review and may potentially be extended by the MIS Collaborative Advisory Group (CAG) who will reconvene in February 2022. Trusts will be provided with a timetable and revised technical guidance in due course and those will also be shared via your submitted MIS nominated contacts and posted on NHS Resolution's website

The reporting period has been extended although we are awaiting confirmation of the reporting and submission periods. In response to the current situation, the 10% uplift to the Clinical Negligence Scheme for Trusts (CNST) for the maternity incentive scheme has not been collected for the year 2020/2021.

The scheme was reviewed and relaunch from 6 May 2022. The scheme's submission deadline has been extended from June 2022 to 5 January 2023 to provide Trusts with extra time to achieve the standards. Interim timeframes within each of the safety actions have also been reviewed and extended.

Safety Action	Compliance	Board Request
1	**Perinatal Mortality Review Tool Compliant**	All perinatal deaths eligible to be notified to MBRRACEUK from 6 May 2022 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. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust

		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 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews 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. For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, 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 Quarterly reports will have been submitted to the Trust Board from 6 May 2022 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.
2	**MSDS** **Partial Compliance**	1. By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme. 2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022. 3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. 4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. 5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2). 6. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)

		7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in 19 the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics: Midwifery Continuity of carer (MCoC) i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information)
3	**TRANSITIONAL CARE** **Partial Compliance**	a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter. c)A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 week's gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family

		integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been 27 cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis. g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion. h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.
4	**Medical Staffing Non Complaince**	**a) Obstetric medical workforce** 1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/ 2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS. **b) Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1) **c) Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress

		against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. **d) Neonatal nursing workforce** 37 The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.
5	**Midwifery Staffing Partial Compliance**	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.
6	**SBLV2 Compliant**	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. 3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.
7	**Maternity Voices Partnership Compliant**	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

8	**Mandatory Training Partial Compliance**	a) A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years b) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include maternity emergencies starting from the launch of MIS year four c) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four
9	**Safety Champions Partial Compliance**	a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-qualitysurveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need. b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes. d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
10	**NHS Resolution Partial Compliance**	1. A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 2. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that:

		4. 1. The family have received information on the role of HSIB and NHS Resolution's EN scheme; and 5. 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

7. SUMMARY

In summary, following a review of the current position the service is declaring full compliance with three standard, partial compliance with six of the standards, and a non-compliance with one standards. A quarterly update will be provided, and the final evidence to be signed off by the Chief Executive will be submitted once the submission dates have been agreed with NHSR.

Attached APPENDIX 1 is a comparison of the year 3 & 4 standards and identified challenges to achieving year 4 safety standards.

8. RECOMMENDATIONS

The Trust Board is requested to:

- Agree that the review of the position at this current time demonstrates full compliance with one standard, partial compliance with seven of the standards, and a non-compliance with two standards.
- Decide if any further information and/or assurance is required.

Lorraine Cooper
Head of Midwifery
June 2022

Joanne ledger
Executive Chief Nurse

Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee

APPENDIX 1

Briefing Paper
Clinical Negligence Schemes for Trust
Year Three and Four Comparison

Background

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions.

Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Rationale

The purpose of this paper is to identify to the Trust Board and Executive team the main comparisons and potential resource required between year three and year four of the CNST scheme. On review of year four CNST scheme, there are significant changes to the following identified safety actions:

Safety Action 1 - Perinatal Mortality Review Tool

- Notification to MBRRACE-UK, changed from 7 working days to 2 working days
- Surveillance form must be completed, changed from within 4 months of the death to within 1 month of the death.
- Timeframe for review using PMRT changed to will have been started within two months of each death.
- PMRT cannot be completed until the HSIB report is complete
- Draft report timeframe changed to within four months of each death and the report published within six months of each death.
- Quarterly reports discussed with Trust Maternity Safety Champions, now includes Board Level Safety Champions.

Safety Action 2 - MSDS data

There are significant detailed targets and dates that are listed for Year 4 for MSDS data ensuring that Maternity Information System procured or fully funded. Data quality criteria for at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs), data submission by January 2022.

Safety Action 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?

- Pathways of care into transitional care reintroduce with a focus on minimising separation of mothers and babies.
- Reintroduce with audit period changed from every other month to quarterly. Audit to also be shared with LMNS, Commissioners and ICS at quality surveillance meeting each quarter.

Safety action 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

- The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: "Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology" https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/. (By January 2022 and monitored monthly from then).
- Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.
- A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times.
- The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year three of MIS as well include new relevant actions to address deficiencies.

Safety action 6

Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

- There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.
- They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).
- Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.
- They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems.

Safety action 8

Can you evidence that a local training plan is in place to ensure that all six-core modules of the Core Competency Framework will be included in your unit-training programme over the next 3 years, starting from the launch of MIS year 4?

- A training plan should be in place to cover all six-core modules of the Core Competency Framework. The training plan will span a 3-year time period and will include;
  - Saving Babies Lives Care Bundle
  - Fetal surveillance in labour
  - Maternity emergencies and multi-professional training.
  - Personalised care
  - Care during labour and the immediate postnatal period
  - Neonatal life support
- A multi-professional 'in house' training day should be reinstated as face-to-face training no later than the 30th September 2021 (in line with Public Health England COVID-19 guidance).
  - Fetal monitoring and surveillance (in the antenatal and intrapartum period)
  - Maternity emergencies training scenarios,
  - Neonatal life support

- Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum:
  - Risk assessment
  - Intermittent auscultation
  - Electronic fetal monitoring
  - System level issues e.g. human factors, classification, escalation and situational awareness
  - Use of local case histories
  - Using their local CTG machines

Safety action 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

- The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the 'implementing-a-revised-perinatal-quality surveillance-model.pdf'(england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.
- Board level safety champions present a locally agreed dashboard to the Board on a quarterly basis. To include, as a minimum, the measures set out in Appendix 2 of the perinatal quality surveillance model, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.
- Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes.

Conclusion

There are significant detailed targets and dates that are listed for Year 4 MSDS data ensuring that Maternity Information System procured or fully funded. Data quality criteria for at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs), data submission by January 2022. HUTH will be transferring over to an LMS system wide maternity IT system, which may affect data capture and submission.

The service has identified that Safety Action 4 will require investment in consultant obstetricians to meet the recommendation in the RCOG workforce document by January 2022.

The neonatal Nurse staffing is an ongoing priority for Safety Action 4 to ensure the service meets the service specifications for nursing standards.

Safety Action 8 will require the release of midwifery, neonatal, anaesthetic, ODPs and medical staff for mandatory training compliance against Ockenden standards.

Safety Action 9 will require a robust plan in line with national guidance to delivery wholescale continuity of carer and sufficient midwifery workforce.

Recommendations

The Executives are asked:

1. Review the paper to meet the year 4 safety actions
2. Decide if any further information and/or assurance are required.

Lorraine Cooper
Head of Midwifery

Agenda Item		**Meeting**	Quality Committee and Trust Board	**Meeting Date**	28 June 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 4

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 4 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. Finally reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet

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% and finally **Quarter 4** 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%
Quarter 4 2021	1223	34.7%	2.6%

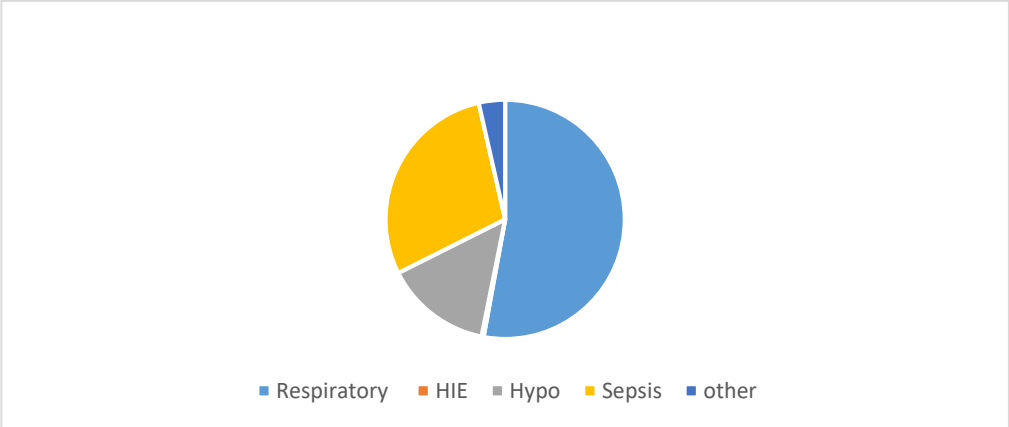
All unexpected term admissions to NNU are reported through the DATIX system and investigated through the weekly Maternity Case Review multi-disciplinary meeting. The CNST approved template ATAIN proforma is completed for data collection purposes. The themes, trends and learning points are shared amongst 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 4 32 Unexpected Term Admissions to NICU cases have been reviewed through Maternity case review compared to 48 cases in quarter 3. Themes identified are presented below. The average gestation at admission to NICU was 38+0 - 38+6 weeks.

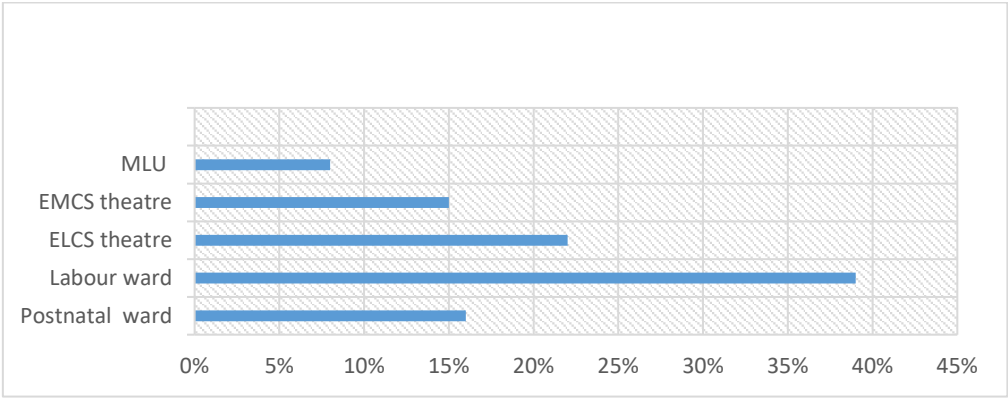
The primary reason for admission at gestation 38.0– 38 + 6 to NNU was for respiratory support requiring Continuous positive airway pressure (CPAP).



Admission Location

Babies were most commonly admitted to NICU from the Labour ward. 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 June 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.



As stated in CNST year 4 all reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet

Within this quarter 1 baby was transferred in for HIE grade 2 from a neighbouring low level unit 7 Intra- utero transfers occurred in this quarter 70 % of which were pre term and reason reported is closure of the NICU due to capacity. It appears from the reviews the transfers were appropriate for the safety of the women and baby. 4 women and families were transferred back to Hull University teaching hospital for appropriate care.

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 as the transitional care support at Hull University teaching Hospital supports NG feeding.

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)
June 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 Update – new data collection sheet being used to comply with CNST year 4
Respiratory management platform to be trialled for respiratory support (CPAP) at the bed side on labour ward	Neonatal consultant	April 2022 Extended July 2022
To embed practice of skin to skin at EMCS/ELCS	Labour ward coordinators Infant feeding co coordinators	April 2022 Extend to July 2022

Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee

Agenda Item		**Meeting**	Trust Board Meeting	**Meeting Date**	12/7/2022
Title	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4** **Safety Action 6 – Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?** **Element 2 – Process Indicators 4 and 7**				
Lead Director	Joanne Ledger Interim 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 Trust Board is requested to: • Receive the report and decide if any further information and/or assurance are required.

Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4
Safety Action 6 – Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Element 2 – Process Indicators 4 and 7

1. Purpose of the Report

The purpose of this report is to provide assurance to the Trust Board that the organisation, to the standard required by the Clinical Negligence Scheme for Trusts (CNST), is compliant with Safety Action 6: Element 2: Process Indicators 4 and 7.

2. Introduction

Saving Babies' Lives care bundle version 2 (SBLCBv2) is a care bundle for reducing perinatal mortality across England published in April 2019. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice.

Element 2 covers the risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction, including:

- publication of small for gestational age/fetal growth restriction detection rates and percentage of babies born <3rd centile and >37+6 weeks gestation
- an ongoing case-note audit of <3rd centile babies not detected antenatal (at least 20 cases per year) to identify areas for future improvement and monitoring of babies born >39+6 and 10th centile to provide an indication of detection rates and management of small for gestational age babies

For the purposes of this report, this links to CNST Safety Action 6, Element 2:

Process Indicator 4 – a quarterly audit of the percentage of babies born <3rd centile >37+6 gestation

Process Indicator 7 – a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks gestation to identify themes that can contribute to fetal growth restriction not being detected & evidence of quality improvement initiative to address any identified problems

3. Process Indicator 4 – a quarterly audit of the percentage of babies born <3rd centile >37+6 gestation

Quarter 1: April, May, June 2021:

Number of babies born at HUTH = **1219**

Number of babies born at HUTH < 3rd centile & >37+6 = **14**

Percentage = 1.15 %

Quarter 2: July, August, September 2021

Number of babies born at HUTH = **1305**

Number of babies born at HUTH < 3rd centile & >37+6 = **17**

Percentage = 1.30 %

Quarter 3: October, November, December 2021

Number of babies born at HUTH = **1282**

Number of babies born at HUTH < 3rd centile & >37+6 = **17**

Percentage = 1.33 %

Quarter 4: January, February, March 2022

Number of babies born at HUTH = **1222**

Number of babies born at HUTH < 3rd centile & >37+6 = **26**

Percentage = 2.13 %

4. Process Indicator 7 - a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks gestation to identify themes that can contribute to fetal growth restriction not being detected & evidence of quality improvement initiatives to address any identified problems

Through the Perinatal Institute Growth Assessment Protocol (GAP) Score system and the Trust's Datix system, maternity cases within this criteria are reviewed as missed cases with a low birth centile and/or missed fetal growth restriction.

For Quarter 1 (April, May, June 2021), there were 14 cases and of these, it was highlighted that:

- 4 cases involved possible incorrect fundal height measurements by midwifery or obstetric practitioners
- 1 case was not referred for serial growth scans when risk factors for growth restriction were identified
- 4 cases involved possible growth ultrasound deviations or that fell within the variance allowed by the ultrasound parameters

After each quarterly report via the GAP Score system, a newsletter is produced for all relevant maternity staff. The September 2021 edition covered Quarter 1 and reminded staff to refer for serial growth scanning when appropriate and to refer for growth scans when indicated by fundal height measurement. In addition, training on fundal height measurement was commenced on the midwives' mandatory training day in January 2021, which aims to improve practitioner skills in this and highlight any issues.

For Quarter 2 (July, August, September 2021), there were 17 cases and of these, it was highlighted that:

- 3 cases involved possible incorrect fundal height measurements by midwifery or obstetric practitioners
- 6 cases involved growth ultrasound fetal weights that fell within the variance allowed by the ultrasound parameters

For this quarter, it is probable that as the fundal height measurement training is still being rolled out to all practitioners up to November 2021, errors may still occur occasionally due to not yet capturing all practitioners for training. In addition, contact was made with the maternity ultrasound department to highlight any cases that appear to have a large amount of deviance from the estimated birth weight.

For Quarter 3 (October, November, December 2021), there were 17 cases and of these, it was highlighted that:

- 3 cases involved possible incorrect fundal height measurements by midwifery staff or obstetric practitioners
- 3 cases involved growth ultrasound fetal weights that fell within the variance allowed by the ultrasound parameters

The December 2021 newsletter covered Quarter 2 data (as it was produced before the end of December 2021) and reminded staff to refer for growth scans where indicated by fundal height measurement. 2022 Plan is for midwifery training to spotlight some missed case and to use GAP Score data to target any specific midwifery learning needs.

For Quarter 4 (January, February, March 2022), there were 20 cases and of these, it was highlighted that:

- 3 cases involved incorrect details on the customised growth charts
- 1 case involved possible incorrect fundal height measurements by midwifery staff or obstetric practitioners
- 1 case involved being missed from the recommended scan protocol entirely
- 2 cases involved growth ultrasound fetal weights that fell outside the variance allowed by the ultrasound parameters

To address these, the Ultrasound department were contacted with the details of the incorrect growth charts generated and the scans which fell outside the accepted variances were discussed within the Fetal Medicine MDT meeting. The March 2022 newsletter again reminded staff to be vigilant for identifying risk factors for the GAP scan pathway and referring for USS outside this pathway where necessary. It is encouraging that the number of apparent incorrect fundal height measurements has reduced in this quarter, hopefully due to the fact that the face to face fundal height assessment/training has been able to identify any issues with individual practitioners.

5. Summary

Audits are undertaken quarterly to assess against the service against process indicator 4 and 7 within the SBLCBv2 document. A quarterly newsletter for GAP is produced to highlight any missed opportunities and required learning. Fundal height measurement and GAP training has been reinstated face to face on mandatory training day two for all trained midwives and medical staff. The clinical lead has updated and developed and new LMS pathway/guideline for management and identification of fetal growth restriction.

6. Recommendations

The Trust Board is requested to:

- Receive the above report
- Receive assurance by the team that the relevant audits and review requested by CNST have been undertaken.
- Decide if any further information is required

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

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12th July 2022
Title	Director of Infection Prevention & Control (DIPC) Annual Report 2021/22				
Lead Director	Jo Ledger, Acting Chief Nurse				
Author	Greta Johnson, Director of Infection Prevention & Control				
Report previously considered by (date)	Considered by members of the Strategic Infection Reduction 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:

This annual report provides an overview of the work done in accordance with the Infection Prevention and Control Board Assurance Framework (IPC BAF) during the financial year 2021-22. It is a record of the Trust's activity and achievements in preventing healthcare associated infection, and in managing infectious diseases, inclusive of the ongoing COVID-19 pandemic more generally. It also describes areas where improvement is needed.

Key points of consideration:

- The COVID-19 pandemic continued to highlight the strengths and weaknesses of the Trust's response and with it a clear understanding of what needs to be addressed to mitigate risk further. The Trust provides care to a naïve population who will remain at risk from infections and therefore the learning and actions to promote patient safety will remain.

- During 2021-22 an increase in patients medically fit but unable to be discharged alongside the Trust ensuring elective recovery was prioritised created other issues such as caring for patients on wards across the Trust with finite staffing resource. Patients with no criteria to reside remain in hospital longer and with it the potential to develop healthcare associated infections during protracted hospital stays.

- During 2021-22, the Trust continued to monitor healthcare associated infection case numbers and trends. The Trust performed at or better than the benchmark in all cases with the exception of hospital onset COVID-19 infections which continued to impact on acuity and flow across the Trust.

- The lack of robust digital systems to support an effective IPCT is a significant risk both from a governance and quality perspective and relies heavily on the IPCT managing with the outdated systems, which with time will affect the quality of data collected, the functionality of the team and potentially impact on patient safety.

- The Trust via an antimicrobial stewardship programme continues to collaborate with clinical teams to develop antimicrobial prescribing guidance in line with national guidance and continues to monitor compliance with regards antimicrobial prescribing and escalate to improve patient outcomes.

- There have been consistent improvements in some specific aspects of infection prevention and control (e.g. clinical engagement in root cause analysis, monitoring healthcare associated infections and mitigating risks within Health Groups and increased partnership working especially with regards COVID-19.

- There are weaknesses in the Trust estate and facilities for managing patients with infections:
  - limited number of single rooms in spite of additional capacity created on the HRI site
  - shared toileting and bathroom facilities
  - inadequate isolation facilities in paediatrics

Solutions to these estate issues are being considered and actioned as part of a wider Trust strategy

- There is inadequate resource (clinical and administrative) to support the necessary level of surveillance of blood stream infections within the Trust, with a risk of failing to take action to prevent avoidable infections.
- There is inadequate resource to reintroduce dedicated antibiotic ward rounds, which were previously demonstrated to improve antimicrobial prescribing and stewardship.

The Board is asked to accept this report as assurance that the Trust is meeting its requirements on infection prevention and control as specified in the Health and Social Care Act (2008). It should also note that there are areas of vulnerability highlighted in this report, which if not addressed may lead to a failure to meet these requirements in future.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)

ANNUAL REPORT 2021-22

1 PURPOSE OF THE REPORT

This report provides an overview of the work done in accordance with the Infection Prevention and Control Annual Plan during the financial year 2021-22. It is a record of the Trust's activity and achievements in preventing healthcare associated infection, and in managing infectious diseases more generally. It also describes areas where improvements are required.

2 BACKGROUND

This report is required by the Code of Practice for the Prevention and Control of Healthcare Associated Infection contained in the Health and Social Care Act 2008.

3 INFECTION PREVENTION & CONTROL ARRANGEMENTS

Greta Johnson is the Trust **Director of Infection Prevention and Control (DIPC)/ Lead Nurse** and was responsible for leading and managing the Trust's Infection Prevention and Control (IPC) plan during 2021-22. Beverley Geary, Chief Nursing Officer, had executive responsibility for infection prevention and control during 2021-22. During 2021-22 the role of **Infection Control Doctor** was facilitated by Dr Debbie Wearmouth, Consultant Microbiologist. During 2021-22, ongoing recruitment for Infectious Diseases Consultants and a Consultant Microbiologist continued.

During 2021/22, following two visits and feedback from NHS Improvement the DIPC, who was also the Lead Nurse for the service concentrated on the DIPC role to ensure there was clear definition between the strategic and operational aspects of the role and recruited a Matron to support her in the delivery of the infection prevention & control team and Infectious Diseases specialist nurse teams. Additional support to the team was provided by a further matron who has focused on team development and expansion. The further restructuring of the Infection Prevention & Control Team has strengthened the team structure with the additional bonus of team expansion and development.

Infection prevention & control meetings are held to ensure the Trust remain compliant with the Health & Social Care Act (2008): code of practice on the prevention and control of infections. During 2021-22, **Strategic Infection Reduction Committee (SIRC)** continued to meet monthly, in light of the ongoing challenges related to the COVID-19 pandemic. The SIRC is a performance management and assurance committee, responsible for holding the Health Groups and Directorates to account for their performance in preventing and managing healthcare associated infections/ infectious diseases, and providing information and assurance to the Trust Board that all issues relating to infection prevention and control governance are being managed safely and effectively. Attendance by the senior HG representatives has been good, with an increase in medical representation and most meetings were quorate.

The **Operational Infection Reduction Committee** (OIRC), continued to meet monthly. During 2021-22 this committee was chaired by the Senior Infection Prevention & Control Nurses and/or the DIPC/Lead Nurse. From August 2021, following feedback from NHS Improvement the responsibility of chairperson was transferred to the Infection Control Doctor. The Committee is a forum for the Health Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been good, and most meetings are quorate. The OIRC is an expert advisory body, with the core role of providing advice to the Trust Board and Health Groups on issues pertaining to infection management (including the structure and governance of the infection prevention and control team). The Committee has representation from each Health Group, from the IPC team, from the Department of Infection, from Occupational Health, from the Estates & Facilities Directorate, and from Pharmacy. It reports to the SIRC. The OIRC has responsibility for guiding infection prevention and control activity within the Trust, interpreting external guidance and instruction, and providing the Chief Executive with relevant information and advice. It also advises the Trust on its statutory requirements in relation to infection prevention and control and the decontamination of medical and surgical equipment.

The clinical IPC team is composed of an Infection Prevention and Control Doctor, specialist Infection Prevention and Control nurses, and supporting secretarial and administrative staff. The nursing team is managed by the DIPC/Lead Nurse for the Department of Infection and for the period covered by this report consisted of 2.0 WTE band 7's, 4.0 WTE band 6 and 1 WTE band 5 IPC Nurses, supported by a secretary and a part-time administrative assistant. The national recommendation is for 1 nurse per 250 acute beds (as part of a fully supported team); 83% of English NHS Trusts achieve this figure (NAO, 2000). This recommendation was reviewed and updated in 2015, in light of a continued burden of healthcare associated infections (Zingg, et al, 2015). The authors of a systematic review and expert consensus advise the ratio of one infection prevention & control nurse per 100 beds in acute care. Advertisement of IPC posts and recruitment during 2021-22 continued, which at times was challenging due to the pandemic, a theme experienced by other organisations over the same time period. A post became vacant due to retirement of a staff member, 1.0 WTE Band 7, providing an opportunity to promote one of the existing band 6's. Further restructure of the service which took place during 2020-21, included a 1.0 WTE Band 8a Matron who came into post during 2021-22. Additional support to the team was provided by a further matron who has focused on team development and expansion. The team have benefitted from team building sessions provided both externally and internally. Continuing to deliver an effective IPC proactive and reactive service has developed further during 2021-22 with support from the Consultant Microbiologist/ Infection Control Doctor, Infectious Diseases Consultants, Corporate Nursing team and site team. There is currently no system analyst, data manager, or epidemiological/ SSI surveillance support for the team.

The **Department of Infection clinical team** includes 8 (5.7 WTE) Consultant Infectious Disease physicians, 2 Consultant Microbiologists (2 WTE) which reduced to 1 during 2021-22, 1 Virology Consultant Clinical Scientist and 1 Principal Clinical Scientist /trainee Consultant Clinical Scientist in Medical Microbiology. The nursing team consists of Specialist Nurses in HIV (1.96 WTE), viral hepatitis (4.0 WTE), sepsis (2.0 WTE), and Outpatient Antibiotic Therapy (OPAT) (5.85 WTE), as well as a team of ward-based nurses managing

the infectious disease ward at Castle Hill Hospital (CHH), these individuals currently are managed by a Matron within the Clinical Support Health Group.

4 OTHER RELEVANT COMMITTEES

The Trust has specific committees responsible for decontamination and for water safety. These committees have representation on the Operational Infection Reduction Committee (OIRC), and report to SIRC. There have been previous concerns about frequency of meetings but attendance continued to be impacted during 2021-22 by the COVID-19 pandemic. The chair of the Water Safety Committee, which is a mandatory institution, saw an improvement in attendance by Health Groups and Fresenius Renal Unit. The Water Safety Committee benefitted from the continuation of input from an Authorising Engineer for water safety. Water safety issues are also reviewed regularly by both the SIRC and OIRC.

The Trust's designated Board level Decontamination Lead (as required by the Health and Social Care Act) is the Director of Estates, Facilities & Development supported by the Surgical Health Group Medical & Nursing Directors. The Trust Decontamination Committee did not formally meet during 2021-22 but any concerns and/or items for escalation were facilitated via OIRC and SIRC. The Trust Decontamination Committee was reconvened in May 2022 and will meet quarterly going forward.

5 THE WIDER INFECTION PREVENTION TEAM

In addition to the core clinical IPC team (DIPC, Infection Control Doctor, IPC nurses, etc.) an increasing number of other clinicians are being recruited to support the Trust's efforts including the Quality Team and clinicians with a special interest in the quality of care patients receive and delivering prudent infection prevention & control practice such as Medical Quality Improvement Leads.

The Infection Prevention and Control Link Practitioners act as a resource for good infection prevention practice within their clinical areas. Study days, which are facilitated by the Infection Prevention and Control Team (IPCT), are normally held twice a year to disseminate new information and guidance but due to the COVID-19 pandemic this was not possible. However, during 2021-22 Link Practitioners continued to be supported by the IPCT to be proactive in implementing guidance both existing and new within their workplace.

Access to infection prevention and control information can also be obtained from the Trust Pattie page and via the Trust's global email address Ask Infection, facilitated by the Infectious Diseases consultants in the first instance, with support available from the IPC team as required. During 2021-22, a global IPC team email address remained available for staff to access and email the team with queries, concerns and/or requests for advice or assistance.

6 SURVEILLANCE OF HEALTHCARE ASSOCIATED INFECTION

Public Health England Fingertips data

PHE produce regularly-updated information on a variety of IPC parameters, benchmarking NHS Trusts against other organisations in England (https://fingertips.phe.org.uk/profile/amr-local-indicators/data). The huge amount of information available can be grouped in various

ways: the appendices contain spine plots of the performance of the Trust against all other acute NHS trusts in England in overall performance on all HAI targets (Appendix 1), in antimicrobial prescribing data (Appendix 2), in antimicrobial resistance data (Appendix 3) and in other IPC measured initiatives/metrics (Appendix 4). This information represents 2021-22 data (depending on availability of information) against the NHS initiative targets, HUTH has performed at or better than the benchmark in all cases. For the wider range of HAI targets the Trust generally falls between the 25th and 75th centile, but was a negative outlier for hospital onset Meticillin Sensitive Staphylococcus Aureus (MSSA) blood stream infections (BSI) during 2021-22, in spite of the ongoing COVID-19 pandemic, a slight reduction on hospital onset cases were reported. With regards performance associated with antimicrobial prescribing targets: the Trust was only required to gather data against total antibiotic consumption, this was a national target and reflected the impact of the COVID-19 pandemic. The national contract required Trusts to reduce total consumption 2% below 2018 baseline. The Trust did not meet this target instead ending the financial year 4.5% above the baseline, although Public Health England Fingertips data would suggest 7%, data produced by the Trust confirms the 4.5% figure. This is due in part to increased use of antibiotics across the Trust, patients not accessing healthcare in a timely manner and thus requiring more complex care once admitted, lack of in reach by Infection Service due to competing demands and suboptimal antimicrobial stewardship.

i Meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infection (BSI)

The Trust had achieved a year on year reduction in cases of MRSA BSI since reporting 102 cases in 2005-6 when mandatory surveillance was introduced. Up until 2013 NHS trusts were set progressively decreasing maximum thresholds for MRSA BSI by the Department of Health & Social Care.

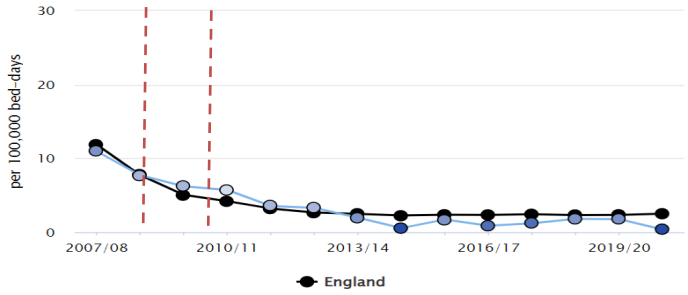


Figure 1. MRSA bacteraemia all rates by reporting acute trust and financial year in England 2007-2019 in comparison with Hull University Teaching Hospitals NHS Trust (red lines indicate introduction of universal screening)

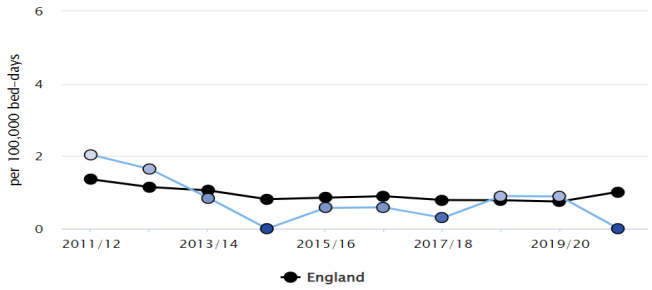


Figure 2. MRSA hospital-onset counts and rates by reporting acute trust and financial year in England 2007-2019 in comparison with Hull University Teaching Hospitals NHS Trust

From 2013-14 the Department of Health & Social Care moved away from a fixed numerical target in favour of a policy of 'zero tolerance of avoidable infection'. It was accepted, that there would continue to be small numbers of infections seen, and that the national aim was to reach an 'irreducible minimum'. National figures support this contention (Figures 1&2). The numbers of total and Trust-attributed MRSA BSI diagnosed in the Trust for the last 6 years are shown in Table 1.

MRSA bacteraemia infections by month & year from 2016 – 2022

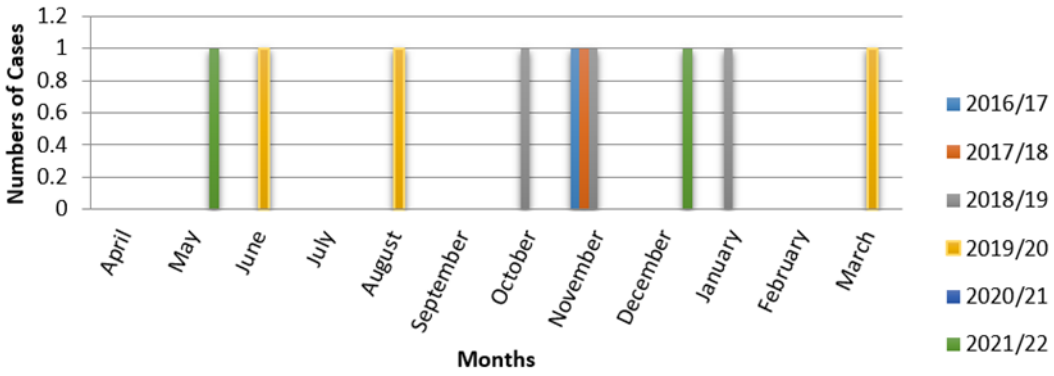


Table 1. MRSA bloodstream infection diagnosed in HUTHT 2015-22

There were no MRSA BSI reported during 2020-21, inclusive of hospital onset cases; a significant improvement for the Trust and especially in context with regards the COVID-19 pandemic.

However, during 2021-22, two hospital apportioned cases were reported, one in May 2021 and the other in December 2021 and investigated via Post Infection Reviews (PIR) by both the Trust and Commissioning Team. The case in May 2021 represented a patient with a history of MRSA and complex comorbidities with the bacteraemia deemed unavoidable and the case in December 2021 represented a patient with a complex medical history inclusive of MRSA colonisation who was admitted with suspected sepsis secondary to MRSA, at the time of writing the report no lapses in practice were identified with regards the care the patient received whilst admitted to the Trust.

During 2021-22, there were four further MRSA bacteraemia cases reported, one community onset healthcare associated which represented a patient not screened for MRSA prior to surgery and was subsequently found to be colonised with an underlying infection which resulted in a surgical site infection on readmission to the Trust this has resulted in a change in patient pathways and screening protocols for this type of surgery. There were a further three community onset community associated cases. This is a marked increase in community cases which the Commissioners are aware of, possibly as a result in patients not accessing or seeking healthcare during the ongoing COVID-19 pandemic. Again all cases were investigated by the respective organisations via PCR and at the time of writing this report again no known lapses have been reported.

From a national perspective, the incidence rate of hospital-onset MRSA bacteraemia peaked at 1.4 cases per 100,000 bed-days in January and March 2021. This was the highest rate seen for hospital-onset MRSA bacteraemia since April to June 2011. The reasons for this increase are still being investigated by UKHSA, although it has been observed that this increase coincided with a rise in the percentage of hospital-onset bacteraemia cases who were also positive for COVID-19.

Among other measures to try to reduce the number of MRSA BSI, the Department of Health in 2010 mandated that all patients admitted to hospital in England must be screened for MRSA skin colonisation. This has proved difficult to implement in practice, and the efficacy of such universal screening (as opposed to testing patients at higher risk) has always been debated. In 2014 the DH Expert Advisory Group on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) reviewed the available evidence, and recommended that all Trusts move from a policy of universal screening to one of selective screening of high risk patients. The Trust developed a proforma to assist clinical areas with identifying which patients, which areas and when HCAI screening is required. To date this has not been formally adopted, especially with regards the fluctuation in reported MRSA bacteraemia cases experienced during 2019-20 & 2020-21 and the competing priorities experienced during the ongoing COVID-19 pandemic, therefore, the Trust continues to screen all admissions for MRSA. It was hoped that the proforma and preferred option would be launched during 2019-20, however, there were impending changes nationally again with regards to MRSA screening and in October 2021, the Hospital Infection Society (HIS) and Infection Prevention Society (IPS) published national guidelines for the prevention and control of meticillin-resistant Staphylococcus aureus (MRSA). The guideline supports screening for MRSA carriage either as a targeted approach but using universal screening as appropriate depending on local facilities. Focus on the management of MRSA, inclusive of screening processes will be a priority and to ensure policies and procedures are aligned to the updated guidance. Opportunities to screen for other HCAI's, including Clostridioides difficile and Carbapenemase producing Enterobacteriaceae (CPE) are taken in line with the drafted proforma which the IPCT continue to monitor.

ii *Clostridioides difficile* Associated Diarrhoea (CDAD)

The Trust has participated in the mandatory surveillance of Clostridioides difficile since 2004. The Trust was a significant outlier with regards hospital acquired C difficile infection during 2011-12 with 105 cases of CDAD attributed to the Trust, against a maximum threshold of 60 set by the Department of Health but following a number of interventions the number of cases

in 2012-13 fell to 58, and the Trust has maintained a steady improvement in performance since then (Figure 2). In 2019, the Department of Health and PHE introduced updated CDAD objectives based on using CDAD data from 1 April 2018 to 31 December 2018. The changes to the CDI reporting algorithm for financial year 2019-20 which included the addition of a prior healthcare exposure element for community onset cases, reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission has continued during 2021-22.

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission (HOHA)

- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (COHA)

- community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA)

- community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks (COCA)

Acute provider objectives were not published for 2021-22 until September 2021 because of the COVID-19 pandemic but data was collected utilising these two categories:

- hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission

- community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

From a national perspective, since the initiation of C. difficile (CDI) surveillance in April 2007, there has been an overall decrease in the count and incidence rate of both all-reported and hospital-onset cases of CD

In 2021-2022 there were 38 HOHA and 14 COHA cases reported, taking the total of CDAD cases to 52, against a threshold of 53 cases, combining HOHA & COHA cases.

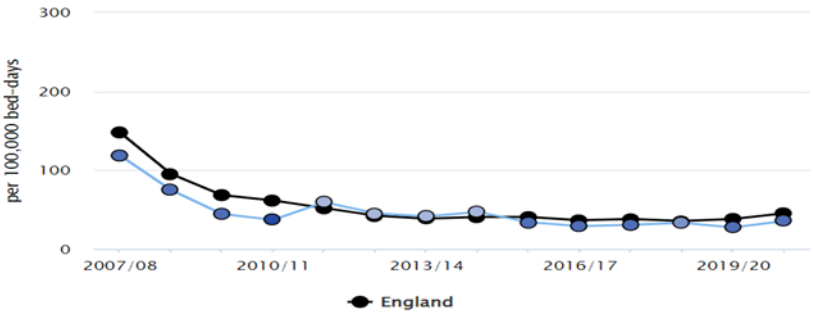


Figure 2. C. difficile all rates by reporting acute trust and financial year in England 2007-2020 in comparison with Hull University Teaching Hospitals NHS Trust per 100,000 bed-days (PHE Fingertips)

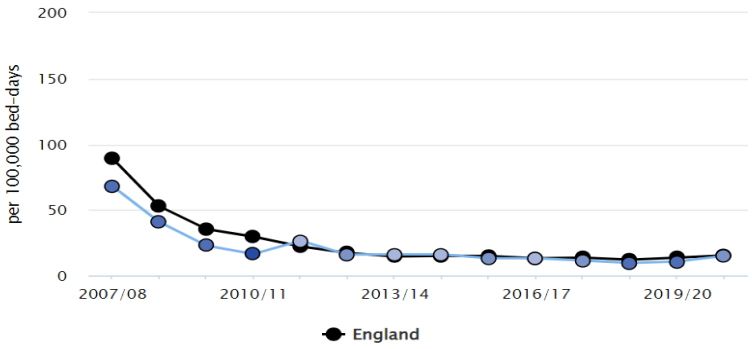


Figure 3. C. difficile hospital-onset rates by reporting acute trust and financial year in England 2007-2020 in comparison with Hull University Teaching Hospitals NHS Trust per 100,000 bed-days (PHE Fingertips)

From 2015-16 there was an opportunity for cases of C difficile for which the commissioners agreed that there had been no lapses of care (and the infection was therefore unavoidable) to be highlighted and removed from any financial penalty, although still included in the total. The Trust agreed a very strict definition with the commissioners, whereby any deviation from Trust or national guidance (even if not necessarily contributory to the development of infection) was classed as a lapse of care. Meetings with the Commissioners to review CDAD cases were postponed due to COVID-19 but opportunity to discuss HCAIs including hospital onset CDAD cases where lapses in practice occurred continued through other outbreak meetings set up to discuss COVID-19 activity. In December 2021, the Commissioner Led HCAI Review Group was reconvened and continues to meet monthly to discuss community and hospital onset cases of Clostridioides difficile along with scope to discuss other complex infections.

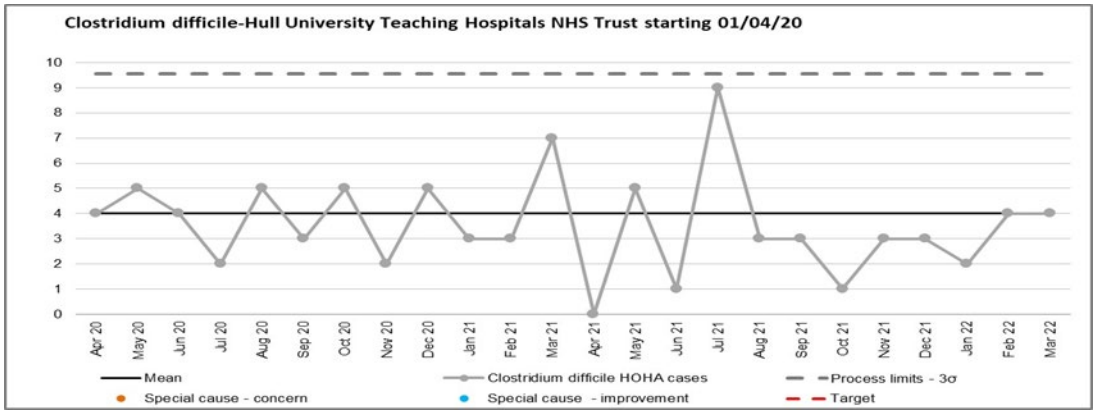


Table 2. Hospital onset Clostridioides difficile infections diagnosed in HUTHT 2019-22

All cases of *C difficile* infection are actively reviewed by the IPCT and the Health Group responsible for the patients care, cases are subject to a Root Cause Analysis (RCA). The RCA process is led by the senior clinicians (medical and nursing) involved with the care of the patient, and supported by the IPCT. Summary outcomes are presented to the IRC. In most cases there were no significant failures of care apparent that had led to the development of CDAD. One identified key issue for improvement related to antimicrobial stewardship and adhering to the Trust antimicrobial prescribing guidance, with lapses in practice identified when this was not congruent with Trust guidance.

Meticillin sensitive *Staphylococcus aureus* (MSSA) BSI

National data show that the general reduction in MRSA BSI has not been mirrored by a fall in MSSA bloodstream infection. This is of concern as the two organisms have similar epidemiology and pathogenesis. The Department of Health therefore introduced mandatory surveillance of MSSA bacteraemia from January 2011.

Benchmarking for MSSA infections is less developed than for MRSA, and the balance between healthcare-associated and other infection less clear. Root cause analysis of MSSA BSI cases are completed and reported via the OIRC. There have been year to year fluctuations, but during 2021-22 HUTH reported the slight reduction by three cases of infection as experienced during 2020/21 it however, remains the one major HAI indicator for which we are significantly worse than the national benchmark.

Since the mandatory reporting of MSSA bacteraemia began in January 2011 there has been a general trend of increasing counts and incidence rates of cases. From a national perspective, the count of all reported cases of MSSA bacteraemia increased by 43.7% from 2,199 to 3,160 between January to March 2011 and October to December 2021. This was accompanied by a 32.4% increase in incidence rate from 16.8 to 22.2 per 100,000 population. These increases are primarily driven by increases in community-onset cases. Between January to March 2011 and October to December 2021, the count and the incidence rate of community-onset cases increased by 49.1% and 37.4% respectively from 1,464 to 2,183 cases and from 11.2 to 15.4 cases per 100,000 population. Over the same period, the count of hospital-onset cases increased by 32.9% from 735 to 977 cases, while the hospital-onset incidence rate increased 38.9% from 8.3 to 11.6 cases per 100,000 bed-days.

Since April 2020, there has been a national increase in the incidence rate of hospital-onset MSSA bacteraemia cases. The overall growth is, in part, a result of reduced hospital admissions and overnight bed-days. This has caused a large increase in the rate of hospital onset cases over a relatively short time since overnight bed-days is used as a denominator for rate calculations. This culminated in a peak during January to March 2021 of 13.4 cases per 100,000 bed-days and 998 cases, which was the highest MSSA hospital-onset rate and count that has been observed since the inception of MSSA surveillance.

It is worthy to note that the Trust has reported a slight reduction in hospital onset MSSA bacteraemia cases, compared to 2020-21. However, The Trust remains an outlier with regards the reporting of hospital onset bacteraemia cases, with the Surgery & Medicine Health Groups reporting the majority of cases.

The Neonatal Intensive Care Unit (NICU) reported two MSSA bacteraemia cases, one in January 2022 and the other in February 2022. Both were related to time and place and isolates sent to Staphylococcal Reference Laboratory confirmed likely transmission on the unit, with both neonates nursed adjacent to one another in the Blue Room. Both cases were subject to root cause analysis investigation and reported via the respective Health Group governance structure and Infection Reduction Committee meetings. No further cases have been reported to date.

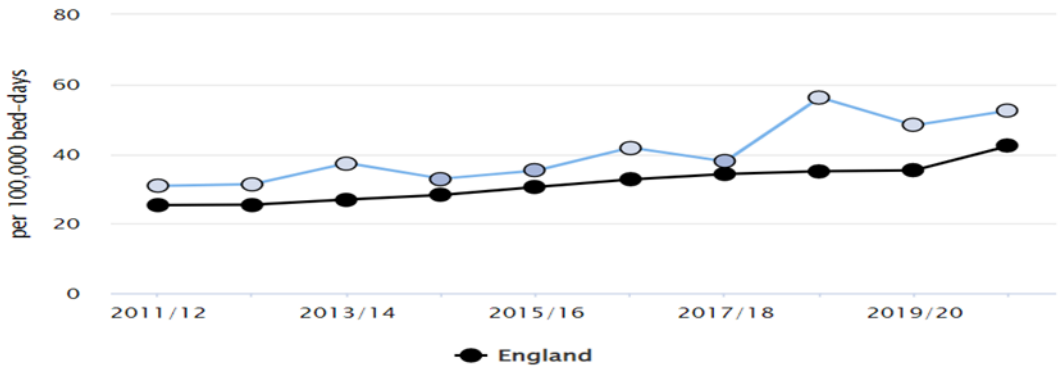


Figure 3. MSSA BSI rates in England 2011 – 2020 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

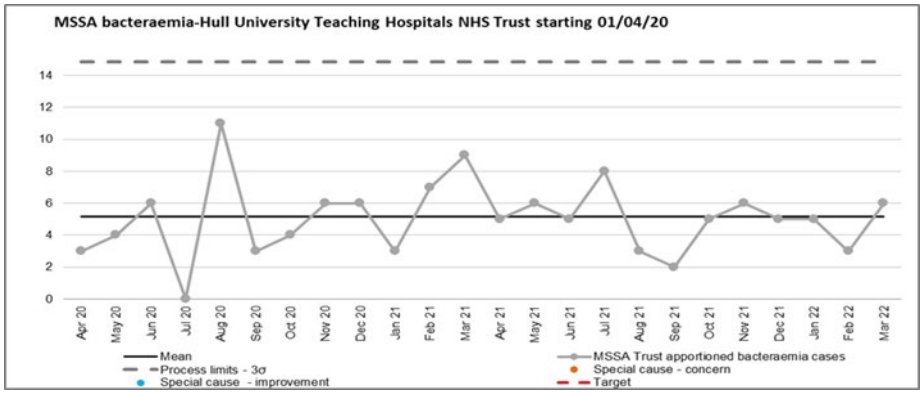


Table 3. MSSA bloodstream infection diagnosed in HUTHT 2019-22

Reasons for the continued rate of MSSA BSI during 2021-22 are multifactorial and relate to a variety of causes including skin and soft tissue infections, ventilator associated pneumonia, and ongoing poor intravascular line insertion and care, specifically peripheral vascular devices but thankfully in lesser numbers during 2021-22 yet these should remain avoidable. During 2021-22, in spite of the COVID-19 pandemic the Device Task, Challenge & Finish Group continued to meet to progress work with regards cannula insertion and ongoing management, with the Trust linking in with BBraun to deliver training, disseminate updated products and posters, including an extension line to mitigate manipulation at the cannula site and risk the development of thrombophlebitis. Other cases associated with intravenous drug use and chronic ulcers are more difficult to address, but further work is needed to investigate why such a high proportion of our overall MSSA BSI cases are hospital-apportioned. During 2021- 22, focus has primarily been working alongside the respective Health Groups to address concerns with regards a number of wards with higher than average MSSA bacteraemia rates. Initial findings suggest a correlation with regards the use of central venous access devices and a lack of robust evidence to support staff competencies. Additional training was being provided along with a Trust wide roll out updated care bundles to improve documentation. In those areas where this has been delivered a marked reduction in MSSA bacteraemia was previously noted. Community Apportioned MSSA bacteraemia cases across Hull & East Riding of Yorkshire during 2021-22 reduced potentially due in part to the reduced footfall of patients accessing treatment and the measures taken to reduce the transmission of COVID-19 in the community. However, Hull Clinical Commissioning Group (CCG) report numbers of bacteraemia higher than the national average.

Escherichia coli bacteraemia

The incidence rate of all reported E. coli bacteraemia increased each year between the initiation of the mandatory surveillance of E. coli bacteraemia in July 2011 and the start of the COVID-19 pandemic (January to March 2020). This was primarily driven by the increase in the rate of community-onset cases. Since the start of the pandemic, the total cases and rates and community-onset cases and rates have fallen but are still higher than the start of the period. In contrast, the incidence rate of hospital-onset cases has remained relatively stable within the same period.

Between July to September 2011 and October to December 2021, the count and the incidence rate of all reported cases of E. coli bacteraemia increased by 10.8% from 8,275 cases to 9,166 and from 61.8 to 64.5 cases per 100,000 population, respectively. Similarly, over the same period, the count of community-onset cases increased by 16.3% from 6,279 to 7,300, while the incidence rate increased by 9.5% from 46.9 to 51.4 cases per 100,000 population. Whilst, the count of hospital-onset cases decreased by 6.5% from 1,996 to 1,866 cases. This corresponded to a decrease in the incidence rate of hospital-onset cases by 6.2% from 23.6 per 100,000 bed-days to 22.1 per 100,000 bed-days.

While hospital admissions were lower during the pandemic, over the same period, between October to December 2020 and October to December 2021, there has been a slow increase in hospital admissions. However, this is happening at a greater magnitude than the increase in cases, which is why a decline in incidence rate is observed.

In previous years, there is a strong seasonality to the incidence of all-reported E. coli bacteraemia cases, with the highest rates observed between July and September of each year. Care is required in interpreting data during 2021-22 as the Trust has seen a reduction in cases and hospital elective activity.

The Department of Health had announced a formal intention to reduce the incidence of E coli bacteraemia by 50% by 2020; this was subsequently reviewed and updated on the 24th January 2019 on the Department of Health publication of 'Tackling antimicrobial resistance 2019–2024. The UK's five-year national action plan'. This publication acknowledged the complexity of reducing gram negative bloodstream infections but reiterated the need to continue work to halve healthcare associated Gram negative BSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021-2022 with the full 50% by 2023-2024.

The majority of E coli BSI diagnosed in HUTH are the cause of admission rather than being hospital-acquired (usually related to urine or gall bladder infections), and are therefore considered as 'non-attributable' to the Trust. However a proportion of E coli bloodstream infections continue to be acquired in hospital, associated with urinary catheters, wound infections, vascular devices, and ventilator-associated pneumonia. Even for the 'community-attributable' bacteraemia the situation is not as straightforward as it may seem, as infections developing in the community may be related to a previous admission to hospital. Although surveillance of cases is reported, it is difficult to determine which infections were potentially avoidable without robust investigation. Each hospital apportioned case is subject to a review by the IPCT and if identified lapses in practice are identified then a root cause analysis ((RCA) is completed, the majority of which are related to urinary catheter associated infections.

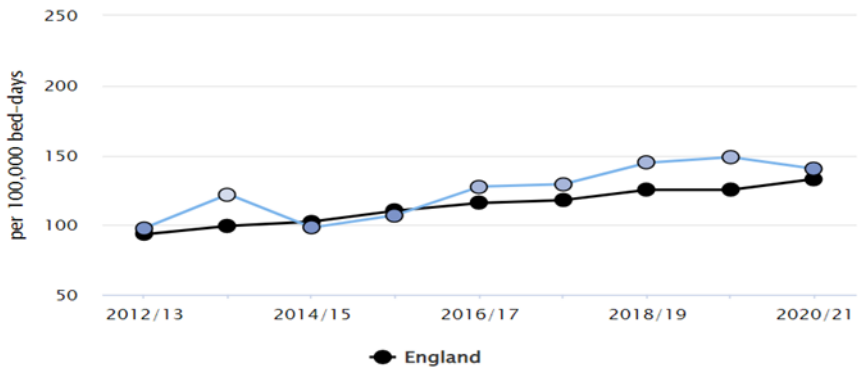


Figure 4. E.coli BSI rates in England 2012 - 2021 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

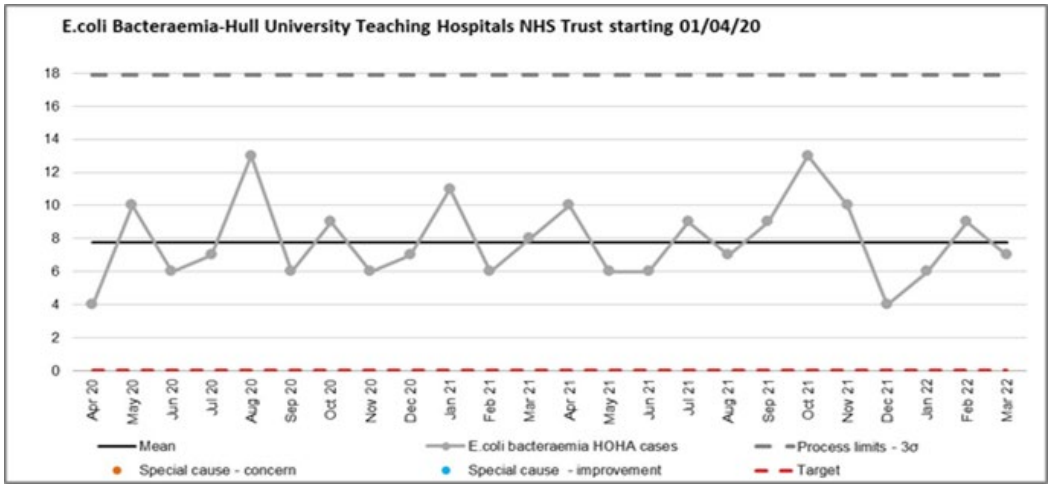


Table 4. E. coli bloodstream infection diagnosed in HUTHT 2019-22

Klebsiella and Pseudomonas Aeruginosa bacteraemia

For the operational period 1st April 2021 to 31st March 2022, UKHSA (PHE) and NHS England required NHS Trusts to continue to report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa. This is to support the government initiative to reduce Gram-negative bloodstream infections by delivering a 25% reduction by the financial year 2021-2022 with the full 50% by 2023-2024, inclusive of E.coli, Klebsiella and Pseudomonas Aeruginosa bacteraemia.

Klebsiella and Pseudomonas Aeruginosa bacteraemia demonstrate similar risk factors as those found with E.coli bacteraemia, with both reported for cases of respiratory and urinary tract infections.

Klebsiella bacteraemia

Between April to June 2017 and October to December 2021, nationally there was a 33.3% increase in the count of all reported Klebsiella spp. bacteraemia cases from 2,348 to 3,131 and a 30.1% increase in the incidence rate from 16.9 to 22.0 cases per 100,000 population, the highest levels seen since surveillance began.

Counts and rates of hospital-onset Klebsiella spp. peaked between July to September 2020 and January to March 2021. Since the start of the pandemic, both counts and rates hospital-onset cases increased to levels which were the highest observed since the inception of Klebsiella spp. surveillance. The hospital-onset incidence rate peaked at 15.5 cases per 100,000 bed-days during January to March 2021.The specific drivers of this increase are still being investigated by UKHSA (PHE), but do know these trends coincided with increased incidence of COVID-19.

In October to December 2021, the number of hospital-onset Klebsiella spp. bacteraemia cases increased by 4.0% and the incidence rate decreased by 6.5%, when compared with the same quarter in the previous year (October to December 2020). Compared to the same period in 2019 (October to December 2019), a more typical year prior to the pandemic, the counts and the incidence rate of hospital-onset cases increased by 24.3% and 30.9% respectively.

During October to December 2021, 71.6% (2,241 of 3,131) of all reported Klebsiella spp. bacteraemia were caused by Klebsiella pneumoniae, a decrease from 72.3% in the same quarter in the previous year (October to December 2020).

Over the same period, the percentage of cases identified as Klebsiella oxytoca was 17.5% (548 of 3,131) in October to December 2021, which is similar to what was reported in October to December 2020 (17.2%). The incidence rate of all species increased approximately proportionally, broadly following the same overall trend. The exception to this was the incidence rate of K. oxytoca, which increased within hospital-onset cases around the start of the pandemic and subsequently stabilised at 1.9 to 2.1 per 100,000 bed days.

There is evidence of seasonality in the incidence trends of all-reported Klebsiella spp. bacteraemia cases, with the highest rates normally observed in July to September of each year, although it is important to evaluate financial year April 2020 to March 2021 and financial year April 2021 to March 2022 with caution due to the ongoing COVID19 pandemic.

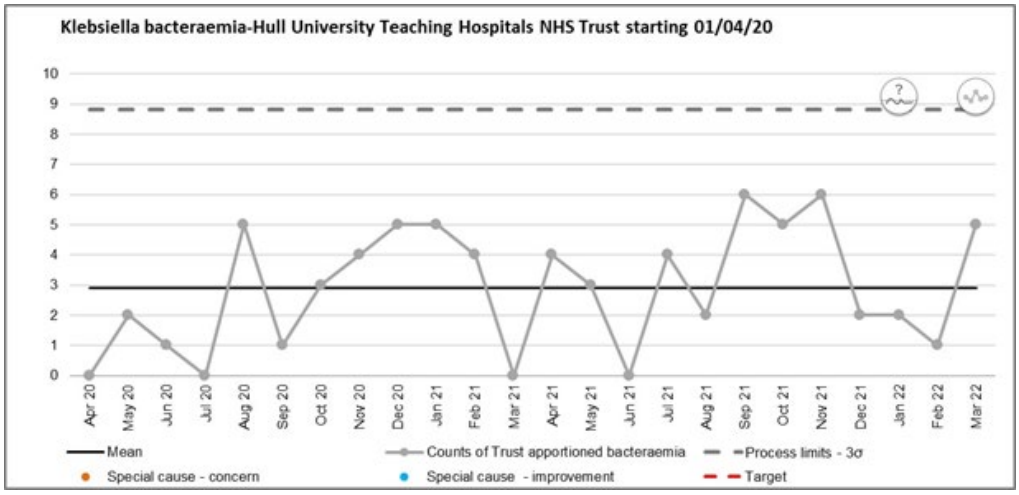
Pseudomonas aeruginosa bacteraemia

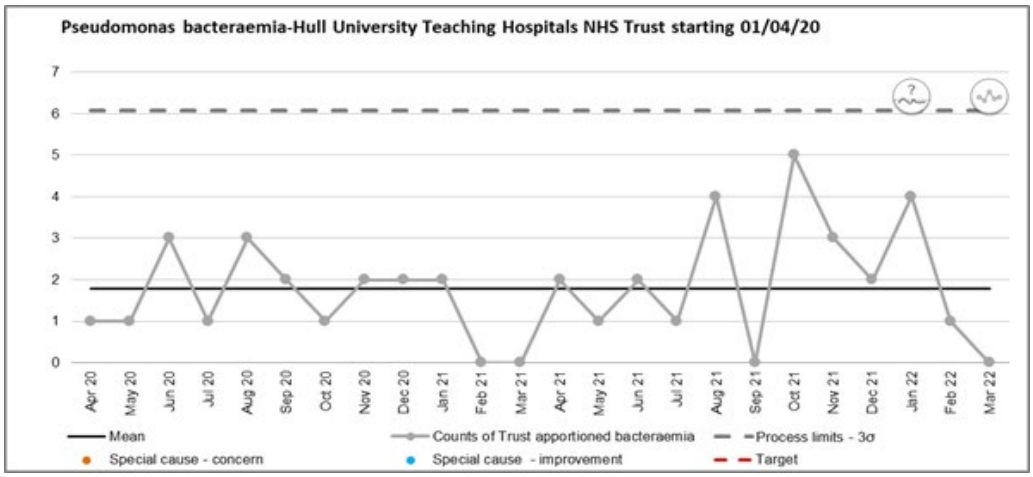
Between April to June 2017 and October to December 2021, there was a 10.1% increase in the count of all reported P. aeruginosa bacteraemia cases from 1,015 to 1,118, and a 7.5% increase in the incidence rate from 7.3 to 7.9 cases per 100,000 population. The count and the incidence rate of community-onset cases increased by 6.1% from 639 to 678 cases and by 3.5% from 4.6 to 4.8 cases per 100,000 population respectively. Over the same period, the count and the incidence rate of hospital-onset cases increased by 17.0% from 376 to 440 cases and by 19.9% from 4.3 to 5.2 cases per 100,000 bed-days respectively.

Like Klebsiella spp. cases, increases in counts and rates of hospital-onset P. aeruginosa were also observed during the second wave of the pandemic. The counts and rates of hospital-onset P. aeruginosa increased between July to September 2020 and January to March 2021. During this period, both the counts and rates of hospital-onset cases increased to levels not seen since the initiation of mandatory surveillance of P. aeruginosa bacteraemia. The incidence rate of hospital-onset cases peaked at 7.0 cases per 100,000 bed-days in January to March 2021. The reasons for this increase have been investigated and it was observed that this increase coincided with a rise in the percentage of hospital-onset bacteraemia cases who were also positive for COVID-19.

Care should be taken when comparing October to December 2021 with the same period in the previous year (October to December 2020) which was largely affected by the COVID-19 pandemic. Both the total reported and community -onset counts and rates remained broadly the same.

Tables 5&6. Klebsiella and Pseudomonas aeruginosa bloodstream infections diagnosed in HUTHT 2019-2022





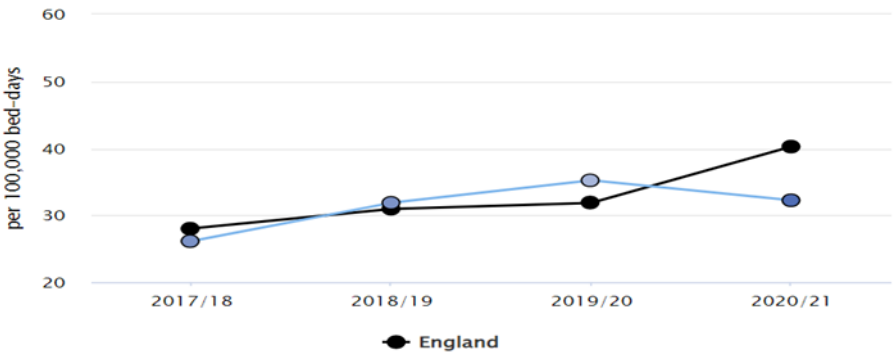


Figure 4. Klebsiella BSI rates in England 2017 - 2021 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

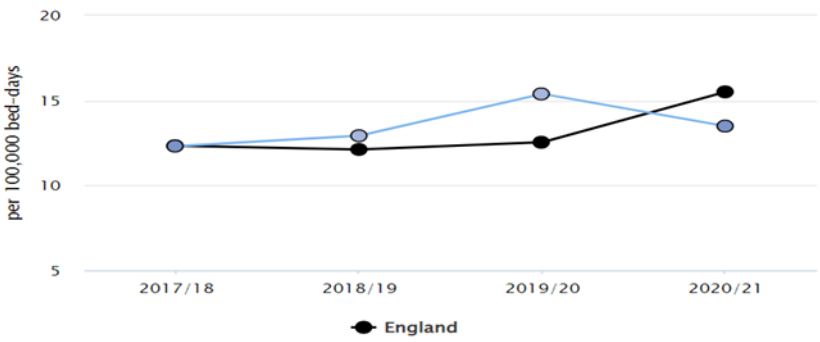


Figure 5. Pseudomonas aeruginosa BSI rates in England 2017 - 2021 in comparison with Hull University Teaching Hospitals NHS Trust (PHE Fingertips)

Figure 4&5 demonstrate an increase in cases in England of both Klebsiella and Pseudomonas aeruginosa with HUTH reporting a reduction of cases to the normal England average.

Surgical Site Surveillance

The Trust continues to participate in both mandatory and voluntary surveillance of surgical site infection: in 2021/22 this included orthopaedic surveillance (fractured neck of femurs) and was commenced during January 2022 – March 2022, providing the opportunity to compare year on year figures.

With regards repair of neck of femur fracture surveillance completed during January – March 2022, one hundred and thirty four repair of fractured neck of femur operations were surveyed, provisional data suggests one patient was reported to have a superficial wound infection providing the percentage of surgical site infections (SSIs) at the Trust at 1.1%, in line with the national hospital SSI rate. These figures remain static from the same surveillance period for January to March 2021. At the time of drafting the report, the surveillance is awaiting sign off and ratification by the PHE Surgical Site Surveillance Service (SSISS).

8 OUTBREAKS AND RESISTANT ORGANISMS

The Trust's policy on outbreaks and incidents of infection was updated during 2020-21 and again during 2021-22 to reflect the challenges of COVID-19 and has been followed by the IPC team and respective Health Groups. Incident and Outbreak Control Group meetings have been held where necessary to support clinical areas in determining whether an incident or outbreak is occurring, ensuring patient safety and preventing onward transmission. The majority of outbreaks during 2021-22 have related to COVID-19 and is covered in this report in a separate section.

Diarrhoea & Vomiting/ Norovirus

During 2021-22, there were very few incidences and/or outbreaks of Norovirus reported although during February & March 2022 there were 3 outbreaks caused by Norovirus which resulted in ward closures, including wards C16, H200 & H5. The outbreaks were promptly

identified but affected both patients and staff, they were short lived in duration with incident meetings held to discuss control measures. All wards were cleaned and reopened following advice taken from the IPCT.

During 2021-22, outbreaks of diarrhoea & vomiting (D&V), mainly affecting medical elderly wards were reported. In the majority of cases, only bays were affected and following applied control measures and sampling, closures was short-lived.

In accordance with national guidance hospital outbreaks of D&V/ Norovirus were managed with partial restrictions but some complete ward closures were necessary.

Carbapenemase producing Enterobacteriaceae (CPE)

Infections with multi-drug resistant Gram negative bacteria are becoming increasingly common in Britain, and there have been a number of healthcare associated outbreaks (including some in other acute trusts in Yorkshire). During 2021-22 Hull University Teaching Hospitals NHS Trust continued to experience imported infected and/or colonized patients, all of whom brought the organism in from elsewhere albeit at lower numbers due to restrictions of patient movement imposed by the COVID-19 pandemic. The Trust continues to identify and respond as per the updated national toolkit 'Framework of actions to contain carbapenemase-producing Enterobacterales' (updated September 2020) on the prevention and management of CPE and during 2021-22 worked on meeting the requirements of the toolkit e.g. identifying, screening and managing at risk patients and those with active infection. During 2021-22 in response to admissions and transfers of patients with CPE and a concern regarding the propensity for CPE to survive in healthcare environments, reactive cleaning of ward/ department areas using Hydrogen Peroxide Vapours (HPV) was conducted where patients had been nursed and/or treated. This was invariably needed out of normal working hours and conducted by an external company who specialise in HPV decontamination.

This represents a cost burden to the Trust in the long term with HPV decontamination out of hours costing the Trust approximately £40,000.00 excluding VAT for 2021-22. During 2021-22, this was deployed because of COVID-19 outbreaks and to facilitate 'red' COVID-19 positive wards being reverted back to 'green' non-COVID-19 capacity.

Influenza

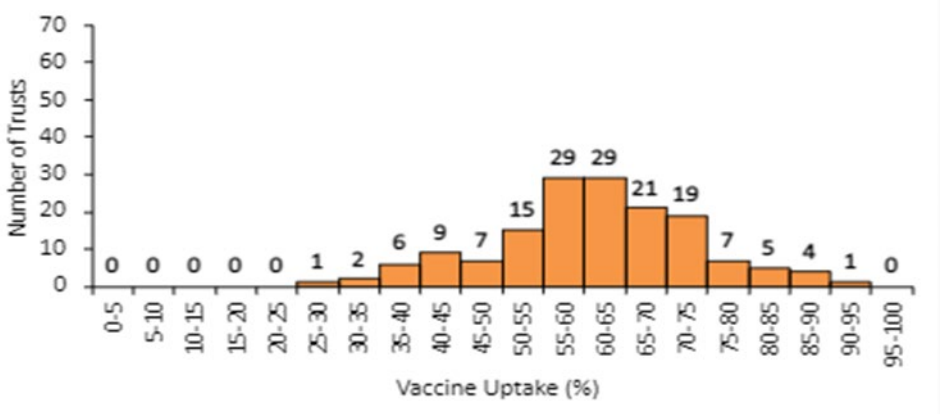
Cases of Influenza were reported from October 2021 onwards and continued to be reported up to and including April 2022.

The majority of cases were reported on admission to the Trust and were identified as Influenza A as the predominant circulating strain.

During March 2022, a noted increase was reported in the identification of Influenza A cases amongst patients due in part to the frequency of asymptomatic PCR testing for COVID-19 which incidentally identified Influenza A. Managing patients as contacts again identified asymptomatic Influenza A cases on repeat screening who were managed separately to any COVID-19 positive patients.

The influenza vaccination campaign for 2021-22 commenced on the 14th September 2021 for healthcare staff and at year end, 71% of Trust staff involved in providing direct patient care had taken up the influenza vaccine a decrease from previous campaigns but comparably higher than other acute Trusts across Yorkshire and the Humber. This was due in part to clinical staff prioritizing COVID-19 vaccination.

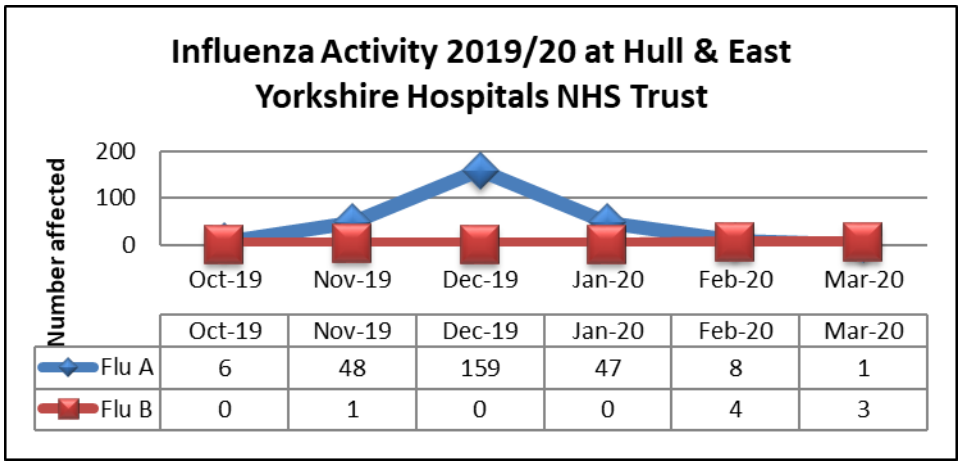
Influenza Vaccine Uptake (%) in HCWs, in NHS England Trusts



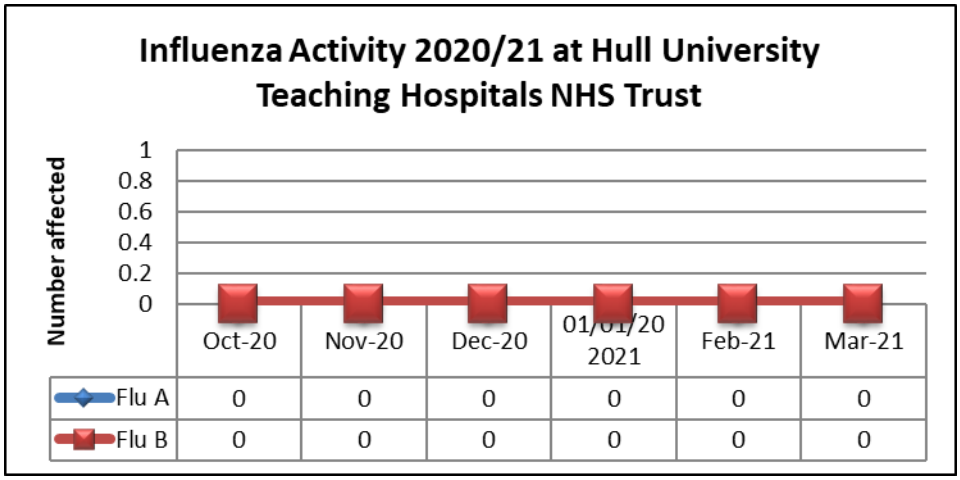
(Source: UKHSA: Seasonal flu and COVID-19 vaccine uptake in frontline healthcare workers: monthly data, 2021 to 2022)

Patients were proactively screened for influenza, along with COVID-19, during admission and/or treatment when presenting with flu-like symptoms which is to be commended and encouraged, ensuring patient and staff safety.

The following three graphs show the distribution of Influenza strains for FY 19-20, 20-21 and 21-22.



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Flu A	6	48	159	47	8	1
Flu B	0	1	0	0	4	3



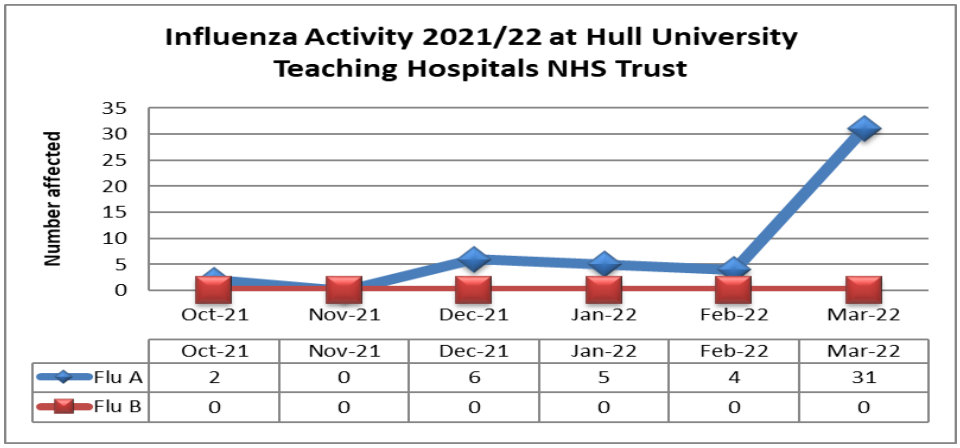
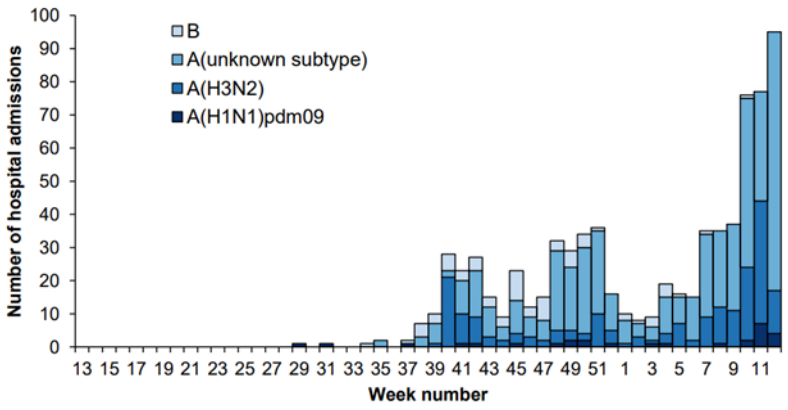


Table 9. Represents influenza activity at the Trust since October 2021 until the end of March 2022

This next graph demonstrates weekly influenza hospital admissions by influenza type in England and reflects the rise in cases in March 2022 as reflected by the Trust. (Source: UKHSA: Weekly national Influenza and COVID-19 surveillance report)



COVID-19

The Trust adopted a Command Structure to manage the pandemic and the subsequent Trust COVID-19 Surge Plan and this continued during 2021-22.

During 2021-22, COVID-19 remained the largest challenge for the organisation in addition to the volume of patients whom medically fit for discharge, had subsequently no criteria to reside, resulting in a number of wards dedicated to their care.

The pandemic during 2021-22 was punctured with different COVID-19 variants which resulted in peaks and troughs of reported COVID-19 cases. Mostly notably Delta and Omicron variants, both of which resulted in high prevalence and incidence within the community and subsequently an increase in hospital admissions and resulting outbreaks of infection.

From April to September 2021, 1,867 COVID19 cases screened positive for COVID-19; the majority were patients screened with a decision to admit and/or in OPD settings, of the 1,867 cases 21 were hospital onset probable cases (8-14days) and a further 17 were hospital onset definite cases (>15 days). Representing a 1.1% and 0.9% infection rate in this time period. These hospital onset cases were linked to reported outbreaks where community onset cases were admitted and nursed in bays resulting in contacts and subsequent positive cases. By way of context, in January 2021 at the peak of hospital onset outbreaks experienced by the Trust there were 1,428 cases reported in January 2021 alone with 258 hospital onset cases reported representing an 18% infection rate.

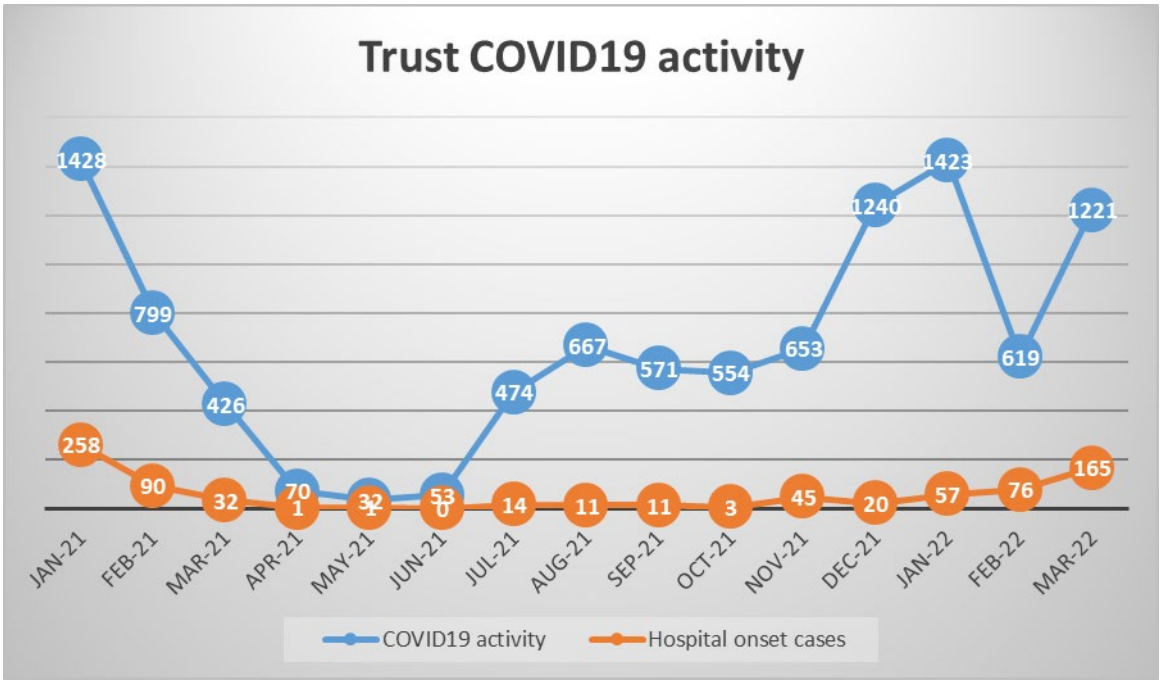
During October 2021, a decrease in reported cases was noted and there were no significant outbreaks of COVID19, whereas during November 2021 cases increased resulting in a number of outbreaks affecting wards at CHH and HRI. The Omicron variant was first noted within the community in December 2021 which resulted in an increase in COVID-19 cases and subsequently became the dominant strain in January 2022. During December 2021, in light of the Omicron variant updated COVID19 guidance was published including the additional need to wear RPE (FPP3 facemasks) when hierarchy of control assessments suggests other measures would be insufficient to protect both staff and patients.

A reduction of COVID19 cases were reported during February 2022 but a marked rise in cases were noted during March 2022, in line with other organisations across Yorkshire & the Humber and due in part to the Omicron variant which was markedly more transmissible. This resulted in a number of outbreaks across the Trust resulting in bay and ward closures. Patients and staff were affected but notably patients did not require escalation of care nor were noted to be symptomatic, however, those patients who were unvaccinated and/or immunocompromised remained particularly at risk.

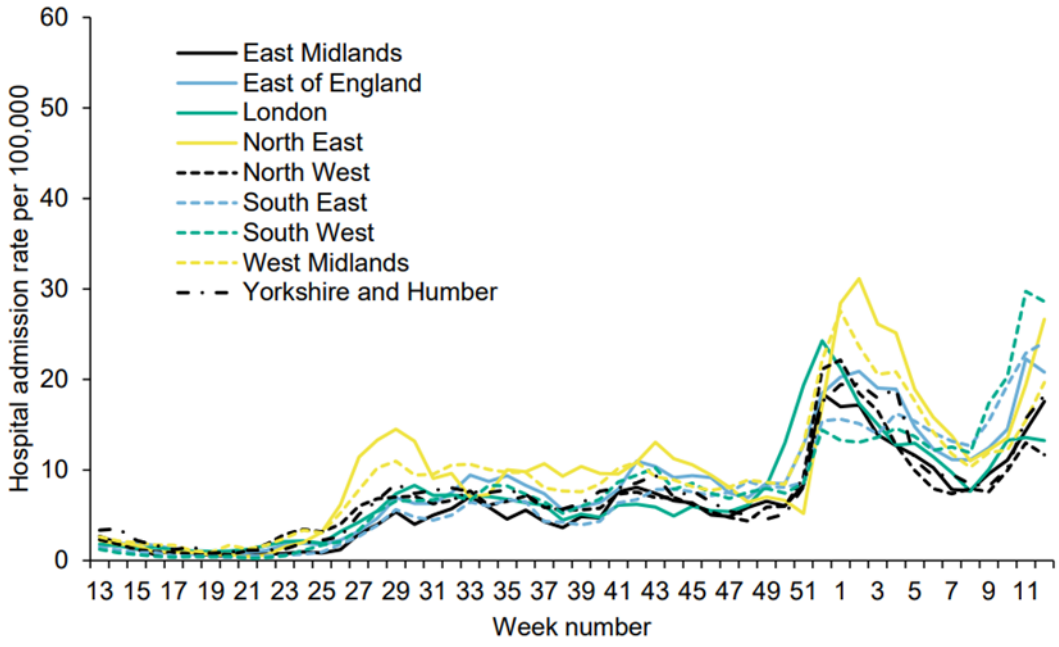
The impact of COVID-19 vaccination including a third dose resulted in patients being affected by COVID-19 differently, patients did not require an escalation of treatment requiring level 2 or 3 care as previously seen in the first waves of the pandemic.

Outbreaks of COVID-19 resulted in convened multidisciplinary incident meetings to improve decision making and escalation locally, regionally and nationally via reporting routes. To improve communication further a daily IPC report was drafted and circulated to ensure clinical and site teams were apprised of IPC recommendations with regards bay and ward closures along with IPC advice.

During 2021- 22, updates to national guidance and changes to the IPC board assurance framework were communicated and escalated to Trust Board as and when necessary with both the ICD and DIPC delivering Board Development sessions.



The graph demonstrates COVID19 activity at the Trust and the number of hospital onset cases.



Weekly hospital admission rate by UKHSA Centre for new COVID-19 positive cases. (Source: UKHSA: Weekly national Influenza and COVID-19 surveillance report)

9 ISOLATION FACILITIES

There have been, for many years, concerns about the Trust's isolation facilities. Like many other NHS trusts with older estate there is a general shortage of single rooms suitable for isolating patients with potentially contagious conditions. This is a long-standing issue, and there is no simple solution.

Ward C7 has had a positive impact on patient management, particularly those patients with difficult to treat infections and infectious diseases requiring specialist isolation facilities, particularly pertinent in light of COVID-19. It also means that we can manage several patients at once with conditions requiring long term isolation, for example multidrug resistant tuberculosis. The ward also forms part of a network of high consequence infectious disease facilities across the UK which can be utilised as and when required.

There remain concerns about the organisation's ability to isolate children, especially those with airborne infections. Although plans are discussed and implemented to minimise the risk of infections, especially during winter with risk assessments and liaison with IPCT - there have been, and will continue to be, cases of hospital transmitted influenza and respiratory syncytial virus (RSV) until more suitable facilities for isolating children with these infections are provided. Cases of childhood respiratory viruses were again significantly reduced during 2021/22 due in part to the measures implemented to mitigate the concerns with regards COVID-19 such as facemasks, social distancing and the importance of prudent hand hygiene. Consequently, paediatric services with reduced surgical elective activity were able to manage any admissions with respiratory infections effectively across the paediatric bed base. During 2021-22, with IPC input and involvement, multi-disciplinary meetings have been held and work has commenced on a new paediatric inpatient, high dependency unit and outpatient facility. Improved isolation capacity and smaller bedded areas e.g. 2 bedded bays will enable prudent management of paediatric patients and minimise the risk but not totally exclude the transmission of infections. Although the scheme has been delayed due to the COVID-19 pandemic and the demand on inpatient facilities, it is scheduled to start during 2022.

The Neonatal Intensive Care Unit (NICU), a tertiary level 3 unit, has had a number of incidents and outbreaks with the environment cited as being a contributory factor and significant work has been undertaken on the unit to mitigate risks. The 'blue room' although reduced by one cot space requires further work to reconfigure the space following a recommendation from the Department of Infection for this to be addressed as soon as is practicable. The COVID-19 pandemic paused any imminent plans and although the reconfiguration has been approved, additional allocated funding is pending at the time of writing this report. This is due in part to changes expected once the paediatric scheme commences, allowing NICU to review parental accommodation and reconfigure the unit accordingly.

During 2021-22, the COVID-19 pandemic continued to provide the opportunity to review the Trust's existing bed capacity and with it the ability to isolate patients effectively in collaboration with the Estates team and the IPCT. Wards H36, H37 & H38 were utilised for nursing COVID-19 positive patients, with H36 provided with 18 cubicles of which 6 had lobbied areas with negative pressure ventilation and H37 constructed and configured to nurse level 2 respiratory patients. Suite 36, an administration block closed and from

December 2021 has been reconfigured to become a further inpatient area, again providing further isolation capacity on the HRI site, this is scheduled to open by June 2022.

The COVID-19 pandemic highlighted the need for compliant isolation facilities in ICU settings on both hospital sites and to this end in January 2021 work commenced on building a fully compliant ICU on the HRI site, in collaboration with clinical teams and involvement of the IPCT. Although the scheme was initially delayed the new unit opened during December 2021, providing fully compliant ICU facilities including isolation cubicles with negative pressure ventilation. Additional capacity to future proof the unit will be made available on the third floor of the scheme during 2022 which will also include additional theatre areas, all of which will improve care for patients requiring intensive care.

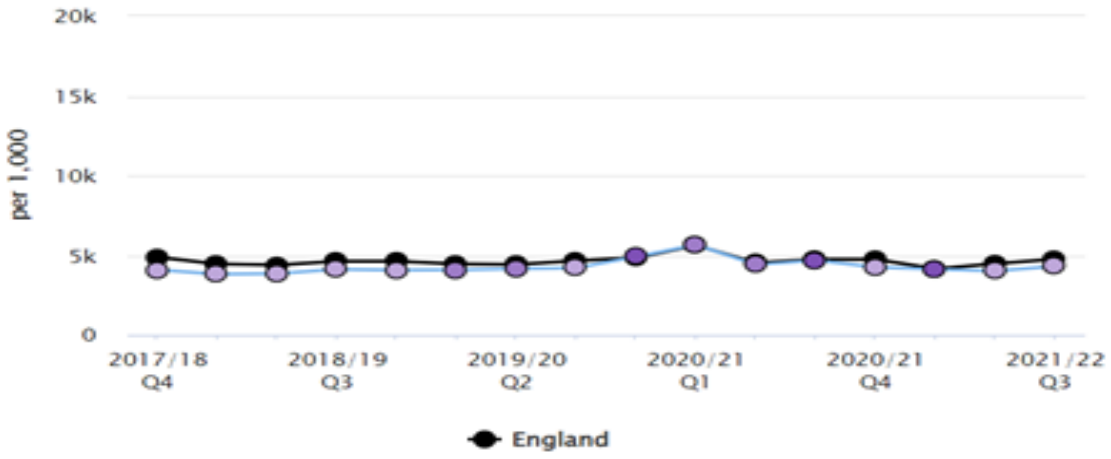
10 ANTIMICROBIAL STEWARDSHIP

Increasing emphasis is being placed nationally on the importance of antimicrobial stewardship as part of infection prevention and control plan. This is useful in reducing the development of C difficile infection, but is even more important in limiting the emergence of bacterial resistance. The Trust has for many years had a good record in antimicrobial stewardship.

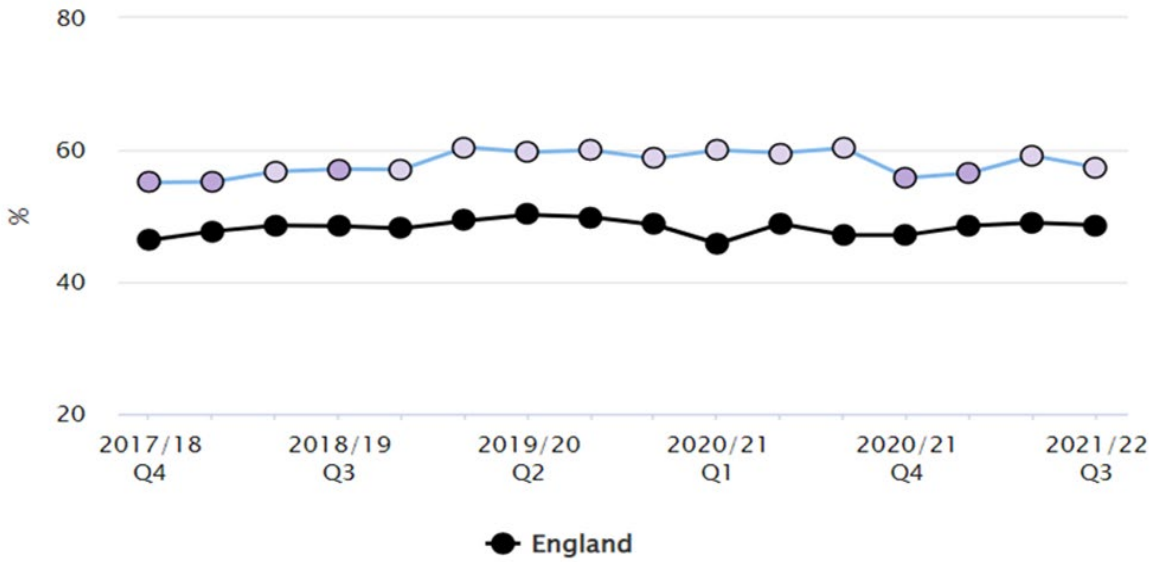
The World Health Organisation created the Access, Watch and Reserve antibiotic categories to assist antimicrobial stewardship and to reduce antimicrobial resistance. The three AWaRe categories divide antibiotics as follows:

- Reserve – antibiotics that need to be reserved due to antimicrobial resistance
- Watch – second-line agents
- Access – key antibiotics which are narrow spectrum and used as first-line treatment options.

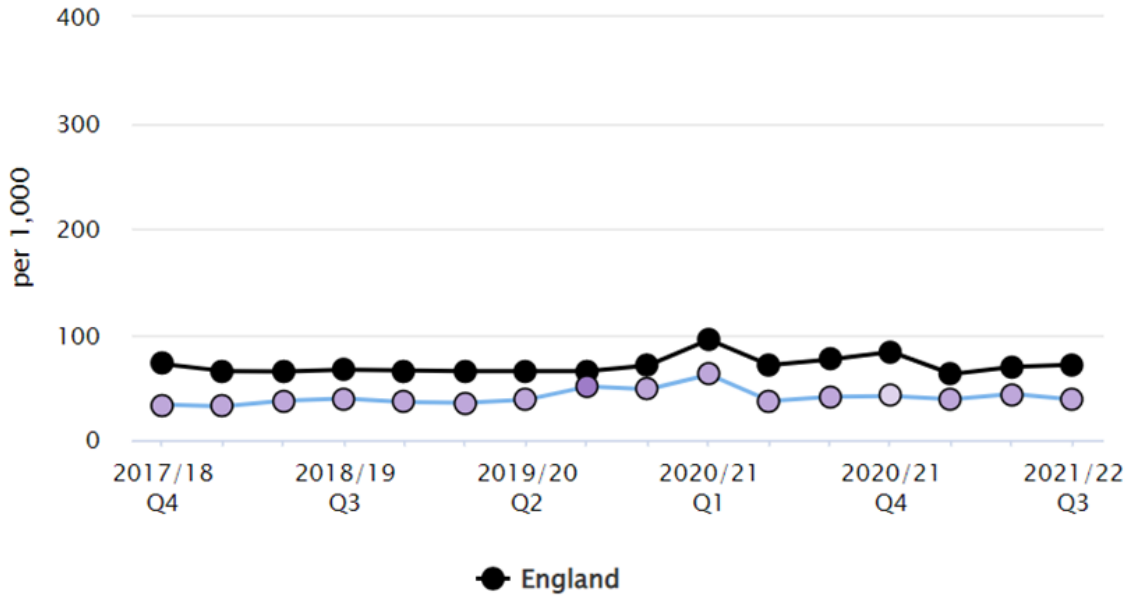
During 2021-22 CQUINS associated with use of antimicrobials and stewardship were not published because of the focused attention on the COVID-19 pandemic. Although the CQUINs were paused the Trust continued to monitor Carbapenem usage throughout 2021-22 and the proportion of ACCESS agents.



Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust



Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust



Carbapenem prescribing DDDs per 1000 admissions; by quarter and acute trust

The Antibiotic Control Advisory Team (ACAT continues to work on improving antibiotic usage within the Trust. Advice on the use of antibiotics was included in consultants' mandatory training day which was postponed during 2021-22 due to the pandemic and junior doctor's induction which continued virtually. In addition to an innovative antibiotic formulary (promoting less use of broad spectrum agents) ACAT has produced guidelines on empiric antibiotic prescribing, antibiotic 'streamlining', and surgical antibiotic prophylaxis. All this guidance is available both in hard copy and on Pattie. The Antibiotic Pattie page has been reviewed and improved so that each specialty has their own section and they are currently being updated. Closer links with the specialties concerned is integral to the development of the updates which will hopefully encourage guideline adherence. During 2021-22, in spite of the challenges faced by the COVID-19 pandemic ACAT continued to meet, less frequently and in some cases virtually.

On the Pattie homepage there is a direct link to the Antibiotic page and it is accessible on mobile devices via Pattie links.

The Empiric Guidance has been further updated during 2021-22 with the addition of new charts to accompany previously published versions available on the wards. Expansion of the guidance to include obstetrics and paediatrics has been a significant achievement during 2021-22. The focus is moving to intranet and mobile device access rather than hard copies with the exception of the new posters. During 2021-22, funding was secured to purchase the Microguide application, suitable for mobile device use, enabling clinical teams to access in real time Trust antibiotic guidelines, enabling greater compliance and improved antimicrobial stewardship. This will go live for use from August 2022 onwards. ACAT meets regularly to review antibiotic usage, and reports to IRC. ACAT and antibiotic pharmacy team have altered the reports that are reviewed at IRC and ACAT, tabling the updated reports throughout the financial year, these include quarterly Health Group reports looking at

antibiotic consumption, indication and duration reporting, antibiotic related incident reporting via DATIX and bi-annual specialty reports. Also the inpatient antibiotic prescribing audits commenced during 2021-22 focused on prescribing as per guidance/ clinical justification and following the initial data collection (baseline set) will replace the monthly indication and duration audits during 2022-23 as provide more qualitative data that allows for more targeted interventions. This audit has helped get the conversations started with the Health Groups/ speciality and hopefully better engagement and MDT working on antimicrobial stewardship so it is a good point to highlight.

During 2021-22 electronic prescribing and medicines administration (EPMA) continued across the Clinical Support Health Group but was expanded to include other wards and departments on the Castle Hill Hospital (CHH) site, predominantly across the Surgery Health Group. There were continued issues regarding the documentation of indication and duration on the electronic system affecting the overall Trust position when audited by Pharmacy teams. This was addressed by training, prompts and escalation by the respective consultants, along with changes to the EPMA interface with improvement noted. These improvements were recognized when extending the EPMA reach across the CHH site, with the Hull Royal Infirmary (HRI) site to follow from June 2022.

Along with conventional antimicrobial stewardship, the benefit of an outpatient parenteral antimicrobial therapy (OPAT) service to manage the delivery of intravenous and complex oral antibiotics to patients who are medically stable, within an outpatient setting eliminates the need to either admit or keep in hospital patients whose only reason to stay in hospital is to receive IV / complex oral antibiotic therapy. All OPAT patients continue to have their medical condition and therapy closely supervised by a multidisciplinary team with a proven record that this service contributes to reducing patient's length of stay in hospital, promotes early discharges and improves patient experiences. It improves quality of life for patients and reduces the risk of hospital-acquired infection. Feedback from OPAT patients is overwhelmingly positive, citing the benefits of receiving treatment as an outpatient, the ability to return to work, and the care, support and expertise of the OPAT team. During 2021-22 the OPAT service worked in close unison with City Health Care Partnership (CHCP) in delivering an OPAT service from Marfleet Community Centre, improving patient's experiences living in and around the Hull area. This was partly funded by CHCP over a six month period and at the time of writing this report is subject to a further business case to continue with this OPAT model.

11. SEPSIS

The Trust Sepsis service consists of 1PA of Infectious Diseases consultant time as the clinical lead for the service and 2 Sepsis specialist nurses. An innovative wrap around review service for patients with Sepsis was designed and due to be introduced during 2020-21 but unfortunately delayed due to the pandemic, reduction in COVID-19 activity provided the opportunity to re-explore this service for patients with Sepsis with the team anticipating a further improvement in the care and patient experience for patients with Sepsis once fully introduced.

The Sepsis team alongside the Infectious Diseases consultant have helped and supported clinics delivering neutralising monoclonal antibodies or antivirals for non-hospitalised patients with COVID-19 (nMABs).

The Sepsis team previously ran a full teaching programme but this was converted to virtual Big Blue Button training and although there was a brief commencement of face to face training this was initially short-lived, although improving as COVID-19 numbers reduce.

11 DECONTAMINATION

The Trust Decontamination Committee convened and chaired by the Surgical Health Group covers decontamination in Sterile Services, Endoscopy, decontamination of medical devices and patient equipment and environmental cleaning. The Committee would normally meet quarterly but due to the impact of the COVID-19 pandemic this was paused. The Trust endoscopy users, sterile services department and theatre report into this group and during 2020-21, escalation of concerns has been via the IPCT and the Surgical Health Group. This committee reports to the OIRC.

Central Sterile Services Department (CSSD) continues to meet the requirements of disinfection, assembly, packing, moist heat and gas plasma sterilisation of theatre trays and procedure packs and supplementary instruments in accordance with ISO 13485:2003 and ISO 9001:2008.

For moist heat and gas plasma sterilisation of theatre trays, procedure packs and supplementary instruments in accordance with Medical Devices Directive 93/42/EEC

Annex V, Article 12 (Sterility Aspects Only). Clinical teams complete DATIX reports should sterile equipment fall short of the required standards and investigated by CSSD accordingly. Activity in CSSD was significantly reduced because of the impact of the COVID-19 pandemic and the cancellation of elective surgery, unless for life limiting conditions such as cancer. Emergency and trauma activity continued unabated.

During the last quarter of the financial year an increase in theatre activity coupled with a reduction in COVID-19 cases has been noted.

During 2021-22 embedded support for CSSD, theatres and endoscopy by the Infection Prevention and Control team, in respect to surgical instrumentation, cleaning and disinfection and advice on quarantining instruments and scopes has continued.

12 WATER SAFETY

Flushing on both Trust sites is now firmly established, with improved compliance now seen. The Estates department utilise a software database to record flushing. This improved the ease with which clinical staff recorded flushing in real time. The system creates compliance reports but will also escalate non-compliance through a pre-determined electronic cascade system. The system continues to be embedded by the Estates Department and respective Health Groups and is reliant on contemporaneous contact details of key team members, in some cases wards and departments use both the electronic system and paper records to record flushing compliance, although reliance on paper records is reducing.

Any positive water samples culturing both Legionella and/ or Pseudomonas are reported by Public Health England to both the Estates team and key members of the Infection Prevention and Control Team with prompt action to reduce risks to patients, including escalation and control of infection incident meetings.

During 2021-22, two incident meetings were held to discuss an increase in water samples culturing Legionella resulting in wards being closed to admissions and remedial actions taken by the Estates team to eradicate contamination. The COVID-19 pandemic resulted in reduced or reconfigured activity on some wards and in some cases closure of wards, thereby increasing the risk of reduced use and irregular flushing of water outlets. Prudent communication to the Estates team by Health Groups, especially when wards were closed to admissions was vital to maintain prudent flushing regimes. During 2021-22, the Estates team continue a consistent and comprehensive regime of water testing especially in augmented care areas and areas managing immunocompromised patients.

13 CLEANING SERVICES

Hull University Teaching Hospitals NHS Trust has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals this is now a key element of how each hospitals performance is judged and it is assessed in a number of ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

During 2021-22, Outsourced Client Solutions (OCS) has been responsible for providing cleaning services for Hull University Teaching Hospitals NHS Trust. The COVID-19 pandemic has brought challenges with regards cleaning services, especially during surges of infection. Enhanced cleaning with additional hours needed and an increased staffing resource over and above the existing Trust contract has been required, in addition an increase of post-infection (Amber) cleans have been required along with specialist cleans involving Hydrogen Peroxide Vapours (HPV).

Changes to the working patterns of the Cleaning Action Team were required during 2021-22 to address the need for both in and out of hours responsive cleaning.

During the financial year the IPCT attended operational meetings to share information with regards risk and/or issues related to COVID-19, HCAIs and outbreaks but also to acquire assurance that hospital cleanliness remained a priority.

An Estates & Facilities COVID-19 Command structure was set up during 2020-21 and continued during 2021-22 to capture actions, concerns and areas requiring improvement and/or further investment e.g. time or additional staffing. Liaison with the DIPC and IPCT was escalated via the COVID-19 Command structure.

During 2021-22, the dedicated monitoring of standards of cleanliness has been impacted by the COVID-19 pandemic, with designated COVID-19 wards limiting footfall onto the wards and departments. Ad hoc monitoring by Domestic Supervisors, who at times have been operational supporting staff in cleaning to the standards expected has taken place. Formal monitoring from Facilities was resumed once COVID-19 activity permitted. Additional monitoring via audit completed by the IPCT, Senior Matrons and dedicated CENSUS audits

during 2021-22 continued to ensure the contract is being delivered to the required standards, Trust expectations and in line with changes to standards of cleanliness due to COVID-19 e.g. enhanced cleaning of high touch points/ bathrooms and toilets.

National Standards of Healthcare Cleanliness 2021 were published in April 2021 and apply to all healthcare environments and replace the National specifications for cleanliness in the NHS 2007 (and amendments) published by the National Patient Safety Agency. To encourage continuous improvement they combine mandates, guidance, recommendations and good practice. The standards incorporate significant changes such as the “percentage scoring” system which was not clear to patients/visitors, replaced with cleanliness ratings from zero – 5, similar as seen in the hospitality industry. A zero star rating equates to “urgent improvement necessary” while a 5 star rating confirms the cleanliness in the area concerned as “very good”.

The Facilities team convened a Task & Finish Group with an experienced project manager during 2021 to progress through the standards and understand the changes required. At the time of drafting the report the Trust are on track with meeting the requirements of the standards within the given timeframes provided by NHS England & NHS Improvement.

Following a tendering process, Synergy Linen Management Services became the linen contractor for the Trust from the 1st August 2021, prior to that Elis UK Ltd held the contract. The IPCT continue to work closely with facilities and the linen contractor to ensure that the contract meets the requirements of the HTM 01-04 and reduces the risk of hospital linen being a source of infection transmission and that adequate safe linen supplies are maintained.

During 2021-22 ongoing construction work at both HRI and CHH, resulted in the need for prudent pest control by both the IPCT, Estates & Facilities teams and external pest control contractors and this will be monitored as ongoing construction continues into 2022-23.

14 PLACE INSPECTIONS

The annual Patient Led Assessment of the Environment (PLACE) inspection of the Trust did not take place during 2021-22 due to the COVID-19 pandemic but work has continued to address and/or monitor the issues previously raised, utilising the national PLACE-lite assessment forms.

15 AUDIT

An annual programme of audit is agreed as part of the annual IPC/ Fundamental Standards programme. The audit programme is a combination of policy and general IPC audits carried out as part of an unannounced visit schedule. Audits of both practice and environment are also undertaken following incidents/outbreaks of infection. Audit results are collated and fed back to the clinical area and action plans are requested as appropriate. During 2022-22 audits were presented to the respective Infection Reduction Committees by the reporting Health Group, summarising all of the audit activity and high level findings. Due to the demands placed on the IPC team with regards COVID-19 and the frequency of audit requirements dependent upon score, completion within the allocated timeframe was not always achievable, resulting in the IPC team developing an action plan to focus on key areas

requiring attention. In addition, during 2021-22 additional audits were completed to gain assurance with regards compliance against management of COVID-19 and compliance with regards infection prevention & control measures e.g. weekly COVID-19 compliance and COVID-19 Census audits.

At ward/ departmental level, monthly IPC audits are undertaken by the nursing/ clinical team these include 5 moments of hand hygiene audit, auditing 20 moments of hand hygiene opportunities and an IPC ownership audit tool capturing key elements of prudent IPC practice and adherence. During 2021-22, ongoing compliance with audit requirements was affected by relocation of teams and change in service delivery e.g. providing care to COVID-19 positive patients. In these circumstances daily, weekly and monthly audits have been completed by Senior Matrons with support from the IPCT.

During 2021/22, a review of IPC audits completed at ward / departmental level was undertaken to ensure ownership of and compliance with IPC practice. The review resulted in an updated audit format, audit schedule and process utilising MyAssurance being developed and going live in February 2022. At the time of drafting the annual report a live dashboard was under development and due to go live in May 2022, thereby allowing Health Groups and the IPCT identify trends and required action to improve compliance and practice. It is anticipated the live dashboard will be scrutinised and challenged at OIRC and escalation as required to SIRC, acknowledging areas for improvement and good practice.

16 POLICIES

The Trust has a programme for review and revision of core IPC policies as required by the Health and Social Care Act 2008 Code of Practice (2015). All policies are available to staff on PATTIE and many are also available to the public on the main internet web page. In addition, policies and procedures on COVID-19 were added and updated accordingly during 2021-22 as and when national guidance was published and/or updated with a dedicated COVID-19 PATTIE page.

A review of all IPC policies was undertaken during 2021/22 following an external audit facilitated by RSM and commissioned by the Trust on a recommendation from NHS improvement following visits during 2021 and 2022.

17 TRAINING AND EDUCATION

Education and training are essential to improve healthcare workers knowledge and understanding of measures to improve infection prevention and control and limit healthcare associated infections (HCAI) in the Trust. They form part of every staff job description, and an integral part of the appraisal process.

Infection prevention & control education forms part of the mandatory induction programme for all staff. Additionally infection prevention and control is included in junior doctor orientation and previously as part of the consultants' mandatory training programme. Staff attendance at mandatory infection control updates is recorded centrally.

The infection prevention and control team conduct ad hoc education sessions to staff groups which have included security, volunteers and Estates staff.

The COVID-19 pandemic provided the opportunity for the IPCT to deliver bespoke training on donning and doffing of personal protective equipment and undertake fit test training to staff required to wear FFP3 masks. This continued throughout 2021-22 with training underpinned by visual cues such as posters and guidance available to staff on Pattie and auditing of compliance.

Department of Health & Social Care (DHSC) in June 2021, wrote to Chief Executives, Medical Directors & Directors of Nursing of all NHS trusts and foundation trusts with a request to strengthen FFP3 resilience in the acute hospital setting. This entailed the need to fit test staff to at least two different FFP3 facemasks, ideally three with FFP3 facemasks being rationalised to include UK make versions. This ask was particularly onerous for the IPCT to conduct in isolation and therefore the responsibility to ensure staff were fit tested was transferred to the Trust's Health & Safety Team. In addition, DHSC offered Trusts the option of accessing further support to conduct fit testing due to the time and investment involved, the DIPC accepted the offer and the National fit test team supported the Trust with additional training resource working alongside the Health & Safety Team. During 2020-21 fit test training compliance was recorded by the IPCT, but the system was not robust as locally delivered sessions although delivered and the staff member provided with a certificate was not always captured. A centrally held database and a robust system of recording fit testing training compliance for clinically facing staff was commenced during 2021-22 and forms part of the staff members appraisal process and is now recorded via HEY24/7 with two yearly updates required.

Face to face training was paused to ensure COVID-19 Secure requirements were followed and replaced with the roll out of 'Big Blue' virtual training with the exception of resuscitation training which continued face to face, albeit at smaller numbers and following advice from the DIPC & IPCT. ELearning utilised for induction and annual training compliance became the default route for staff rather than the face to face Trust Safety Day.

Level 1 IPC ELearning is for all staff with Level 2 IPC ELearning for clinical staff, at the time of writing this report 6620 clinical staff completed level 1 & 2 ELearning during 2021-22, a marked increase from the year before. Compliance with IPC mandatory training during 2021-22 for clinical and non-clinical staff is reported at 87%.

18 OTHER ACHIEVEMENTS IN 2021-22

The Trust has always worked in collaboration with commissioners and other partners in reducing avoidable infections. Although some national targets and CQUINs divide healthcare associated infections into 'acute- attributed' and 'community-attributed' these are artificial distinctions. Many infections diagnosed in the community have their origins in hospital, and vice versa. It is therefore essential that a 'whole system' approach is taken to tackling healthcare associated infections. During 2021-22, this has been vital and the ongoing COVID-19 pandemic has further enhanced Trust collaboration with NHS Improvement, UK Health Service Agency, formally Public Health England (PHE), Local Authorities and Integrated Care Systems (ICSs). The Trust continues to meet regularly with partners in a number of forums, and during 2021-22 successful collaboration continued with regards COVID-19, nosocomial case numbers and investigation of HCAIs and notifiable diseases.

The Trust contributed at regional NHS Improvement meetings with presentations on the challenges posed by the COVID-19 pandemic, nosocomial infections and the associated learning.

19 OTHER RISKS IN 2021-22

During 2021-22, the identification of Tuberculosis (TB) in inpatients, resulting in contact tracing of both staff and patients continued. The infection prevention and control team have worked closely with the community TB nursing team, infectious diseases consultants, respiratory consultants and Public Health England to reduce ongoing risks to patients and staff. These incidences have provided the opportunity to reinforce the importance of appropriate isolation of 'at risk' patients, use of appropriate personal protective equipment (PPE) e.g. FFP3 facemasks and also communication of cases and incidents to local commissioners.

During 2021-22, cases of Pseudomonas Aeruginosa colonisation were detected in neonates nursed on the Neonatal Intensive Care Unit found on twice weekly screening. Reported cases were less than in previous years. No bacteraemia cases have been detected on the unit since August 2018. Extensive investigation regarding a possible source related to the environment had previously taken place with no known source found. Measures to improve water safety and mitigate environmental contamination have taken place during 2021-22 although hampered by the COVID-19 pandemic.

Prudent communication with Public Health England and local commissioners has taken place as has ongoing screening. All samples are submitted to PHE for variable number tandem repeats (VNTR) profiling to enable links to be identified; no linked cases were identified to date during 2021-22.

From the 15th March 2022, the use of a novel sink drain cleaning product was commenced on NICU with all hand wash basins and showers being cleaned with the product. A previous small scale pilot using the product on the unit had demonstrated a significant decrease in environmental contamination rates of Pseudomonas Aeruginosa, further evaluation will be undertaken during 2022/23.

During 2021-22, the IPCT continued to work closely with the cardiac perfusion team to mitigate the risks associated with Mycobacterium chimaera. In 2016, following a worldwide rise in patients developing this infection following cardiac bypass surgery, the Medicines & Healthcare products Regulatory Agency (MHRA) published a medical device alert with regards cardiac perfusion machines and the risks associated with this organism. The issue was compounded in that the majority of cardiac perfusion machines were contaminated during manufacture which was only identified once a rise in cases was noted.

Since 2016, the Infectious Diseases team and IPCT have worked alongside the perfusion team and cardiac surgeons to safeguard patients, undertaken water sampling from the machines and acting on positive results, removing affected machines from use, following PHE and manufacturers guidance and if required contact tracing patients, alerting GPs and providing a follow up service to patients. When required incident meetings have been held with the Surgical Health Group and with involvement of PHE.

Although improvements were made to the environment to facilitate safe physical decontamination and cleaning of the perfusion machines, during 2021-22 three cardiac perfusion machines were found to culture Mycobacteria chimaera or Mycobacteria chelonae and removed from use. Incident meetings were held and patients contact traced who had valve replacement surgery, previously facilitated by the affected machines with no patient harm identified but GPs aware should patients latterly present with health concerns.

At the time of writing the report, additional loan machines are hired to assist with the increase in cardiothoracic surgery and water testing has been undertaken from all remaining machines and from the water supply serving the cardiothoracic theatres. The area has been thorough cleaned and no further issues cases reported.

Nationally, the risk of delaying cardiothoracic surgery now far outweighs the risk of developing Mycobacteria chimaera but until a change in national guidance is published the Trust will continue to respond accordingly when positive results are reported.

During 2021-22, the COVID-19 pandemic continued to highlight the increased need for robust digital systems not only within the Trust but also for the IPCT. This need was brought sharply into focus due to the Pathology merger with York & Scarborough Teaching Hospitals NHS Foundation Trust and the current IT system used by the IPCT not supported following the successful merger. A paper was tabled at the Trust Digital Board by the Department of Infection in March 2021 and an associated risk raised. This risk remains both on the Corporate and IPC risk registers. During 2021-22, the need for a robust digital IPC reporting system was identified by NHS Improvement as a key driver for improved reactive and proactive work undertaken by the IPCT, with current systems outdated. To date, although the Trust has scoped the use of ‘off the shelf’ digital IPC systems, used by other Trusts, with funding available, unfortunately current digital systems used by the Trust e.g. Lorenzo would not support any integration. For 2022-23, this remains a significant risk for the Trust and the Infection Prevention & Control service.

20 EXTERNAL INSPECTIONS

The Trust during 2021-22 at regular intervals were required to provide assurance to the CQC on a number of measures inclusive of IPC in the absence of a formal inspection regime.

Following a marked rise in nosocomial COVID-19 infections, NHSEI Head of Infection Prevention and Control - North East and Yorkshire region visited the Trust on the 4th February 2021 for an informal visit. The visit, which exclusively was at the HRI site, involved the Emergency Department, an intensive care unit, and a number of wards. Following the visit, a letter with recommendations inclusive of removing beds to assist with social distancing and improving ventilation was forwarded to the DIPC for consideration.

Following this visit, an offer of additional support was given by the NHSEI national IPC team who further visited the Trust during June 2021. The visits included both Trust sites at HRI and CHH along with attendance at SIRC and OIRC. Following the visit, a letter with recommendations on the reporting and governance of IPC, defining Trust wide IPC roles and responsibilities including that of the DIPC and ownership of the IPC Board Assurance Framework (BAF) was forwarded to the DIPC and Chief Nurse for consideration.

During August & September 2021, as a result of the visit and a recommendation from the national team, the Trust commissioned an audit of IPC reporting and governance processes through RSM, an external audit and assurance service. This involved a number of fact finding meetings with key members of staff along with requests for information to validate results and findings. A report was forwarded to the DIPC and Chief Nurse for consideration.

Respective action plans were drafted, monitored via SIRC & OIRC and approved as a result of all the visits and service reviews. In addition, an IPC Task & Finish Group was formed in September 2021 and chaired by the Associate Director of Quality to progress actions and ensure the BAF remained the responsibility of the Trust and Health Groups rather than the sole responsibility of the DIPC, ICD & IPCT. Significant progress was made with the last IPC Task & Finish meeting being held on the 6th April 2022. Ongoing monitoring continues via current Trust meeting structures.

A follow-up visit by the NHSEI regional IPC team was scheduled for the 3rd March 2022 to assess progress following the previous visits and recommendations but postponed due to system pressures across the Yorkshire & Humber region. This went ahead on the 5th May 2022 and at the time of writing this report, the feedback received was positive citing the considerable progress made by the Trust and IPCT in ensuring IPC remains a priority for the Trust but acknowledging the ongoing actions required to maintain momentum and traction on this vital element of healthcare.

21 KEY POINTS AND RECOMMENDATIONS

- *The COVID-19 pandemic continued to highlight the strengths and weaknesses of the Trust's response and with it a clear understanding of what needs to be addressed to mitigate risk further. The Trust provides care to a naïve population who will remain at risk from infections and therefore the learning and actions to promote patient safety will remain.*

- *During 2021-22 an increase in patients medically fit but unable to be discharged alongside the Trust ensuring elective recovery was prioritised created other issues such as caring for patients on wards across the Trust with finite staffing resource. Patients with no criteria to reside remain in hospital longer and with it the potential to develop healthcare associated infections during protracted hospital stays.*

- *During 2021-22, the Trust continued to monitor healthcare associated infection case numbers and trends. The Trust performed at or better than the benchmark in all cases with the exception of hospital onset COVID-19 infections which continued to impact on acuity and flow across the Trust.*

- *The lack of robust digital systems to support an effective IPCT is a significant risk both from a governance and quality perspective and relies heavily on the IPCT managing with the outdated systems, which with time will affect the quality of data collected, the functionality of the team and potentially impact on patient safety.*

- *The Trust via an antimicrobial stewardship programme continues to collaborate with clinical teams to develop antimicrobial prescribing guidance in line with national*

guidance and continues to monitor compliance with regards antimicrobial prescribing and escalate to improve patient outcomes.

- *There have been consistent improvements in some specific aspects of infection prevention and control (e.g. clinical engagement in root cause analysis, monitoring healthcare associated infections and mitigating risks within Health Groups and increased partnership working especially with regards COVID-19.*

- *There are weaknesses in the Trust estate and facilities for managing patients with infections:*

- *limited number of single rooms in spite of additional capacity created on the HRI site*

- *shared toileting and bathroom facilities*

- *inadequate isolation facilities in paediatrics*

Solutions to these estate issues are being considered and actioned as part of a wider Trust strategy

- *There is inadequate resource (clinical and administrative) to support the necessary level of surveillance of blood stream infections within the Trust, with a risk of failing to take action to prevent avoidable infections.*

- *There is inadequate resource to reintroduce dedicated antibiotic ward rounds, which were previously demonstrated to improve antimicrobial prescribing and stewardship.*

The Board is asked to accept this report as assurance that the Trust is meeting its requirements on infection prevention and control as specified in the Health and Social Care Act (2008). It should also note that there are areas of vulnerability highlighted in this report, which if not addressed may lead to a failure to meet these requirements in future.

Greta Johnson
Director of Infection Prevention and Control
May 2022

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Appendix 1. HCAI benchmarking data via PHE Fingertips 2021-22

Indicator	Period	Hull and East Yorkshire Hospitals		Trust type	England	England		
		Count	Value	Value	Value	Lowest	Range	Highest
E. coli								
E. coli bacteraemia all rates by reporting acute trust and financial year	2020/21	374	140.2	124.3	132.9	0.0		294.5
E. coli bacteraemia hospital-onset counts and rates by NHS acute trust and financial year	2020/21	95	35.6	27.9	23.7	0.0		61.2
E. coli bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2022	294	91.0	84.2	93.9	0.0		176.8
E. coli hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2022	96	29.7	23.7	21.5	0.0		69.2
E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2022	390	120.7	107.9	115.3	0.0		206.6
E. coli completion of risk factor information, by NHS acute trust New data	Mar 2022	0	0.0%	29.8%	42.6%	0.0%		100.0%
E. coli known risk factor information, by NHS acute trust New data	Mar 2022	0	-	76.5%	72.7%	1.5%		100.0%
E. coli completion of antibiotic information, by NHS acute trust New data	Mar 2022	0	0.0%	25.2%	37.7%	0.0%		100.0%
E. coli known antibiotic information, by NHS acute trust New data	Mar 2022	0	-	75.9%	68.9%	0.0%		100.0%
Klebsiella spp.								
Klebsiella spp. bacteraemia all counts and rates by acute trust and financial year	2020/21	86	32.2	43.1	40.3	0.0		83.4
Klebsiella spp. bacteraemia hospital-onset counts and rates by acute trust and financial year	2020/21	30	11.2	18.0	13.7	0.0		41.9
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2022	121	37.4	36.6	34.7	0.0		74.3
Klebsiella spp. hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2022	40	12.4	14.1	11.2	0.0		38.1
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2022	81	25.1	22.5	23.4	0.0		48.9
P. aeruginosa								
P. aeruginosa bacteraemia all counts and rates by acute trust and financial year	2020/21	36	13.5	17.2	15.5	0.0		50.3
P. aeruginosa bacteraemia hospital-onset counts and rates by acute trust and financial year	2020/21	18	6.7	8.3	6.0	0.0		28.0
P. aeruginosa bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2022	30	9.3	7.5	8.2	0.0		16.5
P. aeruginosa hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2022	25	7.7	6.4	4.9	0.0		29.4
P. aeruginosa bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2022	55	17.0	13.8	13.2	0.0		45.0
MRSA								
MRSA bacteraemia all rates by reporting acute trust and financial year	2020/21	1	0.4	2.6	2.5	0.0		9.9
MRSA hospital-onset counts and rates by reporting acute trust and financial year	2020/21	0	0.0	1.1	1.0	0.0		7.0
MRSA bacteraemia all cases counts and 12-month rolling rates, by acute trust and month New data	Mar 2022	6	1.9	2.3	2.0	0.0		8.1
MRSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2022	4	1.2	1.5	1.3	0.0		6.0
MRSA cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month New data	Mar 2022	2	0.6	0.8	0.7	0.0		5.2
MSSA								
MSSA bacteraemia all rates by reporting acute trust and financial year	2020/21	140	52.5	41.7	42.3	0.0		82.8
MSSA hospital-onset rates by reporting acute trust and financial year	2020/21	62	23.2	13.6	12.1	0.0		41.3
MSSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month New data	Mar 2022	92	28.5	24.6	26.1	0.0		44.9
MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month New data	Mar 2022	59	18.3	12.5	11.3	0.0		29.0
MSSA total cases counts and 12-month rolling rates, by reporting acute trust and month New data	Mar 2022	151	46.7	37.1	37.3	0.0		58.1
C. difficile								
C. difficile all rates by reporting acute trust and financial year	2020/21	95	35.6	44.6	45.3	0.0		140.5
C. difficile hospital-onset rates by reporting acute trust and financial year	2020/21	40	15.0	17.4	15.4	0.0		80.6
C. difficile infection counts and 12-month rolling rates of all cases, by reporting acute trust and month New data	Mar 2022	101	31.3	42.9	43.3	0.0		138.4
C. difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases, by reporting acute trust and month New data	Mar 2022	38	11.8	19.7	18.3	0.0		59.0
C. difficile infection counts and 12-month rolling rates of community onset-healthcare associated, by reporting acute trust and month New data	Mar 2022	14	4.3	7.2	7.4	0.0		32.9
C. difficile infection Hospital-Onset Healthcare Associated (HOHA) counts and rates, by acute trust and financial year	2020/21	47	17.6	19.9	17.7	0.0		80.6
C. difficile infection community-Onset Healthcare Associated (COHA) counts and rates, by acute trust and financial year	2020/21	18	6.3	6.8	7.3	0.0		32.8
C. difficile toxin tests per 1,000 bed-days carried out by reporting acute trust and quarter	2020/21 Q4	-	-	0.0*	15.5	-	*Insufficient number of values for a spine chart*	-
Miscellaneous								
Blood culture sets per 1,000 bed-days performed by reporting acute trust and quarter	2020/21 Q4	-	-	74.5*	68.8	-	*Insufficient number of values for a spine chart*	-
Surgical Site Infection Hip Prosthesis by acute NHS trust and financial year	2019/20	-	*	0.4	0.5	0.0		2.8
Surgical Site Infection Knee Prosthesis by acute NHS trust and financial year	2019/20	1	1.3	0.5	0.4	0.0		3.8

Appendix 2. Antimicrobial prescribing data via PHE Fingertips 2021-22

Indicator	Period	Hull and East Yorkshire Hospitals		Trust type	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Standard contract								
Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust	2021/22 Q3	155,419	4,294.5	5117.1	4741.8	19,058.6		2,065.5
AWaRe & broad-spectrum prescribing								
Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust	2021/22 Q3	89,126	57.3%	47.6%	48.6%	9.3%		75.9%
Proportion of total antibiotic prescribing from the "Watch" category of the WHO Essential Medicines List AWaRe index	2021/22 Q3	57,171	36.8%	47.5%	47.6%	87.2%		21.6%
Proportion of total antibiotic prescribing from the "Reserve" category of the WHO Essential Medicines List AWaRe index	2021/22 Q3	8,487	5.5%	4.5%	3.2%	34.0%		0.0%
Carbapenem prescribing DDDs per 1000 admissions; by quarter and acute trust	2021/22 Q3	1,375	38.0	90.8	71.0	657.7		0.0
AMR CQUIN								
Percentage of antibiotic prescriptions for lower UTI in older people meeting NICE NG109 guidance and UKHSA Diagnosis of UTI guidance in terms of diagnosis and treatment; by quarter <60% 60% to 90% ≥90%	2019/20 Q4	-	*	47%	56%	16%		100%
Percentage of single dose surgical antibiotic prophylaxis prescriptions that meet the NICE NG125 guidance regarding the choice of antibiotic for patients who have undergone elective colorectal surgery; by quarter <60% 60% to 90% ≥90%	2019/20 Q4	0	-	91%	90%	60%		100%

Appendix 3. Antimicrobial Resistance via PHE Fingertips

Indicator	Period	Hull and East Yorkshire Hospitals		Trust type	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Rolling quarterly average proportion of gentamicin resistant E. coli blood specimens; by quarter New data	2021 Q4	8	8.9%	9.8%*	-	-	-	-
Rolling quarterly average proportion of ciprofloxacin resistant E. coli blood specimens; by quarter New data	2021 Q4	10	10.8%	20.2%*	-	-	-	-
Rolling quarterly average proportion of piperacillin/tazobactam resistant E. coli blood specimens; by quarter New data	2021 Q4	7	7.7%	11.1%*	-	-	-	-
Rolling quarterly average proportion of 3rd generation cephalosporin resistant E. coli blood specimens; by quarter New data	2021 Q4	6	6.7%	15.4%*	-	-	-	-
Percentage of E. coli blood specimens with susceptibility tests to gentamicin; by quarter New data <70% 70% to 95% ≥95%	2021 Q4	82	82.0%	80.3%*	80.2%*	-	*Insufficient number of values for a spine chart*	-
Percentage of E. coli blood specimens with susceptibility tests to ciprofloxacin; by quarter New data <70% 70% to 95% ≥95%	2021 Q4	82	82.0%	80.5%*	78.7%*	-	*Insufficient number of values for a spine chart*	-
Percentage of E. coli blood specimens with susceptibility tests to piperacillin/tazobactam; by quarter New data <70% 70% to 95% ≥95%	2021 Q4	83	83.0%	78.6%*	74.9%*	-	*Insufficient number of values for a spine chart*	-
Percentage of E. coli blood specimens with susceptibility tests to a 3rd generation cephalosporin; by quarter New data <70% 70% to 95% ≥95%	2021 Q4	82	82.0%	82.0%*	81.9%*	-	*Insufficient number of values for a spine chart*	-
Percentage of E. coli blood specimens with susceptibility tests to a carbapenem; by quarter New data <70 70 to <100 =100	2021 Q4	83	83.0%	82.0%*	81.5%*	-	*Insufficient number of values for a spine chart*	-

Appendix 4. Infection Prevention & Control Metrics via PHE Fingertips

Indicator	Period	Hull and East Yorkshire Hospitals		Trust type	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Proportion of single rooms available within NHS Acute Trusts by financial year	2019/20	332	30.7%	31.6%*	30.3%*	11.5%		99.7%
Proportion of single rooms with ensuite available within NHS Acute Trusts by financial year	2019/20	189	17.5%	21.1%*	20.8%*	4.8%		99.7%
PLACE Cleanliness Scores; by NHS Acute Trust	2018	-	0.99	-	0.98	0.92		1.00
Percentage of frontline healthcare workers vaccinated with the seasonal influenza vaccine by NHS Acute Trust <60% 60% to 70% ≥70%	2018/19	5,476	82.8%	73.0%*	72.6%*	49.4%		95.4%

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

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12th July 2022
Title	IPC BAF Update Report				
Lead Director	Jo Ledger, Acting Chief Nurse				
Author	Greta Johnson, Director of Infection Prevention & Control				
Report previously considered by (date)	Quality Committee – 29th June 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:

This paper provides an update to the Trust Board on IPC compliance, and progress to date on completion and closure of actions outlined within the IPC BAF improvement plan. Key points highlight the Board to open dynamic actions monitored via Strategic & Operational Infection Reduction Committees.

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

Infection Prevention & Control (IPC) Board Assurance Framework (BAF)

Progress update 12th July 2022

Background

During the COVID-19 pandemic NHS England (NHSEI) produced a series of IPC BAF templates in line with current national IPC guidance. National feedback of the Trust's IPC BAF and visits from NHSEI resulted in the Trust convening an IPC Task & Finish Group with a focus on the BAF and its associated content. Focus groups and sub groups, not exclusively infection prevention & control service driven were convened so that groups would have ownership of the elements of the BAF. The IPC Task & Finish Group continued until the last convened meeting held in March 2022, producing a BAF with an improved layout and a shared folder to evidence compliance against each of the BAF goals.
The Quality Governance Directorate and IPC Service continue alongside the Senior Corporate Nursing team to ensure the BAF remains a 'live' document and that monitoring of the BAF is facilitated via the existing IPC meeting structure.
On the 5th May 2022, NHSEI revisited the Trust and feedback was complimentary, acknowledging the considerable progress made by the IPC team and Trust since the last visit(s). Feedback included the IPC BAF with a recommendation to continue developing and revising the BAF in terms of governance to ensure it provides robust assurance to the Board.

The national approach to the ongoing pandemic is in line with reduced prevalence and incidence of COVID-19 circulating in the community and as such is encouraging healthcare settings to return to pre-COVID-19 pandemic systems and processes. On the 27th May 2022, the government withdrew national guidance on infection prevention and control for seasonal respiratory infections including SARS-CoV-2, replacing with generic COVID-19: information and advice for health and care professionals. This resulted in some actions within the Trust IPC BAF being closed as they were no longer relevant. In addition, changes to national guidance was underpinned with the application and adoption of the National Infection Prevention & Control Manual (NIPCM) and will form the basis alongside the existing Health and Social Care Act 2008: code of practice on the prevention and control of infections as a measure of compliance and assurance.
This report provides the Trust Board with an update on IPC compliance, and progress to date on completion and closure of actions outlined within the IPC BAF prioritisation matrix.

Update

The outstanding BAF actions have been summarised in a prioritisation matrix, updated via Operational Infection Reduction Committee (OIRC) and any exceptions escalated to Strategic Infection Reduction Committee (SIRC) with quarterly updates to the Quality Committee. The matrix is RAG rated and divided into 'red', 'amber/red' and 'amber/green' tables and to accompany the prioritisation matrix is the IPC BAF improvement action plan. For the purpose of this report, the focus is on the prioritisation matrix.

The matrix included three key lines of enquiry (KLOEs) rated as red, following review by the IPC Task and Finish Group and the ongoing work of the respective focus groups these are now rated as amber/green x2 and green x1.

There were 5 KLOEs rated as amber/red and again as above now rated as amber/green.

There were 81 KLOEs rated as amber/green and again as above, 51 are now rated as green with the remaining 30 staying rated as amber/green.

The BAF has been superseded in line with other quality and assurance measures by an IPC Continuous Quality Improvement (CQI) Programme but is linked to IPC BAF key improvement actions. The framework consists of four elements:

- **Quality Design -** IPC governance systems and processes, inclusive of meeting and team structures
- **Quality Assurance -** compliance against local/ regional & national standards & thresholds
- **Quality Control -** BI dashboard/ SPC charts & IPC audit processes
- **Quality Improvement –** IPC QI projects & work streams/ QI Forum

The programme is overseen by Executive leads, Operational leads and HUTHT's QI academy and monitored by the Strategic Infection Reduction Committee (SIRC) and Operational Infection Reduction Committee (OIRC).

IPC CQI Programme elements, linked to IPC BAF key improvement actions include, antimicrobial stewardship, education & training, surveillance of infections, clinical environment, inclusive of cleanliness and CQC compliance & improvement delivery.

Two key IPC CQI priorities include but not limited to –

Development of IPC Work Programme

- Review process for identifying areas with above expected numbers of 'alert' organisms
- Enhance the number of single rooms / cohort and ensuite facilities within the trust to meet needs of service demands
- Continue to provide assurances meeting requirements of Outcome 8 (CQC)
- Build upon the antimicrobial stewardship assurance work currently in place
- Improve clinical areas compliance with 'preventative' infection prevention and control standards and practice
- Develop structured IPC Training and Development Program

IPC Service Delivery

- IPC Team development
- Collaborative working with CCGs, NHSEI, UKHSA/PHE

To underpin the IPC Quality Improvement Work Programme there is an associated timeline with some slippage noted but monitored closely by both the IPC service & Quality Governance Directorate.

The above priorities are being captured via SIRC, tabled every other month with focus groups to lead, influence, and action / embed change and improvement. The first of these has been antimicrobial stewardship and a further report will be tabled via Quality Committee as to progress made.

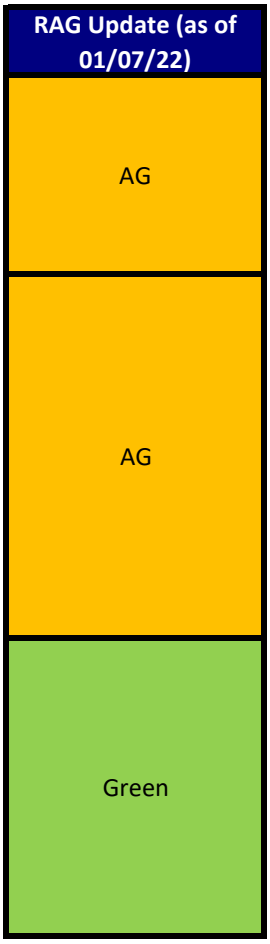
Report drafted by:

Greta Johnson

Director of Infection Prevention & Control (DIPC)

Goal #	BAF KLOE Description
2.12	Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and other national guidance and the appropriate precautions are taken
2.16	Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air
5.11	To ensure 2 metre social and physical distancing in all patient care areas

Mitigating Actions	RAG Status
Supply of red alginate bags to wards to be confirmed with Supplies. **Update**: Monthly Synergy meetings report the Trust using alginate bags appropriately and following soiled/ foul linen processes correctly as per Trust policy and Synergy contract requirements. All soiled and infected linen is managed as per Safe Handling & Processing of Solied Foul Linen Policy	R
Continuation of ventilation survey. Open window posters available in all relevant departments. Need to formally assess and evaluate the efficacy of free standing air purification machines piloted in the Trust. **Update:** Ventilation surveys completed at HRI & CHH sites, identifying key areas of concern (mainly 20 bedded areas in Tower Block wards). Open window posters remain in use. Additional use of air conditioning units to assist with cooling in wards/units. Amber/green as still need to formally assess and evaluate the efficacy of free standing air purification machines piloted in the Trust.	R
Ventilation audit and recommendations/ dynamic risk assessment required if prevalence/ incidence dictate further review. Outbreak and incidences result in IPC advising bed closures/ withdrawal of beds from capcity to aid social distancing.Frailty assessment beds including discharge lounge SOP to be drafted. **Update**: National guidance stepped down with regards return to pre-pandemic systems and processes, inclusive of 2 metre social and physical distancing. Screens and partitions remain in place in ED/OPD settings to facilitate decrease in distancing.	R


RAG Update (as of 01/07/22)
AG
AG
Green

Goal #	BAF KLOE Description
1.3	Triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways
3.1	Arrangements around antimicrobial stewardship (AMS) are maintained
5.2	Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidelines
6.10	Staff understand the requirements for uniform laundering where this is not provided for on site

9.1	Staff are supported in adhering to all IPC policies, including those for other alert organisms

Mitigating Actions	RAG Status
BI report for screening compliance available and in use. Review and update required of triaging template. **Update**: BI report in use, all patients screened using POCT and if positive confirmed on PCR screens. Assurance needed re. version of triage template utilised in ED	AR
Development of process for HGs to report back actions taken on receipt of reports Development of process to allow HGs to feedback quality improvements taken due to poor compliance with guidelines Report of guideline usage data to be submitted to ACAT meetings quarterly Investigation of options for more readily accessible, user friendly multi-platform solutions for guidelines Development of process for HGs to share on lessons learnt from RCAs and PIRs at OIRC Business case for admin support for IPCT/AMS to collate key data including epidemiology and susceptibility data **Update**: AMS Task & Finish Group convened and addressing this BAF goal and all related elements. Seperate AMS action plan developed which can be evidenced and complememt the BAF.	AR
BI report for screening compliance in progress/ Review and update required of triaging template - BI report for screening compliance available and in use. Review and update required of triaging template. / Estates & Facilities limitations to be added to IPC risk register. **Update**: BI report in use, all patients screened using POCT and if positive confirmed on PCR screens. Assurance needed re. version of triage template utilised in ED	AR
The Trust posted guidance regarding the wearing of uniforms during the Pandemic on Pattie. Advice for staff regarding the washing of uniforms was posted on Pattie: "It is also recommended that work uniforms and scrubs worn in clinical areas should be washed on a high temperature cycle." The current Gov.uk Covid guidance links to the attached Uniform & Work wear guidance document https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations This advises • a ten minute wash at 60ºC is sufficient to remove almost all microorganisms. In tests, only 0.1% of any Clostridioides difficile spores remained. Microbiologists carrying out the research advise that this level of contamination on uniforms and workwear is not a cause for concern. **Update:** Trust Uniform Policy in its final stages of ratification includes a section on the laundering of uniforms	AR

Laboratory IT system update due to introduce LIMS in Spring 2022 - demo for IPC team and micro team at the end of 2021, planned launch in 2022, which will allow new system to cascade/ communicate with other IPC systems. Action date: To be completed by end of April 2022 **Update:** Unfortunately delays with LIMS means the earliest opportunity to realise this action will be 2022/23 QTR 4 Updating fundamental audit tools to ensure this captures the required information, i.e. patient, careplan, isolation, management plan in place. Patient notes and care plans. Make care plans available online, via IPC Pattie page, for clinical areas. Action date: To be completed by end of April 2022. **Update**: Action remains outstanding on the 1st July 2022 Adherence to IPC practices with meet and greet volunteers at entrances to buildings on site - keep a record of times and placement of these volunteers. Action Complete. Completion of hand hygiene audits. Enhanced audits during Covid outbreaks. Permission to challenge in place around the Trust - further empowerment work recommended. Action date: To be completed by end of April 2022 (3-6 months). **Update:** My Assure audits developed and implemented and capturing HH and PPE compliance. Annual hand hygiene audits need further review	AR

RAG Update (as of 01/07/22)
AG
AG
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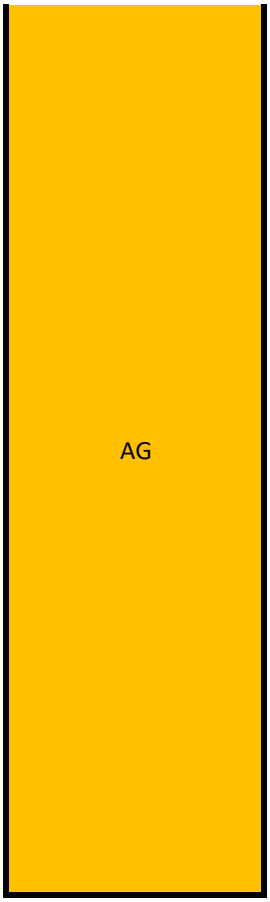

AG

Goal #	BAF KLOE Description	Mitigating Actions	RAG Status	RAG Update (as of 28/02/22)
Missing Mitigating Actions				
2.9	Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily.	Review practices in clinical and non-clinical areas review IPC audits. **Update**: National guidance updated in line with pre-pandemic processes, cleaning encouraged once daily but not required twice daily	AG	Green
2.10	Rooms/areas where PPE is removed must be decontaminated, ideally times to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Need to review theatres staff changing rooms to ensure cleaned twice daily. **Update**: Theatre changing rooms cleaned once dialy and then check cleans performed in between	AG	Green
2.15	Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Review of Policy for non clinical areas and ensure sufficient assurance can be evidenced that policy is followed. **Update**: National guidance updated in line with pre-pandemic processes, monitoring of non clinical areas in place as per NHS Cleaning Standard frequencies	AG	Green
2.18	Monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	Senior Matron and Senior Sisters to ensure education of staff to ensure decontamination is in place as per guidance and that this is monitored through weekly IPC audits. **Update**: Weekly IPC audits conducted but still gaps noted in cleaning checklists. Facilities monitoring audits suggest gaps in nursing cleaning requirements	AG	AG
6.7	Staff regularly undertake hand hygiene and observe standard infection control precautions	**Update**: Weekly My Assure audits completed by ward sisters/ charge nurses and Senior Matrons capturing HH & PPE compliance, underpinned by additional Insights audits. Enhanced IPCT audits demomstrate mixed compliance	AG	AG
Mitigating Actions Related to Policies				
1.4	When an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be given	Advice provided by IPCT/ Incident meeting convened and advises accordingly dependent on risk profile. Consider development of policy and inclusion of KLOE 1.4. **Update**: RPE advised during periods of increased incidence/ outbreaks of infection in clinical settings. Paragraph re. the use of RPE added in outbreak policy and standard precautions policy.	AG	Green

6.14	Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings	Review and disseminate learning from outbreaks via completion of RCAs and outbreak IIMARCH from Board to Ward. DIPC & ICD reinforced importance to IPCT and Site Team (out of hours) of need to escalate on the reporting of two or more cases in line with national guidance. Recruited into IPC secretary post. Daily Trust BI report available and is crossed checked on a daily basis by the IPC iwth the labs and RCA forms are completed online and outbreak policy has recently been reviewed - JC to submit policy as evidence. The Outbreak policy (CP204) has been updated to reflect the national guidance regarding Covid Outbreak management this has been presented to the Operational IRC Committee for validation but the copy on Pattie has yet to be updated. **Update:** RCAs completed by ward sister/ charge nurse. IIMARCH report forms drafted and circulated. Outbreak themes and trends tabled at OIRC. IPC daily 5pm bed management plan commenced in January 2022 and extended to include weekend plan to provide oversight on outbreaks and items for escalation. IPC Secretary returned from maternity leave. Respective policies updated and ratified via OIRC awaiting formatting and upload to Pattie.	AG	Green
8.5	Screening for other potential infections takes place	Audit of compliance with IPC screening policies	AG	Green
Mitigating Actions Related to Audits				
1.7	That on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	**Update**: IPC ward sister/ Matron Audit (My Assurance) against national standards BI COVID-19 reporting/ Lorenzo bed management for contact tracing capacity being scoped for IPCT usage. IPC 5pm & weekend bed plan provides additional information to underpin decisions. Outbreak and incident meeting convened and actions identified. IPCT enhanced audit specific to affected area	AG	Green
		Update: IPC ward sister/ Matron Audit (My Assurance) against national standards BI COVID-19 reporting/ Lorenzo bed management for contact tracing capacity being scoped for IPCT usage. IPC 5pm & weekend bed plan provides additional information to underpin decisions. Outbreak and incident meeting convened and actions identified. IPCT enhanced audit specific to affected area	AG	Green

1.8	Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice - staff adherence to hand hygiene? - patients, visitors and staff are able to maintain 2m social and physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE - staff social distancing across the workplace - staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) clinical b) non-clinical setting	H&S team review & update latest COVID Secure risk assessment congruent with Hierarchy of Controls. Monthly audits required. Clinical areas require bespoke risk assessments congruent with Hierarchy of Controls. **Update**: My Assurance audit inclusive of IPC and COVID-19 developed and completed weekly by ward sister/ charge nurse with additional support from Senior Matron. Electronic tool enabling immediate access to data and resullts, requiring additional refining. IPC enhanced audits completed during periods of increased incidence. Changes to national guidance to pre-pandemic processes	AG	Green
		Continued reminders required at ward/ departmental level along with challenge of non compliance at individual level. H&S team review & update latest COVID Secure risk assessment congruent with Hierarchy of Controls. Monthly audits required. Clinical areas require bespoke risk assessments congruent with Hierarchy of Controls. **Update**: My Assurance audit inclusive of IPC and COVID-19 developed and completed weekly by ward sister/ charge nurse with additional support from Senior Matron. Electronic tool enabling immediate access to data and resullts, requiring additional refining. IPC enhanced audits completed during periods of increased incidence. Inspite of changes to national guidance healthcare workers across the Trust required to wear facemasks, non clinical staff working in non clinical areas mask wearing as personal preference but reviewed alongside incidence and prevalence. Social and physical distancing reduced congruent with updated national guidance. Ways of working reverted to pre-pandemic levels.	AG	AG
5.9	Monitoring of inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	COVID19 compliance audit requiring update. **Update**: My Assurance audit inclusive of IPC and COVID-19 developed and completed weekly by ward sister/ charge nurse with additional support from Senior Matron. Electronic tool enabling immediate access to data and resullts, requiring additional refining	AG	AG
8.3	Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	1. TAT parameters to be consider in lab audits programme; 2. IT to establish TAT reports. **Update**: Turnarounds are regularly audited within the laboratories as required by UKAS, and audit findings are discussed at Laboratory meetings. Time of specimen collection is more clinically relevant but not always apparent in Lorenzo - laboratory working with IT to find a solution. UKAS requires target turnaround times are set in conjunction with service users and laboratory endeavour to resolve escalated issues.	AG	AG

8.4	Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	Define and establish a process review of screening compliance audits within IPCT. **Update**: Audit of screening compliance, monitoring of BI report on missed screens and HOCI cases. Change in national and Trust guidance, screening on admission, on reporting of symptoms and when advised by IPCT. Systems in place by IPCT to review daily all positive screening results	AG	Green
8.10	That those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	• Audit of screening compliance, monitoring of BI report on missed screens. **Update**: to facilitate discharge NCTR patients are screened whilst inpatients every 48hrs.	AG	Green
8.11	That those being discharged to a care facility within their 14 day isolation period should be discharge to a designated care setting, where they should complete their remaining isolation	• Audit of screening compliance, monitoring of BI report on missed screens. **Update**: Changes to national guidance reduced the need for 14days to 10 days and if negative LFT at day 5 & 6 isolation ends on day 7	AG	Green
8.12	That all elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission	• Audit of screening compliance, monitoring of BI report on missed screens. **Update**: updated national guidance advises patients to complete LFT prior to surgery no isolation required and high risk patients to complete PCR and isolate for 72hrs	AG	Green
Mitigating Actions Related to 'Every Action Counts'				
1.2	The documented risk assessment includes: - a review of the effectiveness of the ventilation in the area; - operational capacity; - prevalence of infection/variants of concern in the local area	IPCT to lead on dissemination of 'Every Action Counts' resources. Neil Kaye to provide clinical areas with information about Estates & Facilities risks. Develop risk assessment for clinical areas and patient group versus surge planning. Update: National IPC guidance withdrawn and replaced with COVID-19: information and advice for health and care professionals. Need to produce overaching document with regards wards and departments with regards Estates & Facilities and IPC risks	AG	AG
1.16	National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPCT to lead on dissemination of 'Every Action Counts' resources. **Update**: National IPC guidance withdrawn and replaced with COVID-19: information and advice for health and care professionals. Signposted to National Infection Prevention & Control Manual - IPCT reviewing content of manaul againgst Trust IPC measures	AG	AG
Mitigating Actions Related to BI Report				

1.5	Infection risk is assessed at the front door and this is documented in patient notes	BI report for screening compliance in progress/ Review and update required of triaging template. **Update**: BI report in use, management of COVID-19 and flowcharts produced and disseminated. Need to review current triage template	AG	AG
5.1	Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	BI report for screening compliance in progress/ Review and update required of triaging template. **Update**: management of COVID-19 and flowcharts produced and disseminated inclusive of screening protocols. Need to review current triage template	AG	AG
5.3	Staff are aware of agreed template for triage questions to ask	BI report for screening compliance in progress/ Review and update required of triaging template. **Update**: BI report in use, management of COVID-19 and flowcharts produced and disseminated. Need to review current triage template	AG	AG
5.4	Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	BI report for screening compliance in progress/ Review and update required of triaging template. **Update**: BI report in use, management of COVID-19 and flowcharts produced and disseminated. Need to review current triage template	AG	AG
5.14	There is evidence of compliance with routine patient testing protocols in line with key actions - infection prevention and control and testing document	BI report on patient screening compliance created for HGs to review screening compliance at ward level. **Update:** BI report in use, management of COVID-19 and flowcharts produced and disseminated.	AG	Green
6.12	A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Review and disseminate learning from outbreaks via completion of RCAs and outbreak IIMARCH from Board to Ward. DIPC & ICD reinforced importance to IPCT and Site Team (out of hours) of need to escalate on the reporting of two or more cases in line with national guidance Daily Trust BI report available and is crossed checked on a daily basis by the IPC iwth the labs and RCA forms are completed online and outbreak policy has recently been reviewed and ratified. **Update**: Daily 5pm IPC plan inclusive of weekend provides oversight and clarity with regards IPC issues including outbreaks of infection	AG	Green

6.13	Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Review and disseminate learning from outbreaks via completion of RCAs and outbreak IIMARCH from Board to Ward. DIPC & ICD reinforced importance to IPCT and Site Team (out of hours) of need to escalate on the reporting of two or more cases in line with national guidance. Daily Trust BI report available and is crossed checked on a daily basis by the IPC iwth the labs and RCA forms are completed online and outbreak policy has recently been reviewed. The BI report continues to be used to identify Covid positive cases; & Covid positive cases are reported on the Lab system – "Tel list". The IPC team follow up positive Covid cases daily, contacting the area concerned to provide appropriate IPC advice. **Update**: Daily 5pm IPC plan inclusive of weekend provides oversight and clarity with regards IPC issues including outbreaks of infection	AG	Green
Mitigating Actions Related to SOP				
6.5	Adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	Update: My Assurance audit inclusive of IPC and COVID-19 developed and completed weekly by ward sister/ charge nurse with additional support from Senior Matron. Electronic tool enabling immediate access to data and resullts, requiring additional refining. IPC enhanced audits completed during periods of increased incidence. Changes to national guidance to pre-pandemic	AG	Green
5.6	individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation	**Update**: BI COVID-19 reporting/ Lorenzo bed management for contact tracing capacity being scoped for IPCT usage. IPC 5pm & weekend bed plan provides additional information to underpin decisions. Outbreak and incident meeting convened and actions identified. IPCT enhanced audit specific to affected area. Management of COVID-19 and flowcharts produced and disseminated.	AG	Green
5.12	For patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	Symptomatic Patient Pathway/SOP required. **Update**: management of COVID-19 and flowcharts produced and disseminated.	AG	Green
5.13	Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re- tested and contacts traced promptly	Late onset COVID19 Patient Pathway/SOP required. **Update:** management of COVID-19 and flowcharts produced and disseminated.	AG	Green
5.15	Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	OPD Triage policy/ SOP required. **Update**: Requires update	AG	AG

8.2	Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Produce SOP on inpatient screening. **Update**: management of COVID-19 and flowcharts produced and disseminated.	AG	Green
8.6	That all emergency patients are tested for COVID-19 on admission	• Produce SOP on inpatient screening. **Update**: management of COVID-19 and flowcharts produced and disseminated.	AG	Green
8.7	That those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise	Produce COVID-19 patient screening SOP, • Audit of screening compliance, monitoring of BI report on missed screens. **Update**: management of COVID-19 and flowcharts produced and disseminated.	AG	Green
8.8	That those emergency admissions which test negative on admission are retested on day 3 of admission and again between 5-7 days post admission	Produce COVID-19 patient screening SOP, • Audit of screening compliance, monitoring of BI report on missed screens. **Update**: management of COVID-19 and flowcharts produced and disseminated, routine testing at days 3 and 5-7 not completed as agreed by the Trust Board. Exceptions, high risk patients in augmented care and oncology and NCTR patients - screening undertaken every 48/72hrs.	AG	Green
8.9	That sites with high nosocomial rates should consider testing COVID negative patients daily	Produce COVID-19 patient screening SOP, • Audit of screening compliance, monitoring of BI report on missed screens. **Update**: management of COVID-19 and flowcharts produced and disseminated, outbreak and incident management advise appropriate escalated screening	AG	Green
Mitigating Actions Related to Risk Assessments				
1.1	Local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;	H&S team review & update latest COVID Secure risk assessment congruent with Hierarchy of Controls. Monthly audits required. Clinical areas require bespoke risk assessments congruent with Hierarchy of Controls. High risk areas Neil Kaye to provide details of locations with regards ventilation. Database of all areas clinical & non clinical to be created. **Update**: Need to produce overarching document with regards wards and departments with regards Estates & Facilities and IPC risks	AG	AG
10.1	Staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and psychological wellbeing is supported	Risk assessment prompt to be added to on staff member's HEY24/7 education/appraisal page and link to risk assessment provided for both individual and line manager. Individual staff member and line manager to take responsibility and ownership of process via HEY24/7. Risk assessment to be revisited every 2 years and/or in light of changing health and/or working conditions. **Update**: Ways of working reverted to pre-pandemic levels as per national guidance, however systems as described above in place to support 'at risk' groups.	AG	Green

10.2	That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	Risk assessment prompt to be added to on staff member's HEY24/7 education/appraisal page and link to risk assessment provided for both individual and line manager. Individual staff member and line manager to take responsibility and ownership of process via HEY24/7. Risk assessment to be revisited every 2 years and/or in light of changing health and/or working conditions. **Update**: Ways of working reverted to pre-pandemic levels as per national guidance, however systems as described above in place to support BAME staff.	AG	Green
10.13	All staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	Non-clinical areas to be reassessed by departmental managers/ COVID19 Secure champions, utilising the COVID-19 Secure Risk Assessments. **Update**: Ways of working reverted to pre-pandemic levels as per national guidance. Social distancing and mask wearing optional but under review with regards prevalence and incidence	AG	Green
10.14	Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	Non-clinical areas to be reassessed by departmental managers/ COVID19 Secure champions, utilising the COVID-19 Secure Risk Assessments. **Update**: Ways of working reverted to pre-pandemic levels as per national guidance but additional measures remain in place in clinical settings with use of screens	AG	Green
10.15	Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	**Update**: Non clinical staff working in non clinical areas mask wearing as personal preference but reviewed alongside incidence and prevalence. Ways of working reverted to pre-pandemic levels as per national guidance. Healthcare workers within clinical settings continue to wear facemasks	AG	Green
Mitigating Actions Related to Fit Testing				
10.4	Staff who carry out fit test training are trained and competent to do so	During September 2021, IPCT & H&S revisited fit testing processes with the support of the National Fit Testing Team National Fit Testing Team facilitated Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams. **Update**: National fit testing team remain supporting the H&S team with regards fit testing both at HRI and CHH. Centrally held record available on HEY24/7	AG	Green
10.5	All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	During September 2021, IPCT & H&S revisited fit testing processes with the support of the National Fit Testing Team. National Fit Testing Team facilitated Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams. **Update**: National fit testing team remain supporting the H&S team with regards fit testing both at HRI and CHH. Staff required to wear an FFP respirator prioritised by fit testing team. Centrally held record available on HEY24/7 and provided to trainee	AG	Green

10.6	A record of the fit test and result is given to and kept by the trainee and centrally within the organisation	During September 2021, IPCT & H&S revisited fit testing processes with the support of the National Fit Testing Team National Fit Testing Team facilitated Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams. Fit testing record recorded on staff member's HEY24/7 education/appraisal page. **Update**: National fit testing team remain supporting the H&S team with regards fit testing both at HRI and CHH. Centrally held record available on HEY24/7 and provided to trainee	AG	Green
10.7	For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	During September 2021, IPCT & H&S revisited fit testing processes with the support of the National Fit Testing Team National Fit Testing Team facilitated Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams. Fit testing record recorded on staff member's HEY24/7 education/appraisal page and held centrally on HEY24/7. **Update**: National fit testing team remain supporting the H&S team with regards fit testing both at HRI and CHH. Records of failed fit testing and tried alternatives provided to trainee and held centrally, record available on HEY24/7	AG	Green
10.3	Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	During September 2021, IPCT & H&S revisited fit testing processes with the support of the National Fit Testing Team. Centrally held training record established and maintained. Fit testing record recorded on staff member's HEY24/7 education/appraisal page. Lead to be appointed and business case for dedicated team to be developed. **Update**: National fit testing team remain supporting the H&S team with regards fit testing both at HRI and CHH. Centrally held record available on HEY24/7. H&S business case for fit testing resource drafted but paused whilst national team remain within the Trust	AG	AG
10.11	Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	During September 2021, IPCT & H&S revisited fit testing processes with the support of the National Fit Testing Team. National Fit Testing Team facilitated Fit to Fit accredited training for fit testers to be fit test trainers to cascade training to other teams. **Update**: National fit testing team remain supporting the H&S team with regards fit testing both at HRI and CHH. Centrally held record available on HEY24/7	AG	Green
Mitigating Actions Related to PPE				

1.9	Monitoring of compliance with wearing appropriate PPE, within the clinical setting, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Wards and departments / HGs to identify PPE guardians. **Update**: PPE guardians not introduced but weekly My Assure audits completed by ward sisters/ charge nurses and Senior Matrons capturing PPE compliance, underpinned by additional Insights audits	AG	AG
1.14	All staff (clinical and non-clinical) are trained in - putting on and removing PPE; -know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	**Update**: Donning and doffing PPE included in Skills for Health training. Updated posters on PPE - what and when to wear	AG	Green

6.2	All staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other national guidance, to ensure their personal safety and working environment is safe	Proposal to change training frequency for clinical staff from 3 years to 1 year - to be agreed. The vast majority of Acute Trusts favour the current National Recommendations from Skills for Health with regards a yearly update National PPE & IPC training are currently on-line e-learning packages, which meet Core Skills Training Framework (CSTF) requirements, and have been updated to include reference to Covid. Managers to monitor new starter training that has to be completed within 4/6 weeks HYMS - Years 0,1,2 only attend hospital fully supervised, no COVID areas. Patients are identified for them in advance so no known COVID either. They are provided with scrubs and trained in handwashing but no other Trust stat mand training. Years 3 – 5 and Physician Associates (years 1 and 2). These students are all provided with scrubs and visors. They are allowed appropriate access to any area of the Trust. They receive all the same stat mand training as any member of staff. However, they are not FIT tested centrally. If they are required to be in level 3 PPE then it is the responsibility of the hosting department to FIT test them and provide appropriate PPE. This is not recorded centrally but should be recorded on a departmental level. Please note that year 3 and 4 students rotate clinical site (Hull, York, Grimsby, Scunthorpe, Scarborough) every 16 weeks and every 8 weeks in Year 5. **Update:** Annual IPC training approved at PEC & MEC	AG	Green
6.3	All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to don and doff it safely	Video on HEY247 can be monitored and names who have watched recorded. Key areas - staff to sign to say they have been trained.	AG	Green
9.4	PPE stock is appropriately stored and accessible to staff who require it	· Assurance required regarding out of hours access to PPE; supply services to provide an update regarding storage facilities for PPE and ward access to PPE/Emergency stock. **Update:** Adequate PPE stock available across the Trust. Weekends and Bank Holidays additional 'top up' ensures additional supplies	AG	Green
Mitigating Actions Related to Estates				

5.10	Ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Estates and HS to provide evidence of compliance and adaptions applied with regards screens. **Update**: National guidance stepped down with regards pre-pandemic systems and processes. Although physical screening still in place in ED and outpatient settings	AG	Green
6.1	Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Estates and Facilities to maintain clutter free lift lobby area and ensure clear signage is in place and area at times policed by volunteers. NK agreed with Ian Stanley to reapply floor markings out socially distanced spaces in the lift lobby and increase keep left signs. OCS audit communal areas. **Update**: National guidance stepped down with regards return to pre-pandemic systems and processes. Although COVID-19 positive pathways still in place and prioritisation of side room utilisation by the Site Team. COVID-19 surge plan required as needed.	AG	Green
Mitigating Actions Related to Bed Modelling				
7.1	Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	Bed modelling proposal drafted and tabled at Execs - no reduction in bed capacity Wards scoped which from an IPC perspective provide safer environments with regards ventilation/ social distancing . COVID-19 surge plan aligned to pathways. Wards affected by outbreaks of infection closed to admissions. **Update**: Trust utilising the Living with COVID-19 guidance, cohorting COVID-19 positive patients as and when required. Utilising Wards H37 /H38 as needed. Contacts risk assessed and managed according to guidance. COVID-19 surge plan required as needed.	AG	AG
7.3	Patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Bed modelling proposal drafted and tabled at Execs - no reduction in bed capacity Wards scoped which from an IPC perspective provide safer environments with regards ventilation/ social distancing Ongoing need to evaluate the use of Redirooms in areas where space is compromised and deploy as required. **Update**: Trust utilising the Living with COVID-19 guidance, cohorting COVID-19 positive patients as and when required. Utilising Wards H37 /H38 as needed. Contacts risk assessed and managed according to guidance. COVID-19 surge plan required as needed.	AG	AG

7.4	Areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Bed modelling proposal drafted and tabled at Execs - no reduction in bed capacity Wards scoped which from an IPC perspective provide safer environments with regards ventilation/ social distancing to accept COVID-19 patients New ICU facility on HRI site - compliant with the environmental requirements set out in the national guidance. **Update**: Trust utilising the Living with COVID-19 guidance, cohorting COVID-19 positive patients as and when required. Utilising Wards H37 /H38 as needed. Contacts risk assessed and managed according to guidance. COVID-19 surge plan required as needed.	AG	AG
Mitigating Actions Relating to Training				
1.12	Training in IPC standard infection control and transmission-based precautions are provided to all staff	E&D to work in partnership with IPCT to scope and deliver IPC training annually. **Update**: Annual IPC training approved at PEC & MEC	AG	Green
1.13	IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	E&D to work in partnership with IPCT to scope and deliver IPC training annually. **Update**: Annual IPC training approved at PEC & MEC	AG	Green
Other Mitigating Actions				
1.10	Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace	All additional measures to increase uptake taken. Trust to support both LFT and LAMP testing for staff and to adopt changes on asymptomatic staff screening processes as they arise. **Update**: Staff encouraged to complete twice weekly LFD testing, ordering kits via the .GOV website and reporting results via Test & Trace. LAMP testing withdrawn from HUTH use. Evidence that staff are using LFDs and reporting positive results to the ESC Helpdesk but lack of assurance staff are reporting via NHS Test and Trace website	AG	AG
1.11	Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control / Public Health team	Option scoped and costed to facilitate and deliver staff screening out of hours on the HRI site - rapid screening for staff to enable prompt assessment and return to work as appropriate. **Update**: additional targeted PCR testing facilitated by the staff testing team but need for prompt testing on HRI site stepped down. Beneficial use of LFD testing by staff	AG	Green
1.15	There are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	Need for HUTH website to be reviewed and updated for the general public. **Update**: completed	AG	Green

1.18	Risks are reflected in risk registers and the Board Assurance Framework where appropriate	Stand alone IPC risk register being drafted by Quality & Risk Team. **Update**: IPC risk register drafted and tabled at SIRC, ongoing monitoring in place to ensure remains 'live' document	AG	Green
1.19	Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	DATIX compliance report to be tabled at OIRC. RCA documentation reviewed and updated. RCA training to be scoped and delivered to key members of HGs. **Update**: Datix compliance report tabled at OIRC but gaps noted in reporting by HGs and IPCT. RCA documentation reviewed and updated, rapid RCA tool piloted in MHG but as yet not embedded fully. RCA training outstanding.	AG	AG
1.22	Ensure Trust Board has oversight of ongoing outbreaks and action plans.	Outbreak review to be tabled at OIRC by HG with lessons learnt and action plan so monitoring in place. **Update**: Outbreaks and associated lessons learnt captured in HCAI/IPC report submitted to Quality Committee	AG	Green
1.23	There are check and challenge opportunities by the executive / senior leadership teams in both clinical and non-clinical areas	Feedback added as agenda item for November 2021 OIRC. **Update**: Exec and Non-Exec 'walk-abouts' rescheduled and areas divided to ensure adequate coverage and visibility	AG	Green
2.4	Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	Consider if Site Matron are able to take on this role and function. **Update**: checklist developed to facilitate effective sign off following outbreak clean, enabling IPCT and Site Team to gain assurance	AG	Green
2.8	'Frequently touched' surfaces, e.g. door/toilet handles, patient call bells, over-bed tables & bed rails, should be decontaminated more than twice daily & when known to be contaminated with secretions, excretions or body fluids.	Need to scope additional support to wards and departments such as ward hygienists and ward housekeepers if these are not already in place. **Update**: Facilities and OCS scoping via a business case additional support out of hours to provide further cleaning of frequently touched surfaces in wards and units	AG	AG
2.11	Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol - before inspection, servicing or repair equipment	Senior Matron and Senior Sisters to ensure education of staff to ensure decontamination is in place as per guidance. **Update**: Further work is required with regards a consistent approach to cleaning healthcare equipment.	AG	AG
2.13	Single use items are used where possible and according to Single Use Policy	Contact with Debbie Sutton to check. **Update**: outstanding	AG	AG

4.1	Implementation of national guidance on visiting patients in a care setting	Nominated person to review generic Visiting and Maternity website content on a regular basis to ensure it remains in line with national guidance Add a banner at top of 'Getting to our hospitals' page and 'Patient information leaflets' to direct people to the latest advice on visiting during the Covid pandemic/say this supercedes any leaflets dated pre-pandemic. Operationally effective with regards to visiting and communications are sent via the daily updates as required from the Trust Silver meetings with any changes. **Update**: Visiting Policy refreshed in light of national guidance changes with visiting leaflet developed and available	AG	Green
4.3	Information and guidance on COVID-19 is available on all Trust websites with easy read versions	PHE contacted with regards to the latest Easy Read information. Browsealoud functionality allows audio as an option. **Update**: appropriate versions available on Trust internet page	AG	Green

4.6	Implementation of the supporting excellence in infection prevention and control behaviours implementation Toolkit has been considered	Examples of implementation of the toolkit are as follows: Clear messaging/posters with regards to •2m distancing – use of face masks/coverings •Staff masks & distancing when on breaks & guidance for outside of work. **Update**: posters redeveloped and standardised in clinical areas with clear messaging •Front door 'greeters' to ensure compliance with mask wearing volunteers introduced at the front door to further help explain the measures in place across the service, as well as providing direction and support within the building. **Update**: Volunteers in place but due to changes in national guidance risk reduced Estate •Removable signage Consider developing signage that can be moved and flexed to the needs of the facility. One example of this could be a pull-up banner i.e. You are now entering a red zone. **Update**: posters redeveloped and standardised in clinical areas with clear messaging. Pull-up banners available with regards D&V but additional versions required. • Waiting room layout Some waiting rooms are not conducive to IPC compliance. Consider how chairs are spaced and restrict use of other chairs and surfaces between these spaces. Diagnostics waiting rooms were raised as a particular area for consideration. **Update**: change in national guidance reverting to pre-pandemic measures has reduced risk but partitions and screens still in use in waiting areas • Safety huddles	AG	Green
5.5	Face coverings are used by all outpatients and visitors	Ongoing need to reinforce messages for maximum impact. **Update**: national guidance does not require all outpatients and visitors to wear facemasks and is personal choice unless increase in prevalence and incidence noted	AG	Green
5.7	Face masks are available for all patients and they are always advised to wear them	Additional visual reminders required for patients whilst nursed in bedded areas. **Update**: facemask posters produced and in use on wards	AG	Green

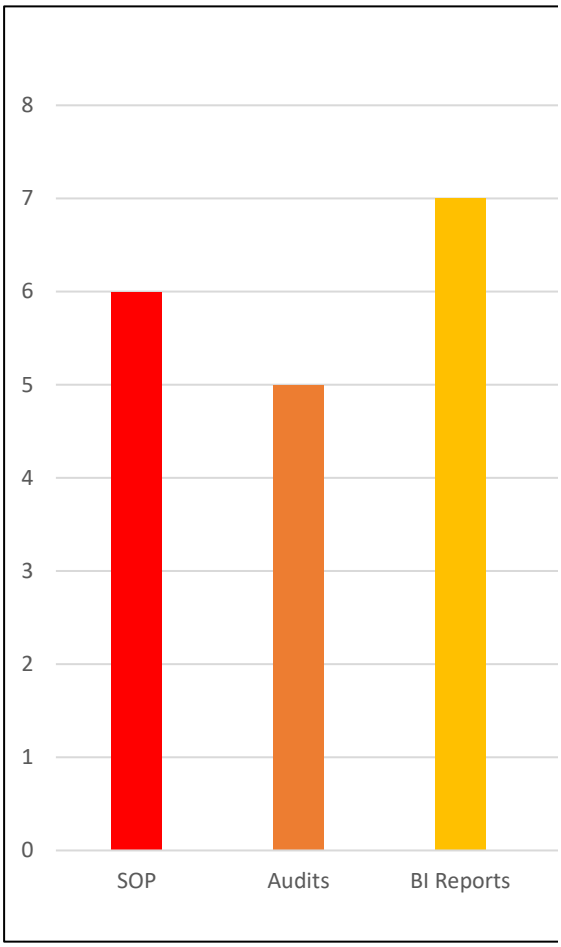
5.8	Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care	Additional visual reminders required for patients whilst nursed in bedded areas. **Update**: facemask posters produced and in use on wards	AG	Green
8.1	Testing is undertaken by competent and trained individuals	Incorporate documentation of swabbing training in nursing competencies	AG	Green
10.10	Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	Source nationally agreed algorithm and undertake gap analysis of Trust process againgst algorithm to identify any changes/ updates required. **Update**: nationally agreed algorithm in use but gap analysis reamins outstanding - reduction in COVID-19 has minimised this risk	AG	AG
10.12	Consistency in staff allocation is maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	Staff working on COVID-19 positive areas not moved to non COVID-19 areas. **Update**: reduction in COVID-19 numbers has minimised this risk but nurse staffing remains a daily challenge	AG	Green

Last Updated :
28th Feb 2022

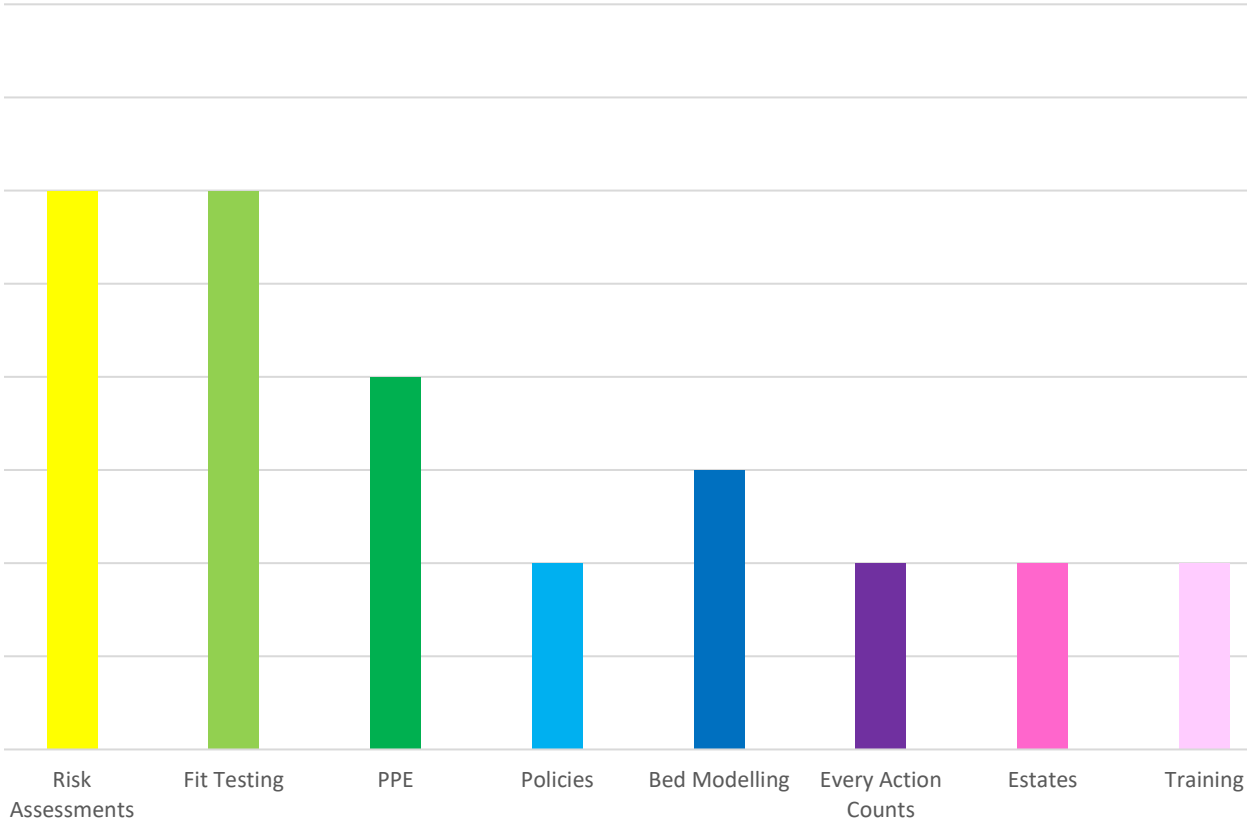
Amber Green Breakdown	
SOP	6
Audits	5
BI Reports	7
Risk Assessments	6
Fit Testing	6
PPE	4
Policies	2
Bed Modelling	3
Every Action Counts	2
Estates	2
Training	2

* This chart does not include KLOEs with missing actions or those that are uncategorised.

Misc.	
Missing Actions	5
Uncategorised	20



Mitigating Actions Relating to:



HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12 July 2022
Title	Learning from Mortality and Morbidity Report – Q4 2021/22				
Lead Director	Dr Makani Purva – Chief Medical Officer				
Author	Chris Johnson – Effectiveness and Improvement Manager				
Report previously considered by (date)	This report was considered at the Mortality Committee 11 May 2022 And the Trust Board 30 May 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 Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
MORTALITY - LEARNING FROM DEATHS QUARTER 4 2021/22

1. PURPOSE OF THIS REPORT

The purpose of this report is to provide the Trust 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 4, 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).

This report should be read in conjunction with the "Analysis of Current Mortality and Morbidity Review Practices within the Trust" report that was circulated at the Trust M&M Committee in April 2022.

2. SUMMARY OF IN-HOSPITAL MORTALITY IN Q4 2021/22

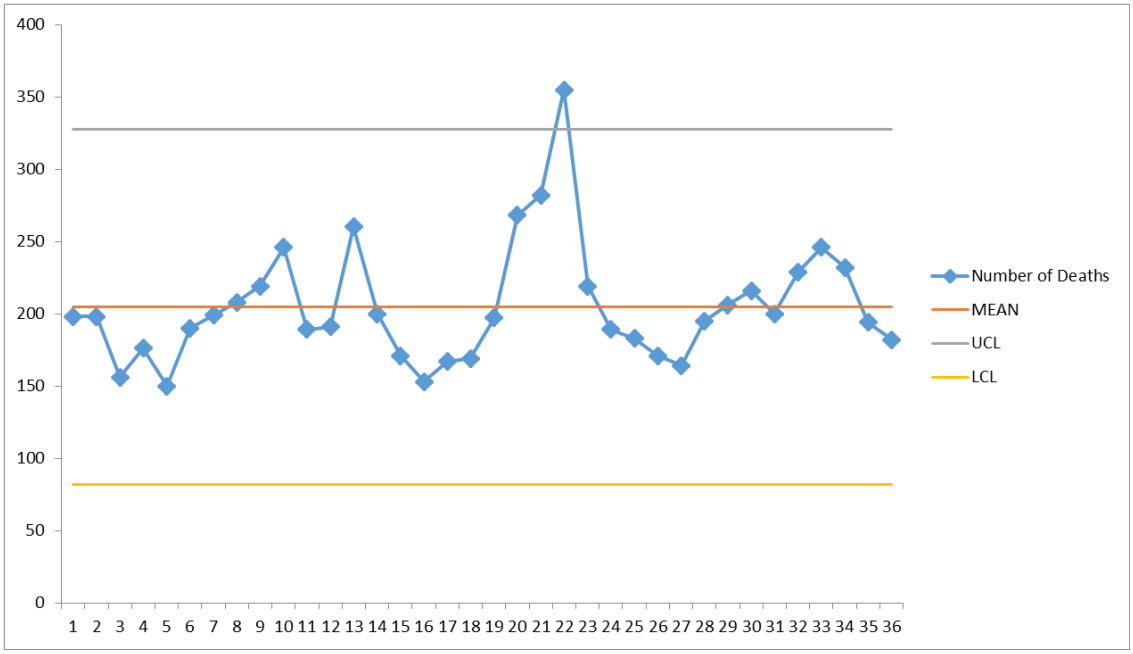
The following table provides a breakdown of patient deaths that occurred within the Trust (excluding the ED) during Q4 2021/22, drawing comparison to last year:

	Year for Comparison	Total number of In-hospital deaths
Q4	2020/21	763
	2021/22	**608**

There was a **20.3%** decrease of in-hospital deaths, compared to the previous year's Q4.

Patients who die within the Emergency Department are not reported at in-hospital deaths, as they are not classed as inpatients. However, discussions are taking place with the possibility of including this patient cohort within the Business Intelligence system going forward.

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.

2.1 Common Clinical Conditions Present at Time of Death
The three most common clinical conditions (CCS) present at time of death (excluding Covid-19) during Q4 were:

Clinical Condition	Number of Patients
Pneumonia	**85** (representing **14 %** of the total)
Sepsis	**48** (representing **7.9 %** of the total)
Acute Cerebrovascular diseases (Stroke)	**30** (representing **4.9 %** of the total)

Additionally, there were 37 deaths attributed with Covid-19 during Q4.

2.2 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 Q4.

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)	19	At of time of writing, 6 reviews have completed, with the remaining cases to be reviewed by nominated reviewers. – Cases escalated by the ME Office will be reviewed by a new central review team that is currently in formation (See the QI section of this report).
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 officially raised with the provider (mortality alert – Dr Foster)	NA	NA
Number of deaths that escalated to a Serious Incident Investigation and completed, within the Quarter, where it is likely that problems in care contributed to patient death.	0	0
Further sample of deaths where the learning will inform a provider's quality improvement work	Fracture Neck of Femur SJR: 5 Stroke SJR: 12	Fracture neck of femur cases, in addition to Stroke patients, are reviewed regularly and on an on-going basis by the Specialities involved.

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.

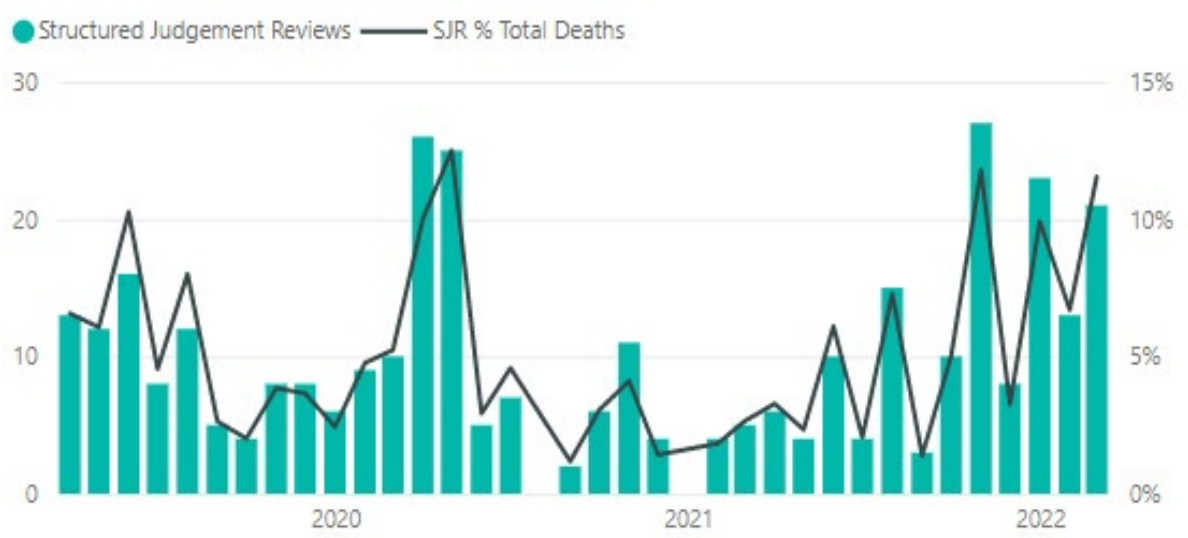
3. SUMMARY OF STRUCTURED JUDGEMENT REVIEWS

The following table illustrates the number of SJR's completed within Q4; 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
Q4	48 (On Lorenzo) 13 (Paper based) Total 61	10	4	
% reviewed out of total number of deaths	10%			

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, 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
1. Phase of Care						
Admission & initial care (1st 24hrs)	3.9	2	22	72	97	82
Care during a procedure	4.1	1	1	8	45	24
End of life care	4.0	3	16	49	110	95
Ongoing care	3.8	3	25	71	108	66
Overall assessment of care	3.7	1	32	73	115	52
Perioperative care	3.9	2	2	10	38	15
2. Avoidability of death						
Avoidability of death judgement	4.6		1	2	6	2
3. Themed Analysis						
Ceiling of care	3.5	1	4	6	1	7
Communication with patient/family	3.6	3	6	3	8	12
Documentation	2.8	7	12	16	11	2
End of life care	3.9	1	5	11	18	21
Fluid balance	2.5	4	7	6	2	1
Interventions	3.4		6	6	2	6
Management plans	3.4	1	7	8	3	8
Medication \ Prescribing	2.1	3	7	5		
Multi-disciplinary care	3.5	1	4	4	2	6
Other	3.2	3	14	15	11	9
Senior clinical involvement	3.4		4	9	6	3
Sepsis management	2.6	2	3	3	1	1

Overall, the average care scores represent a high quality of care delivered to patients who received an SJR.

The outcomes 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 & IMPROVEMENT

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 Oncology

The Oncology Department undertake regular, standalone M&M meetings, chaired by a Consultant Oncologist, which is recorded (minutes) along with learning and action plans. This reflects excellent practice and the following section of the report will highlight some of the key learning that has taken place within the department, with the intention of sharing across the Trust.

Key Learning – Lesson 1

A review focused on potential delays in the diagnosis of potentially curable cancer, especially with raised germ cell tumour markers. There was an assessment for the possible reasons that these cases could be referred to Haematology for work up of lymphoma (differential diagnosis) rather than to oncology to commence radical anticancer treatment.

The Urology team had reviewed the case on request by the Oncology team and demonstrated that the correct diagnostic pathway was followed, as demonstrated by the use of a best interest meeting.

Action

The Acute Oncology Speciality will be delivering teaching on the diagnosis of testicular germ cell cancers.

Key Learning – Lesson 2

Patients who are at end of life are at risk if they still have a defibrillator fitted. These patients will invariably have arrhythmia as a terminal event, if the defibrillator is still active, it will shock the patient and potentially restart the heart.

Multiple opportunities were missed to contact the Cardiology team to remove the defibrillator to anticipate end of life and have a peaceful death.

Action

The Oncology department would like to share the following key message:

For all end of life scenarios, a mandatory Cardiology Consultant must switch off the defibrillator.

It was discussed that there is a requirement to reach an agreement as to the most appropriate form to warn and highlight it in the notes that a patient requires their defibrillator turning off.

Key Learning – Lesson 3

A failure to adjust the doses of nephrotoxic chemotherapy (Capecitabine), despite the patient's abnormal kidney function. The chemotherapy regimen used for the patient was correct, but modified combinations are preferred in all patients with this type of cancer.

Action

To ensure that the chemotherapy electronic regimen is updated regularly, along with teaching to be delivered on nephrotoxic anticancer systemic agents and the proper use of adjustment of dosage.

Key Learning – Lesson 4

A patient was resuscitated. There was no ReSPECT plan in the notes, however there was a ReSPECT plan on Lorenzo from a previous admission, but it appears that although a DNACPR recommendation had been acknowledged in clerking, it had not been printed off Lorenzo, nor had a new ReSPECT plan been completed

The Oncology department would like to share the following key message:

Always check Lorenzo for a ReSPECT plan.

If a ReSPECT plan is on Lorenzo, this should be printed off and the clinical recommendations outlined on the plan must be reviewed to check they are still relevant to the patient.

4.2 Mortality and Morbidity Review in the Renal Department
The Renal Department undertake regular, standalone M&M meetings, chaired by a Renal Consultant, which is recorded (minutes) along with learning and action plans. Below is an excerpt from the Speciality M&M minutes that highlights some key learning opportunities, in addition to good practices.

ReSPECT Plan – A ReSPECT plan should have being considered when an echo showed a global Left Ventricular impairment. A timely ReSPECT plan should be discussed with the patient and patient's next of kin, with the outcomes recorded.

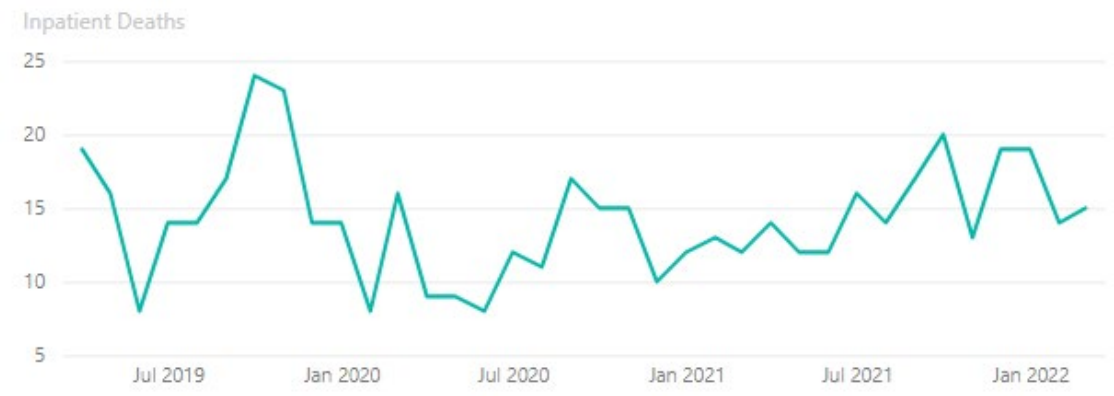
Dialysis Withdrawal – Best practice was observed, acting in the patient's best interest. The patient was withdrawn from dialysis as ceiling of care was agreed and end of life was approaching. An early discussion was held with the patient and family and recorded.

Delay in Central Line Removal – In some cases that were discussed with the Speciality M&M, there was an apparent delay in the removal of the patients central line.

Ensure that Lines / Cannulas / Catheters are removed as soon as they are no longer required

5. SEPSIS RELATED MORTALITY & QUALITY IMPROVEMENT PLAN
The Trust continues to be an outlier against Sepsis Mortality. Sepsis related mortality is one key area that the Trust is focussing quality improvement initiatives on. There are several known issues that are proven to affect the care of patients with Sepsis, as well issues that have had a negative impact on Sepsis statistics, some of which are related to inadequate documentation that unfortunately leads to incorrect coding.

The following dashboard provides crude mortality (in-patient) statistics covering the last 36 months to date, for patients who died with a Clinical Condition as "Sepsis".



Since January 2021, the number of in-hospital deaths for patients coded as Sepsis appears to have increased overall. 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.

By Month

Month	2019/20	2020/21	2021/22	Total
Apr	19	9	14	**42**
May	16	9	12	**37**
Jun	8	8	12	**28**
Jul	14	12	16	**42**
Aug	14	11	14	**39**
Sep	17	17	17	**51**
Oct	24	15	20	**59**
Nov	23	15	13	**51**
Dec	14	10	19	**43**
Jan	14	12	19	**45**
Feb	8	13	14	**35**
Mar	16	12	15	**43**
Total	**187**	**143**	**185**	**515**

The following table provides a breakdown of the number of patients who died with Sepsis as a main clinical condition, over the last 36 months, per ward area.

Ward	No.	Ward	No.	Ward	No.
H9 - Ward 9	65	H36 - Ward 36	8	H37 - Ward 37	2
H8 - Ward 8	54	H50 - Ward 50	8	C11 - Ward 11	1
H90 - Ward 90	49	H60 - Ward 60	8	C14 - Ward 14	1
HAAU - Acute Assessment Unit	48	CICU - CICU2	7	C15 - Ward 15	1
H80 - Ward 80	32	H6 - Ward 6	7	C4 - Ward C4	1
FAB	31	C32 - WARD 32	6	H100 - Ward 100	1
H10 - Ward 10	26	C33 - WARD 33	6	H110 - Ward 110	1
HGHD - HICU2	25	CGI1 - CICU1	6	H120 - Ward 120	1
H70 - Ward 70	20	H500 - Ward 500	5	H30 - Cedar Ward	1
HICU - HICU1	20	C31 - WARD 31	4	H4 - Ward 4	1
H1 - Ward 1	15	H200 - Ward 200	4	HNHD - Neurosurgery HOB	1
H5 - Ward 5	11	H38 - Ward 38	4		
HICU3	10	C16 - WARD 16	2		
C30 - WARD 30	8	C28 - Ward 28	2		
H11 - Stroke Unit	8	C7 - WARD 7 Infectious Diseases	2		

As part of the wider Quality Improvement Plan, the Sepsis Team aims to conduct a departmental audit on all patients with NEWS2 score >5 or 3 in one parameter within a 7 day period, to measure compliance with National Guidelines and Local Policy for Sepsis. Additionally, the aim is to determine potential staff knowledge gaps in relation to standards of best practice for Sepsis. Results will be used to inform a departmental Quality Improvement Project (QIP), directing the provision of resources, educational development plans, clinical support and governance support, led by the departmental auditors in collaboration with the Sepsis Team to improve standards of practice, care quality and patient outcome.

Sepsis Quality improvement Plan – Rationale
The HUTH Sepsis Team is a small but effective team. Formed in 2015, it now consists of two full-time band 7 Sepsis Specialist Nurses and one Consultant Sepsis Lead, funded for 3 hours per week. The formation of the team was in response to high Sepsis mortality rates recorded within HUTH.

Data collection, instructed by Commissioning for Quality and Innovation (CQUIN) is focused around emergency admission rates for Sepsis and the administration of antibiotics within 1 hour of sepsis identification, later extending the focus to antibiotic usage and review within 72 hrs. Multiple quality improvement projects related specifically to Sepsis have been conducted since 2015, including the introduction of the Sepsis Pathway, although its use within HUTH has never been analysed or measured. The crude mortality rate within the past 12 months is deemed high and has risen from 27.6% to 28.5% (as from 31/1/22). The death count due to Sepsis in this time period is 369, with 1294 Sepsis admissions and an average length of stay which has increased by 14.6% (14 days increased to 16 days). Sepsis also contributes to Trust SHMI and SHMI statistics, which are one of the focuses of the Trust in terms of overall reduction.

CQUIN data collection has now ceased, however, it is deemed crucial that the Sepsis Team and the wider Trust are able to establish a baseline of departmental compliance with guidance in identifying and treating Sepsis. The results will be used to guide individual departments, the Sepsis Team and HUTH as a whole to direct resources and educational programmes effectively and efficiently, with the ultimate aim of reducing mortality rates and improving patient outcome.

Sepsis Quality improvement Plan – Objectives

- To identify if patients are considered and screened for sepsis within an appropriate time frame.
- To identify if patients receive the appropriate treatment for sepsis within an appropriate time frame.
- To identify if antibiotic treatment is prescribed, and reviewed appropriately.
- To identify if patients with sepsis or suspected of having sepsis are reviewed by the appropriate level of staff at an appropriate time.
- To identify if a sepsis diagnosis, when appropriate, is explicit in documentation and coded appropriately.
- To determine staff (nursing and medical) knowledge in relation to sepsis guidelines and local policy.
- To compare the above standards against factors including: Patient sex, age, number of co-morbidities, DNAR and critical care escalation status, hospital location and speciality, day shift versus night shifts and patient outcome.

Knowledge
- How confident staff feel in identifying and managing sepsis
- How confident medical staff are in prescribing antibiotics according to HUTH policy
- Staff knowledge of what NEWS2 scores should trigger a sepsis screen
- Staff knowledge of sepsis red flags
- Staff knowledge of diagnostic criteria for sepsis
- Staff knowledge of the expected time frames in which to examine, investigate and treat patients with suspected sepsis or sepsis.
- Staff knowledge of the minimal investigations required as part of a septic screen.
- Staff knowledge of the sepsis 6 components and the timeframe in which it should be complete
- Staff knowledge of where to find empiric and broad spectrum antibiotic guidance

- Staff knowledge of timeframes for antibiotic review
- To compare the above knowledge points, against factors including:
- Job role (nursing or medical)
- Time since last training for sepsis (<1 year, 1-2 yrs, 2-3 yrs, 3+ years)
- Whether previous training has been HUTH Trust specific or not.

Sepsis Quality improvement Plan – Expected Outcomes

- As recommended by NICE, an audit is required to quantify a baseline for the level of compliance with National and local guidelines and policy for sepsis within Hull University Hospital Teaching Hospitals. Departmental audits will contribute to collective data for HUTH performance.
- To improve moral by identifying and acknowledging areas of good or excellent guidance compliance.
- To direct future quality improvement initiatives aimed at encouraging sepsis guideline compliance in relation to the targeting of specific staff disciplines and HUTH locations/specialities.
- To identify specific elements of the guidelines that require consideration for future quality improvement initiatives or educational focus.
- To raise awareness within HUTH of sepsis guidelines and best practice, empowering and facilitating departments to analyse results, identify areas for improvement and to make changes accordingly with the collaboration of the Sepsis Team.
- To enable shared learning Trust wide, with local primary care and ambulance services.
- To measure future quality improvement initiates against for evaluation purposes.

The audit will give insight as to how reflective sepsis data for National reporting is in comparison to actual sepsis cases in the clinical area.

6. TRUST & HULL CCG COLLABORATIVE REVIEW

A sample of 20 case notes was 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

Aim 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

The rationale behind this review was to highlight any potential issues in relation to patients who re-presented to the ED within 48 hours, assessing the options that were considered and choices made in terms of planning and patient care.

The following is a summary of the main discussion points from the review.

- On the whole, patients brought themselves back to the ED, on the basis of safety netting, which the ED Consultant on the review team explained was viewed as a positive thing in ED. After a group discussion, it was found that in primary care, this was viewed as a

missed diagnosed, or that something had gone wrong. Further work may be required to alter the perception of this approach for care providers outside of the ED.

- There was also a general lack of discharge comments to the GP, with two records writing in the management section, rather than the discharge comments box asking for O/P scans and specialty referrals. There is need for increased training at induction in this area.

- There was one case where the discharge comment box (IDS) had been filled in appropriately but this still hadn't translated onto the IDS (potentially an IT issue) but it was agreed that it is frustrating when important comments recorded into Lorenzo IDS are not seen. An audit could prove to be beneficial to determine if the IDS summaries are in fact remaining within the Lorenzo system, or if there is an IT related issue that is resulting in the loss of this data.

- One of the General Practitioners on the review group brought up the lack of being able to contact ED to discuss cases that were directed to the ED, as a letter doesn't always convey thoughts very well. It was discussed that the feeling was reciprocated when Trust staff want to talk to a GP about concerns or admission reasons and unable to get through the receptionist queue.

- A GP discussed a concern around a lack of communication on discharge between the Trust and the GP. It prompted a request for full CASCARD sharing between the Trust and the GP, so that GP's can see a full detail of events.

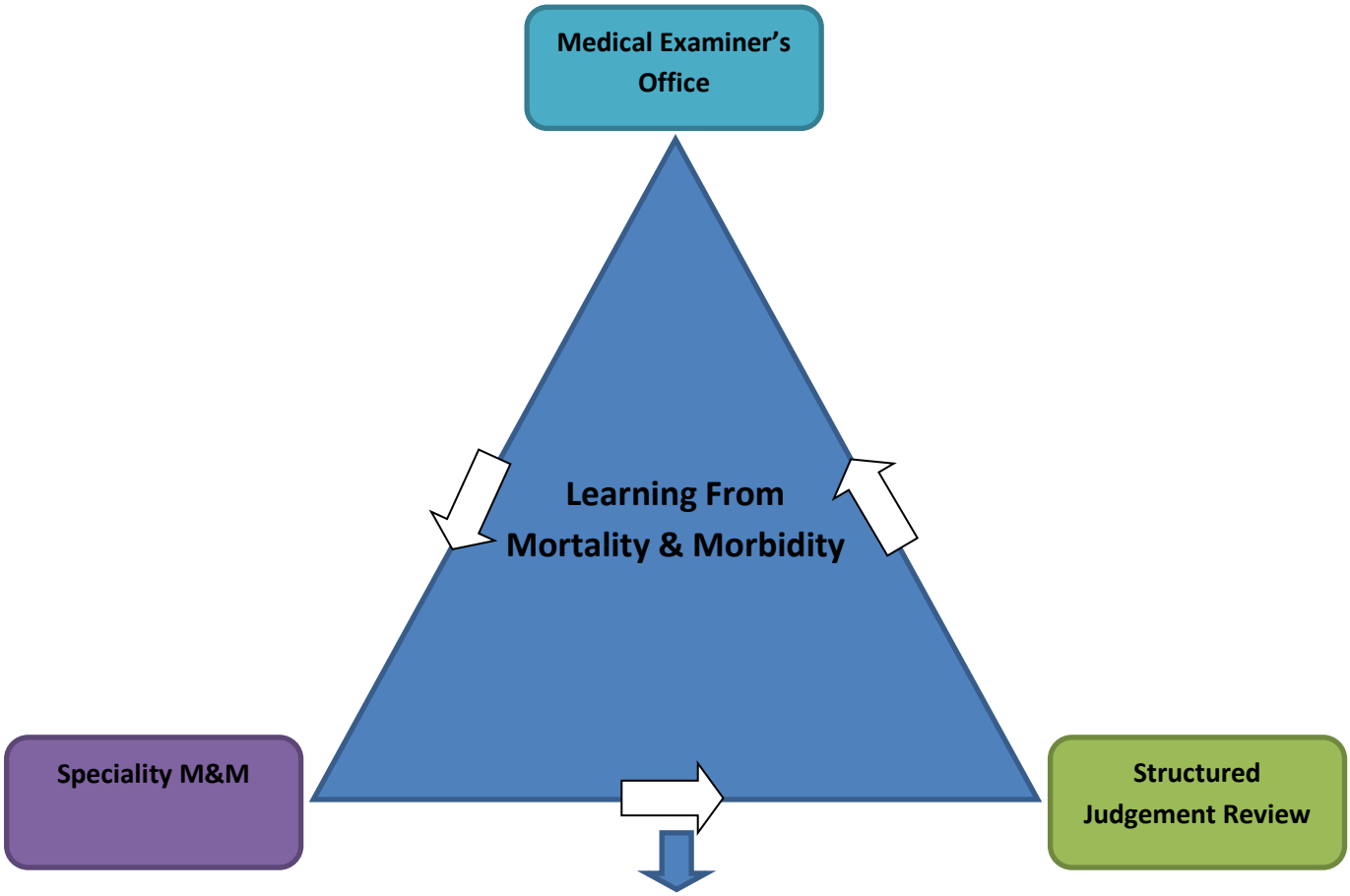
Overall, it was a very constructive meeting and review. There were some obvious misconceptions about how ED works and some frustrations (not inappropriately) about our communication on discharge.

7. PROPOSED SYSTEM OF FEEDBACK, SHARING AND ESCALATION

There are 3 main sources of regular information in regards to learning from mortality & Morbidity. In addition to these 3 main sources, there are occasional Serious Incidents where the patient may die. This source of learning will also be factored in to the learning cycle. The medical examiner's office is usually the starting point / flagging mechanism for further review, however, information can be sent in all directions to ensure that we effectively feedback and share our findings with the wider leaning network, as well as regular reports to the Trust Board.

It is imperative that these 3 main sources of information share and collaborate on findings in order to highlight areas that may require improvement, and equally as importantly, good practices.

The M&M Triangle

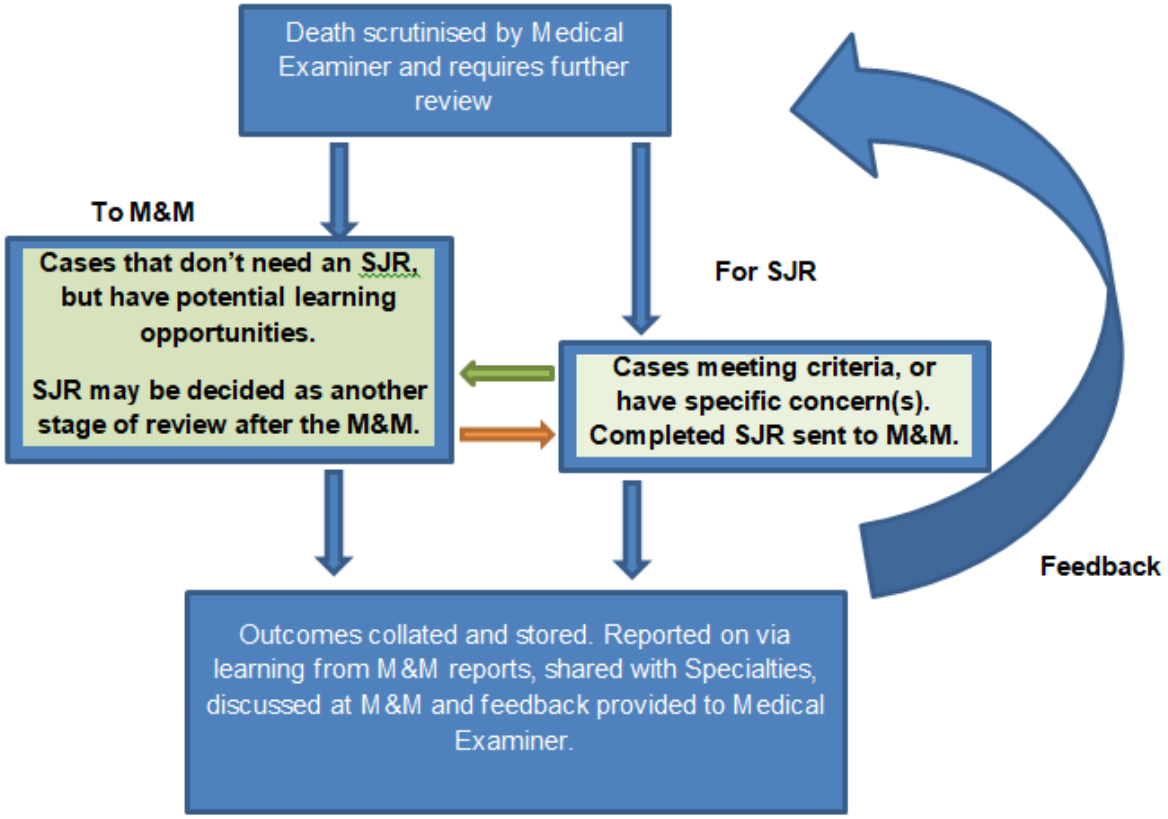


Learning, as well as good practices, can be shared in any direction around the M&M learning triangle, as well as out to the wider learning network. However, there is need for a uniform, standardised approach to information sharing which outlines expectations in terms of what content should be shared, in addition to what the expected outcomes/actions should be, as well as proper escalation routes.

The following diagram illustrates a proposed pathway for cases that require further review, after they have received Medical Examiner (ME) scrutiny. The proposed pathway should ensure that:

- Cases that require an SJR are properly flagged
- Cases that may be considered for M&M discussion are properly flagged and communicated with the corresponding M&M lead
- The SJR backlog does not grow out of control, as some cases may just require an M&M meeting rather than a full SJR

Several Specialties have requested assistance from the Medical Examiner's Office to flag cases to help with their M&M case selection.



SJR's should be routinely discussed in an M&M setting, with outcomes and actions minuted. This route of escalation would help ensure that the SJR process is linked up with the M&M process, and that feedback is provided to the Medical Examiner's Office, in addition to Trust Clinical staff.

8. MEDICAL EXAMINERS UPDATE

The Medical Examiner Office (MEO) currently now scrutinise all deaths that occur at HRI and CHH. There is an improvement plan in place to roll out scrutiny to cover community deaths, along with the improvement of capturing themes, identification of learning and reporting.

Scrutiny of death commenced at the Castle Hill Site in February 2022, during the middle of the month. The table below provides a summary of scrutinised deaths vs. total number of deaths (in this case, the table will only illustrate the first full month in which scrutiny was undertaken at CHH)

	January 2022	**February 2022**	**March 2022**
HRI	Total deaths Scrutinised: 190 %	Total deaths: Scrutinised: 160 %	Total deaths: Scrutinised:156 %
CHH	NA	NA	Total deaths: Scrutinised: 40 %

8.1 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.

8.2 Updates from the Regional Medical Examiner's Office

Coronavirus Act: death certification and registration

Requirements for death certification and cremation forms changed with expiry of the Coronavirus Act on 24 March 2022. Many helpful changes introduced by the Coronavirus Act have been carried forward, including seeing the deceased 28 days prior to death rather than 14 days, and sending MCCDs to Register Offices electronically. The provision for any medical practitioner to complete an MCCD in times of emergency has been discontinued, and medical practitioners completing MCCDs must satisfy requirements set out in General Register Office guidance around attendance and seeing the deceased. The requirements for form Cremation 4 are the same as for MCCDs. Official guidance from the General Register Office/ HM Passport Office and Ministry of Justice has been updated.

New good practice papers

The National Medical Examiner has issued two more good practice papers for medical examiners, published by the Royal College of Pathologists. They cover post-mortem examinations, and deaths of children. We are grateful to all those who have participated in discussions and contributed to drafting these papers. In coming months, we plan further papers on mental health and eating disorders; anti-microbial resistance; homelessness; and dementia.

Medical examiner case management system

The Department of Health and Social Care (DHSC) has commissioned NHS Business Services Authority (NHSBSA) to develop a national case management system for medical examiners and medical examiner officers in England, 'Medical Examiner Service - Manage My Caseload'. NHSBSA are building the system based on requirements from DHSC, the National Medical Examiner and medical examiner offices. NHSBSA are currently testing the system with a number of medical examiner offices in NHS acute trusts, with the feedback from these settings is informing system improvements.

Medical Certificate Cause of Death digitisation

DHSC has also commissioned NHSBSA to develop a digitised Medical Certificate of Cause of Death (MCCD). DHSC is working with stakeholders including all relevant government departments and Welsh Government. It is anticipated that the digitised MCCD will be introduced not before Summer 2022. If your role involves completing MCCDs and you are interested in supporting the user research, please contact nhsbsa.researchops@nhs.net.

9. YORKSHIRE & HUMBER IMPROVEMENT ACADEMY REGIONAL SJR PILOT PROPOSAL

The regional mortality steering group was set up in 2013 to develop the Yorkshire and Humber Mortality programme. This work formed the basis for a successful collaborative bid with the RCP to lead the national mortality case record review programme for HQIP. This group has brought together 13 acute and 5 mental health and community Trusts, with a collaborative approach to sharing and embedding initiatives on a region wide basis. The region has a wealth of experience in retrospective case note review.

Following the introduction of the national mortality case record review programme, the structured judgement review (SJR) method for retrospective case note review has been implemented within most acute Trusts across the UK.

Despite the successful spread of this review method, the learning and improvement from

SJRs is less well established. Within our own collaboration there are some excellent examples of teams using SJR to make significant improvements. However, these processes have relied on the endeavours of individuals and have not been systematically developed or spread. The Improvement Academy have been passionate about the development of this process for some time and have recently developed a partnership with NHS England and Improvement to take this agenda forward.

The Y&H Improvement Academy believe this is an incredible opportunity to support the learning and improvement agenda around SJR findings.

The Better Tomorrow team at NHS England and Improvement, in partnership with the Improvement Academy, and with the additional support from the NIHR Yorkshire and Humber Applied Research Collaboration (ARC-YH) and Health Education England (HEEYH), has formed a lobbying group with an aim of driving this agenda forward. As the most mature mortality collective in the UK, the Yorkshire and Humber Regional Mortality Group is uniquely placed to develop these processes using a systematic and collaborative approach, and to advise the national team regarding the outcomes. It is believed that this will become an exemplar programme for national implementation.

Project Deliverables
The Improvement Academy proposes a regional pilot, using their mortality review knowledge and collaborative working relationships, to test and develop a systematic and sustainable approach to learning from SJRs across the region. Given the level of expertise within the region, this is an entirely collaborative process which values continued input from participating organisations into the programme's iterative development. The Improvement Academy will bring expertise in training, quality improvement and implementation science.

The initial proposal consists of the following elements:

1. Mapping (2-3 months)
The initial phase will be a mapping exercise to understand the starting point of different teams across the region. The Academy recognise that some Trusts already have well-developed learning and improvement systems. Through the mapping exercise they will be interested to learn how these were developed and which processes have been found to be effective. They will also welcome information about any barriers that have been encountered by teams.

2. Training
The Academy will host a 2 day virtual or face-to-face training session at the Improvement Academy, focussed on the skills and knowledge needed to translate SJR findings into genuine improvements. From each Trust the mortality lead or representative, a senior nurse, a member of the quality improvement team and a junior doctor would be invited to attend. They envisage the training to include thematic analysis of SJR data, statistical analysis and quality improvement, using either an example developed by the Improvement Academy team or a worked example brought by the Trusts.

3. Supported Collaborative Improvement Programme (6-9 months)
The Trusts will then have the opportunity to use this knowledge to do thematic analysis of their own SJRs and to initiate improvement work on the basis of these outcomes. Through this collaborative improvement programme they will also support Trusts to review their processes for improvement and how they share learning effectively within their organisation. The Improvement Academy will host further sessions for Trusts to attend. The expectation is that different Trusts will bring examples of their ongoing quality improvement work and we will offer support regarding the improvement processes involved and how to develop and embed these to become sustainable practices. This will also enable

different Trusts from across the region to share and collaborate on their improvement initiatives.

4. The role of the regional mortality group
The regional mortality group will provide a forum for different Trusts to work collaboratively in sharing their experiences. This approach will allow regional teams to adopt effective processes and to learn from each other's practices.

5. Implementation
The Improvement Academy implementation team will bring expertise in the systematic uptake of effective processes into shared practices. They will have regular contact with teams to learn about the processes that they are employing and whether they have had positive outcomes or are encountering barriers.

6. Collate, report and disseminate learning
All learning from the regional pilot will be regularly shared with the national lobbying group to inform national policy and the continued development of the learning from deaths curriculum.

The Academy hopes to continue to shape this proposal on the basis of recommendations from the Regional Mortality Group or following insights gained through the mapping exercise, and is likely to evolve over time as we gain understanding through our work.

9. RECOMMENDATIONS
The Trust Board is recommended to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required

Chris Johnson
Effectiveness and Improvement Manager
May 2022

Contributions made by Speciality M&M Leads, ED Consultants and the Trust Sepsis Team.

Report to the Board in Public
Quality Committee
June 2022

Item: Infection Prevention and Control Board Assurance Framework	Level of assurance gained: Reasonable

The background of the IPC BAF was shared with the committee. The BAF is a live document which is monitored through existing IPC meeting structures.

- The national approach is now to encourage organisations to return to pre-pandemic systems and processes and will not be issuing any further BAF.
- The Trust received external assurance visit that confirmed the IPC BAF had moved on.
- Outstanding actions are summarised in a prioritisation matrix and will be escalated to the Trust Board.
- The IPC BAF will be superseded by an IPC Continuous Quality Improvement Programme (CQI)
- Two IPC CQI priorities will be Development of IPC Work Programme and IPC Service Delivery
- Ongoing concerns were raised with the unpredictable nature of covid and the increased risk to patients of onset hospital infections with an increased length of stay

Item: Quality Accounts	Level of assurance gained: N/A

The quality accounts were shared with the committee following Trust Board delegation for the committee to approve.

The committee approved the Quality Accounts. The timeframe of submitting and publishing on the Trust website by the 30 June 2022 will be met.

Item: Board Assurance Frameworks	Level of assurance gained: Reasonable

The committee was in agreement of the 2022/23 proposal;

- Quality Strategy has been linked to this years BAF risk 3.1 and reflects the risk appetite and tolerance.
- BAF risk 3.2 has been re-scoped to reflect the risk of no criteria to reside and mental health patients.
- Risk has increased for the Research and Innovation due to the lack of investment.
- Actions have already been taken in quarter one.

Item: Cardiology	Level of assurance gained: Reasonable

The cardiology governance lead shared the updated action plan following the Royal College and the provided an overview on progress for the red rated actions;

- Open ward at HRI, recruitment in process for consultants and aims to open later this year.
- Opening ward at HRI will also address the requirement for a dedicated room to echocardiography near to the inpatients at the HRI site.
- The ambulatory area of HRI ward also has additional nurse staffing, recruitment is in process. Currently the ward is being utilised for no criteria to reside patients, plan in progress to operationalise cardiology SDEC in July.
- Network lead is looking at the out of hours temporary pacing wire provision with a network solution.
- The department has reviewed the governance structure and has brought processes and procedures in line with other departments across the organisation.
- Current plan to recruit 8 consultants that will work between NLAG and HUTH, which will equate to 4 WTE added to the existing establishment that will provide adequate cover across both sites.
- Ongoing work to address the cultural issues, with HR support address behaviours. Acknowledged that culture takes time to change.

Item: Falls Annual Report and Strategic Action plan for Falls Prevention	Level of assurance gained: Reasonable

The committee received a presentation on the strategic action plan which covered;

- Key Risk Factors
- Best Practice
- NICE Guidelines
- How are we going to get there
- Organisational Strategic Action Plan
- Falls Prevention Education – Aims
- Education targeted at new starters including; Supporting a new generation in Gold Standard falls prevention.
- Developing a “no fall” culture
- QI projects & Dementia
- Equipment
- Governance
- National Falls Prevention week 19th -24th September

Item: QRP / Enhanced Monitoring	Level of assurance gained: Reasonable

Verbal update provided to the committee;

- Quality Delivery Group provided with options papers as requested
- Option 3 preferred which was to shift the focus from one organisation (HUTH) and look at the system actions required to manage these risks once the ICS structure in place.

Item: Dementia and Delirium Strategy	Level of assurance gained: Reasonable

Strategy has been developed in collaboration with consultants, steering groups, safeguarding, provider services, expert by experience.

- 5 year strategy picking up the pre-pandemic work, improving patient and staff experience.
- Business intelligence has improved, will see an improvement in reporting.
- Good work has been achieved over the last year.

Item: Mental Health Strategy	Level of assurance gained: Reasonable

The strategy was presented for approval at the committee, expectations on acute trusts have changed and increased over the past few years.

- Improved mental health paperwork
- Diamond standards for LD an autism awareness.
- Mental health use of forces act
- Great collaboration and escalation processes in place
- Investment in mental health into the Trust is increasing and Humber and HUTH are working together to provide training.

Item: Clinical Negligence Scheme For Trusts (CNST) / Maternity Report’s	Level of assurance gained: Reasonable

Head of Midwifery updated the community on three separate reports in relation to maternity, which would be submitted to Trust Board next month.

- The CNST background and Covid-19 impact on reporting was shared along with a receive of the year four safety actions.
- Following a review of the current position the service is declaring full compliance with three standard, partial compliance with six of the standards, and a non-compliance with one standard. 24/7 resident on call consultant is the non-compliance and recruitment is underway to move this forward.
- Avoiding Term Admissions into Neonatal Units (ATAIN) quarter four data was shared with the committee.
- There has been a decrease in term admissions to NNU since 2016
- All unexpected term admissions to NNU are reported through the DATIX system and investigated through the weekly Maternity Case Review multi-disciplinary meeting.

- The primary reason for admission at gestation was for respiratory support requiring Continuous positive airway pressure (CPAP).
- Saving Babies' Lives care bundle version 2 (SBLCBv2) is a care bundle for reducing perinatal mortality across England published in April 2019.
- Audits are undertaken quarterly to assess against the service against process indicator 4 and 7 within the SBLCBv2 document.
- A quarterly newsletter for GAP is produced to highlight any missed opportunities and required learning.
- Fundal height measurement and GAP training has been reinstated face to face on mandatory training day two for all trained midwives and medical staff.

Item: Patient Safety and Clinical Effectiveness	Level of assurance gained: Reasonable

The committee received the quarterly update from the Head of Patient Safety.

- The report provide information and assurance on Never Events / Serious Incidents, Incident reporting, duty of candour compliance, patient safety alerts and HSIB reporting.
- The highest proportion of incidents causing harm to patients are hospital acquired pressure ulcers (category 2 and above) and inpatient falls.
- There were 34 serious incidents declared between March – June 2022.
- Timescales for serious incidents being completed has seen a reduction and the number of open investigations has reduced from 100 to 63.
- There is a decrease in compliance in the written element of the Duty of Candour Process, an in-depth review of the Duty of Candour process will be undertaken.
- 4 Patient Safety Alerts was issued, 2 were closed and 2 remains open within timescales.
- 4 HSIB reports were published.

Item: Quality Indicator Report	Level of assurance gained: Reasonable

The committee received the report and advised work was ongoing to review and update the format. The committee would begin to schedule presentations from services to share progress for action plans and a deeper insight than just the reports.

Report to the Board in Public
Quality Committee
May 2022

Item: QRP / Enhanced Monitoring	Level of assurance gained: Reasonable
The exit report was shared with the committee prior to the meeting on the QDG meeting on the 13th June. The committee had an extensive discussion and were supportive of the exit proposal and held reasonable assurance, the Trust continue to provide substantial assurance at the meetings and agreement remains to pursue an exit strategy.	
Item: Quality Report	Level of assurance gained: Reasonable
The committee agreed the assurance level was reasonable. The committee had an extensive debate on the on the tolerance on avoidable harm, and the report provided reasonable assurance.	
Item: Mortality and Morbidity	Level of assurance gained: Reasonable
The report provided reasonable assurance showing that we were learning from SI's and had used the information to inform QI projects. M&M update provided reasonable assurance regarding the ongoing work and the identified improvement work, although acknowledged that the population we service had an impact on figures.	
The following reports were shared with the committee for information; • Operational Risk and Compliance Sub-Committee •	

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item	9	**Meeting**	Trust Board	**Meeting Date**	12.7.22
Title	Our People				
Lead Director	Simon Nearney - Director of Workforce and Organisational Development				
Author	Simon Nearney - Director of Workforce and Organisational Development				
Report previously considered by (date)	This report has not been received at any other meeting.				

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

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

Hull University Teaching Hospitals NHS Trust

Trust Board

12th July, 2022

Our People

1. Purpose

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

2. Background

At the previous Board meeting in May, 2022 the Trust had 63 Covid-19 inpatients. As at 4th July, 2022 the Trust have 56 Covid-19 inpatients. The pandemic still poses a real threat to the Trust and staff absence remains higher than normal. Covid-19 staff absences have surged over recent weeks following the Platinum Jubilee celebrations. The Trusts key challenge remains the number of 'No Criteria to Reside' patients in a hospital bed which is currently 194 patients which affects the number of surgical patients that can be seen and treated. The Trust's Emergency Department also remains under extreme pressure.

3. Key Issues

Staff Absence

The total staff sickness absence for the financial year 2021-22 was 3.91%. The total absence including sickness and Covid-19 for 2021-22 was 6.71%. The Trust attendance target for attendance is 96.1% (sickness not to be greater than 3.9%).

The Trust currently has 110 staff absent due to Covid-19 which is 1.2% of the workforce. Total sickness and Covid-19 absence is currently 5.6%. This is a decrease from 5.9% as at the last Board meeting in March.

With effect from 7th July Covid-19 absences will be treated the same as other sickness absence meaning all NHS staff off with Covid-19 after this date will have this absence recorded as sickness and it will contribute toward an individual's sick pay entitlement. NHS Employers issued this national change to guidance late June.

4. Staff Testing

Symptomatic Testing (PCR)

The guidance for NHS staff to self-isolate and be tested has significantly changed. Staff can now continue to attend work if they have symptoms, but return a negative (Lateral Flow Device LFD) result. If the LFD is positive then the staff member will isolate and not attend work until a negative result is shown. The only exception to this is for C33, C33 and H50 where we have extremely vulnerable patients. There is no requirement for staff to have a PCR test and therefore PCR results will no longer be reported.

Employee Service Centre (ESC)

Earnings On Demand: The ESC is launching a system that will enable staff to draw down a % of their gross basic pay during the month to help support any urgent needs e.g. car breakdown etc to avoid taking payday loans etc. The first withdrawal each month up to £100 is free of charge, thereafter staff can withdraw more up to certain maximum amount, but this will incur a charge of 2.5% of the amount paid. The amount borrowed will be then recovered at the end of the month via payroll. Staff will access this through an APP which will also include tools to support financial wellbeing. The initiative is to help staff manage their financial wellbeing.

ESR Self Service

The Trust has now rolled out ESR Self Service to all AFC staff and their managers. This enables managers or an administrator to enter all absences directly into ESR and removes the need for the old 'ABIS' system. In addition to this annual leave is now being uploaded from eRoster. Over

11,500 annual leave and bank holidays were recorded in ESR for the months of April and May 2022.

ESR Self Service also enables budget holders to submit pay impacting changes for employees (e.g. promotions and hours changes). This will remove the need for a paper notification of change form for AFC staff. Paper will be fully withdrawn for these staff in the Autumn. Budget Holders have been contacted and training offered which will continue through the summer to assist in the transition from paper to automation.

Workforce BI Reports
The Workforce Planning and Insight Team have worked closely with colleagues within Information Services to develop a suite of workforce business intelligence reports. These reports will enable managers across the Trust to access workforce reports on absence, turnover, appraisals, training, vacancies and staffing levels when they wish to access the information instead of receiving monthly reports the month after. The roll out of the BI reports to managers is happening throughout July, 2022.

5. Staff Vacancies
The Trusts overall vacancy position as at 31st May 2022 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1341.3	1295.2	69.2	0.0	0.0%
Add Prof Scientific and Technical	367.4	321.5	2.2	43.6	11.9%
Administrative and Clerical Staff	1636.8	1605.3	11.5	20.0	1.2%
Allied Health Professionals	510.4	467.6	4.0	38.8	7.6%
Estates and Ancillary	606.3	518.9	1.5	85.9	14.2%
Healthcare Scientists	189.4	157.2	0.0	32.2	17.0%
Medical & Dental - Consultant	508.8	462.0	11.3	35.6	7.0%
Medical & Dental - SAS	74.4	60.0	0.2	14.2	19.1%
Medical & Dental – Trainee Grades	674.0	652.6	22.4	0.0	0.0%
Nursing and Midwifery Registered	2466.8	2342.7	44.6	79.6	3.2%
Trust Total	8375.6	7883.0	166.9	325.7	3.9%

Overall the Trust vacancy position is 3.9%. The Consultant vacancy rate has increased to 7.0%. The vacancy rate for Registered Nursing and Midwifery is currently 3.2% across the organisation.

The Trust has offered 146 adult nurse students a post and 20 paediatric nurse students predominantly from the University of Hull to commence in September / October, 2022. In addition we have employed 340 international nurses and are recruiting a further 60 this year.

As detailed in previous reports the Trust offers a range of apprenticeship programmes across clinical and non-clinical services including our Registered Nursing Associate (RNA) programme, our Registered Nursing Degree (RND) programme and our Health Care Support Worker (HCSW) programme.

6. Vaccination programme.
Our Head of Occupational Health and Chief Nurse Information Officer operationally jointly manage the staff seasonal flu and Covid-19 vaccination programme.

Covid-19 vaccine is still available for new starters to the Trust and anyone who has not completed a course or had a first booster dose.

Planning has started for the 2022/23 staff vaccination programme which will include seasonal flu vaccine for all staff and a second Covid-19 booster for frontline staff. Vaccination hubs will be set up in the Lecture Theatre at CHH and the vacant IVF unit at HRI and roving teams of vaccinators and peer vaccinators in some area will also offer vaccination.

In response to the increase in Monkeypox cases nationally the Occupational Health Department has developed plans and are ready to offer Smallpox vaccine to staff on Ward 7, CHH who may be required to care for confirmed cases when the vaccine becomes available.

7. Communications and engagement
During May and June the executive team conducted a series of focus groups in order to understand what the current barriers are to staff in terms of delivering great care and services. A number of key themes were identified: staff-led improvement, recruitment and retention, long-term strategy and bureaucracy/control. The executive team will be leading on addressing these concerns. Meetings are now taking place with Health Groups to discuss how they can also help to tackle these issues at a local level.

A series of manager briefings, led by the Chief Executive are being scheduled for July-September. These will enable the executive team to set out the long-term strategy for the next few years to help restore activity and ensure staff wellbeing is paramount. The sessions will include reference to the key themes above and set out a series of minimum expectations of managers to ensure staff feel valued, engaged, motivated and safe at work.

The Barrett Values survey closed in June with over 1500 responses received. This will now enable us to review our current organisational values and understand if they remain relevant or whether we need to reset these in the post-Covid landscape. Either way we will then seek to reinforce the importance of adopting a values-led approach to our work and relaunch our staff charter setting out in detail acceptable and unacceptable workplace behaviours.

8. Staff Support

The Trauma Risk Management (TRiM) service will launch officially at the end of August 2022 focusing on the Emergency Department and ICU initially, rolling out to Maternity and then the wider Trust as we build the network of TRIM practitioners and TRIM Managers. TRIM is a structured, safe and screening process for staff experiencing difficult incidents. We have 27 practitioners trained across ED, ICU, Pastoral Care, Occupational Health, and OD. 16 more practitioners (form Midwifery, and ED) will be trained in September 2022. We now have 4 TRIM Managers trained and the Critical Incident Stress Management (CISM) policy is being updated to reflect this new offer for staff and managers. This is alongside the Emergency Preparedness Policy and looking to test the TRIM process in upcoming exercises and simulations.

9. Learning and Organisational Development

Great Leaders Programmes

Our new **WITH: STAND** programme is a positive action programme, which presents a unique opportunity for us to consider how we support our staff from Black, Asian and minority ethnic groups with the everyday racism they may experience within the organisation. The first cohort of 30 participants has completed Part 1 of the programme. The cohort mostly includes Staff Nurses, Research Nurses and Clinical Nurse Educators alongside staff from Occupational Therapy and Physiotherapy. The programme is for staff between bands 3 to 7, who identify as 'people of colour' within white presenting settings. The cohort will complete the programme in September when they participate in Part 2.

A new Anti-Racism Learning session will be offered in September to support Managers to have meaningful conversations about racism within the workplace. This will create a space for staff and leaders to have conversations about racism and to be constructively challenged and supported to be more anti-racist and inclusive leaders. This will be a half-day session offered to 90 leaders. As the **WITH:STAND** programme has been offered to mostly Nursing roles, the Anti-Racism Learning sessions will be offered to Managers within the Nursing Staff Group as a first priority, but also will be available to other staff groups within HUTH.

Mandatory Training - Resuscitation

The team have increased capacity on sessions from 10 delegates to 16 but are receiving "DNA" figures of up to 50% at each session. Despite the capacity increasing to 16 the DNA rate is exacerbating the non-compliance issues. It is important to highlight than non-compliance is becoming a service issue as staff are not being released to attend the training. Support is sought to help increase the learners at these sessions. Resus are supporting the workforce by allowing individuals to book late or simply turn up to a session if they are free at the time.

Hull Institute of Learning and Simulation (HILS) Update

Cognitant Project

HILS are currently working with an external company "Cognitant" using funds awarded ia the NHS-X bid, Dr David Wright is developing content for a patient application which can be accessed via smart devices and available in virtual reality to help patients to become a suitable candidate for day surgery, reducing the risks of admission. The application will provide education and awareness around issues such as:

- Smoking Cessation
- Diet and Exercise
- Weight Loss

The project has an implementation date of 31st October 2022 – The project has been initiated with the involvement of Alistair Pickering.

Schools Programmes

In addition to the portfolio of courses expanding within the Surgical Skills lab, the centre are now providing a "SSTiCH" course for students and have piloted a couple of sessions with St Marys Academy which have been very well received, the programme will be expanded and offered to schools within our area. Students get to experience hands on surgical skills prior to them applying to university for key, medical, dental, nursing and other allied health professional degree programmes. Grass roots funding has been sought from the Royal College of Surgeons of England to deliver these sessions allowing more students to attend.

10. Equality, Diversity & Inclusion (EDI) Initiative

On the 10th June the BAME Leadership Network held its annual conference, after previous years virtual conferences this one was hybrid with over 80 staff able to meet up in person at the Mercure hotel with a further 40 members of staff able to participate remotely.

A hugely successful event the highlights were the People Promise video's BAME Leadership Network Conference on Vimeo the keynote speech by Cynthia Davies outlining how BAME staff can take ownership of their Career Development and the launch of the Trusts Zero Tolerance to Racism Framework which will be implemented from 1st August 2022.

The following summarises concisely how the Framework will operate supported by an online reporting tool accessed on a mobile device via a QR code:

Racism is very real both in society and across NHS organisations. Yet despite a large number of reports and pledges over the years we have seen inequalities persist and some areas even get worse. The NHS is built on a founding principle of equality and social justice. It's more important than ever that as public sector organisations we are contributing to ensuring Racism has no place in our society and is addressed within the organisation.

Hull University Teaching Hospitals NHS Trust (HUTH) is committed to eliminating Racism in all of its forms in our organisation. The Zero Tolerance to Racism Framework aims to empower staff to call out Racist attitudes and behaviour and encourage staff involved in incidents to access support. Racism in any form will not be tolerated in HUTH as we believe that we all have the right to work and live in an environment free from prejudice and discrimination.
The Zero Tolerance to Racism framework aims to:

- Provide clarity on what constitutes Racism, in all its forms and outline the anti-Racist expectations of staff
- Empower and enable staff to approach and manage incidents involving Racism effectively and in a timely manner
- Inform recipients or bystanders of Racist attitudes or behaviours to know what they can do next to report the incident or access support
- Educate staff on practical steps on how to approach supporting individuals
- Set clear and accessible Racism reporting pathways and defined support for all those subjected to acts of Racism
- Being clear through our robust processes that acts of Racism will be dealt with.

11. Recommendations

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

Officer to contact:
Simon Nearney
Director of Workforce and OD

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.07.22
Title	**Equality Objectives 2022-26**				
Lead Directors	Michelle Cady, Director of Strategy and Planning Simon Nearney, Director of Workforce and Organisational Development				
Authors	Jackie Railton, Deputy Director, Strategy and Planning Helen Knowles, Head of HR Services Lucy Vere, Head of Learning and Organisational Development				
Report previously considered by (date)	Equality objectives agreed at Equality Diversity and Inclusion Steering Group (09.06.22) Executive Management Committee 15.06.22 Workforce Transformation Committee 16.06.22				

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

Key Recommendations to be considered:
The Trust Board is asked to approve the proposed equality objectives for 2022-26 and the arrangements for monitoring progress.

Hull University Teaching Hospitals NHS Trust

Trust Board

Equality Objectives 2022-26

1. Purpose

The purpose of this paper is to present for Trust Board approval the proposed Equality Objectives for 2022-26.

2. Background

The Equality Act 2010 (Specific Duties) Regulations 2011 (Section 3) requires listed bodies to prepare and publish one or more specific and measureable equality objectives that they think will achieve the aims of the general equality duty and thereby:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by or under the Act:
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between people who share a protected characteristic and those who do not.

The purpose of setting equality objectives is to strengthen the Trust's performance of the general Equality Duty and to ensure that we are making year on year progress in advancing equality and human rights for all groups and beyond, with our patients and carers and those who work in the organisation.

The Trust's equality objectives (2016-2020) were approved by the Trust Board in April 2016. They are:

- To improve our evidence base for patient equality of access to services
- To make information more accessible to better meet the needs of people who have a disability, impairment or sensory loss
- To build an inclusive environment for all staff
- To demonstrate progress against indicators within the NHS Workforce Race Equality Standard (WRES).

The Trust's equality objectives were linked to the achievement of the goals and outcomes within the NHS Equality Delivery System, ie:

Goal 1 - Better health outcomes
Goal 2 - Improved patient access and experience
Goal 3 - A representative and supported workforce
Goal 4 - Inclusive leadership.

In accordance with the general equality duty, the Trust is required to review and refresh its equality objectives every four years. The review should be informed by:

- Progress against our current equality objectives
- The requirements of the NHS Equality Delivery System.
- Engagement with stakeholder groups, including staff and patient/service users.
- The findings and recommendations of key reports such as the Care Quality Commission Inspection Reports

- Results of national and local surveys, including NHS Patient Surveys, NHS Staff Surveys
- Compliance with the Accessible Information Standard
- Benchmarking against the NHS Workforce Race Equality Standard and NHS Workforce Disability Equality Standard
- Gender Pay Gap reporting
- Analysis of patient and workforce equality data.

Due to the Covid-19 pandemic it had not been possible to undertake the wider engagement with the public, patients, service users and staff that is a requirement of the NHS Equality Delivery System. In March 2021, the Executive Management Committee agreed to extend the Equality Objectives for 2016-20 to cover the financial year 2021/22 and allow time for the development of refreshed/new equality objectives for 2022-2026.

3. Progress Update

The Trust's Equality Diversity and Inclusion Steering Group has reviewed the Trust's progress against the current Equality Objectives. To date:

- 9 measures have not been achieved
- 4 measures have been partially achieved
- 1 measure achieving as per plan
- 4 measures have been achieved.

A detailed update on achievement against each of the goals and supporting measures is attached at Appendix 1.

The Trust's Equality, Diversity and Inclusion Steering Group has considered the progress against the existing Equality Objectives, the impact that the Covid-19 pandemic has had on the local community, staff and patients and how it has widened existing health inequalities.

The Group has also taken into consideration the ambitions set out in the NHS Long Term Plan, the NHS People Plan and the role that the Trust can play as an Anchor Institution within the local community.

4. Proposed Equality Objectives

The following proposed equality objectives for 2022-26 have been developed in consultation with the adult and youth patient councils and the Trust's Staff Networks. They build on our previous equality objectives and the ongoing areas for improvement and reflect the required outcomes of the NHS Equality Delivery System.

The proposed equality objectives are:

- To work with our partners and stakeholders to improve health outcomes by developing a better understanding of the local variations in access to and experience of treatment by the Trust.

- To build an inclusive, positive environment for all staff, free from discrimination.

- To ensure our leaders have the capacity and capability to support, empower and enable staff.

Detailed information on each of the objectives, the context, actions and key performance measures is attached at Appendix 2.

5. PERFORMANCE MONITORING

Delivery of the key actions and achievement of the proposed Equality Objectives will be monitored through the Trust's Equality Diversity and Inclusion Steering Group, which will submit half yearly reports to the Workforce Transformation Committee and the Executive Management Committee, with an annual report on progress being presented to the Trust Board.

6. HEALTH INEQUALITIES LEAD

In August 2020, NHS England published an update to its July 2020 paper: *Implementing phase 3 of the NHS response to the COVID-19 pandemic*. The document set out a series of actions, in collaboration with local communities and partners, to increase the scale and pace of progress in reducing health inequalities. These included:

- Protecting the most vulnerable from Covid-19
- Restoring NHS services inclusively
- Developing digitally enabled care pathways in ways which increase inclusion
- Accelerating preventative programmes which proactively engage those at greatest risk of poor health outcomes
- Supporting those who suffer mental ill health
- Strengthening leadership and accountability
- Ensuring datasets are complete and timely
- Collaborating locally in planning and delivering action.

There was a specific requirement that all systems and every NHS organisation should identify a named executive board-level lead for tackling inequalities. The Trust's Health Inequalities Lead is the Chief Medical Officer.

7. RECOMMENDATIONS

The Trust Board is asked to endorse the proposed equality objectives for 2022-26 and the arrangements for monitoring progress.

Jackie Railton
Deputy Director, Strategy and Planning

Helen Knowles
Head of HR Services

Lucy Vere
Head of Learning and Organisational Development

June 2022

Progress Against Trust Equality Objectives 2016-22

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
1. To improve our evidence base for patient equality of access to services	Year on year percentage increase in the number of patients/service users for whom the Trust holds data by protected characteristic	**Gender** – **100% achieved** **Marital status** – **88% compared to 77%** (2015) **Religion or belief** – **47% compared to 62%** (2015) **Age** – **100% achieved** **Ethnic group** – **80% compared to 84%** (2015)	**Partially Achieved**	Demographic details updated via national spine with ongoing opportunities via face to face and virtual contacts to check patient details. Potential opportunity through Patient Knows Best to enable patients to update their demographic profiles.
	Improvement in the capture and recording of protected characteristic data on Datix	Gathering of protected characteristics data reviewed at PALS team training session on with a view to improving data capture and recording. Data collected in relation to age, gender and ethnicity.	**Partially Achieved**	Data not collected on all protected characteristics.
2. To make information more accessible, to better meet the needs of people who have a disability, impairment or sensory loss	Trust compliance with the conformance criteria specified within the Accessible Information Standard Specification (July 2015)	Process established to ensure recording of patient preferences within Lorenzo and alerting system in place on patient record. Process in place to provide clinical correspondence in line with patient preferences. Interpretation services include increased access to British Sign Language interpretation. Reachdeck software on Trust website to improve access to information. Functionality with Patients Know Best enable users to receive information digitally AIS training and information available to all staff via Pattie.	**Achieved**	Work ongoing with Synertec to address communication support preferences relating to paper-based correspondence eg braille, large print, easy read. Work ongoing to maintain compliance and continuously improve with the AIS.

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
	Number of PALs issues/complaints raised by patients/service users whose information/communication support needs have not been met	2015/16 – 0.15% 2016/17 – 0.04% 2017/18 – 0.10% 2018/19 – 0.78% 2019/20 – 0.32% 2020/21 – 0.58%	**Partially Achieved**	Whilst a minor improvement has been seen, it is noted that this relates only to reported issues. Discussion with members of the Hull Deaf Club highlighted a number of areas of concern in relation to timely and consistent provision of British Sign Language interpreters. The new interpretation contract includes provision of online BSL services, as well as face-to-face provision. Additional ipads have been purchased to increase online access.
	Year on year improvement in the Trust's performance in national patient surveys in relation to communication with professionals	Inpatient survey satisfaction score – communication with doctors and nurses) 2015: 8.0/8.1 2019: 8.0/8.1 2020: 8.9/8.9	**Achieved**	Improvement seen in 2020 survey results
3. To build an inclusive environment for all staff	NHS Staff Survey KF7 – Year on year improvement in the percentage of staff able to contribute to improvements at work, with a view to achieving a score of 'average for acute Trusts' by April 2018 and being in the 'better than average for acute Trusts' by 2020.	Baseline 2015 = 68% below, (worse than) average 2020 = 55.8% (just above average) 2021 = 49.5% (below average)	**Not achieved**	Whilst the Trust saw improvement in 2020, the Trust was below the peer average (53.3%) in the 2021 survey results. Nationally results were lower in the last two years as a result of the Covid-19 pandemic.
	NHS Staff Survey KF10 – Year on year improvement in the number of staff receiving support from their immediate managers, with a view to achieving a score of 'above (better than) average by April 2018 and 'highest' (best) 20% of acute Trusts by April 2020.	Baseline 2015 = 3.70 (average for acute Trusts) 2018 = 67.7% compared to average of 68.5% 2019 = 67.8% (70.2%) 2020 = 68.0 (69.2) 2021 = 65.8% (69.0) below average	**Not achieved**	Trust has not achieved above average performance when reviewed against the 2018 near equivalent question (Q9a)

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
	NHS Staff Survey KF21 – Year on year improvement in the percentage of staff believing the Trust provides equal opportunities for career progression or promotion, with a view to achieving a score of average by April 2018 and better than average by April 2020.	Baseline 2015 = **85% worse than average** 2016 = 88% above (better than) average 2017 = 64.1% above average 2018 = 62.5% above average 2019 = 58.6% above average 2020 = 56.3% average 2021 = 57.0% above average	**Partially achieved**	Closest mapped question in new 2017 survey results shows the Trust is above the average score. (Q15) However, year on year improvement not achieved.
	NHS Staff Survey KF26 – Year on year improvement in the percentage of staff experiencing harassment, bullying and abuse from staff in the last 12 months, with a view to achieving a score of 'average for acute Trusts' by April 2018 and being in the 'better than average for acute Trusts' by April 2020.	Baseline 2015 = **38% worst 20% of acute Trusts** 2017 – 20.0% worse than average (18.6%) 2018 – 27.0% worse than 2019 – 20.4% worse than 2020 – 21.5% worse than 2021 – 20.5% worse than	**Not achieved**	2017 survey – closest question used as comparison
	CQC Well led domain – Trust achieves and maintains an overall rating of 'good' or higher for this domain	Baseline 2015 = **requires improvement** 2016 = **requires improvement** 2018 = **good** 2019 = **good** 2020 = **good**	**Achieved**	
4. To demonstrate progress against indicators within the NHS Workforce Race Equality Standard (WRES)	To increase the proportion of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) by 2% per annum over the next 4 years	Baseline 2015 = 1.43% 2016 = **2.25%** 2017 = **3.90%** 2018 = **4.13%** 2019/20 = **5.05%**	**Not Achieved**	Whilst the proportion of BME staff in Bands 8-9 and VSM has been increasing year on year compared to white staff, the 2% pa increase has not been achieved. The Board did not have a BME member until 2018/19.

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
	To increase the relative likelihood of BME staff being appointed from shortlisting so that BME candidates are just as likely as White candidates to be appointed from shortlisting by April 2020.	Baseline 2015 =1.98 (white staff almost twice as likely to be appointed as BME staff) 2016 = **1.67** 2017 = **1.39** 2018 = **1.38** 2019 = **0.88** 2020 = 1.30 2021 = 1.43	**Not Achieved**	Year on year improvement to 2019 when BME staff were more likely to be appointed then white staff. However this position changed from March 2020.
	To ensure that the relative likelihood of BME staff entering the formal disciplinary process is not disproportionate to that of White staff by April 2020.	Baseline 2015 = 2.13 (BME staff twice as likely to enter formal disciplinary compared to white staff) 2016 = **1.67** 2017 = **1.59** 2018 = **0.94** 2019 = **0.69** 2020 = **0.66** 2021 = **0.52**	**Achieved**	Performance has moved from BME being twice as likely to enter the formal disciplinary process to BME being less likely in 2021..
	NHS Staff Survey KF25 – Reduction in the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months with a view to achieving 'the lowest (best) 20% of acute Trusts' by April 2018	Baseline 2015 = 27% 2016 = 21% 2017 = 21% 2018 = 24% **(better than average of 29.8%)** 2019 = 24.1% 2020 = 25.3% 2021 = 26.5%	**Not Achieved**	
	NHS Staff Survey KF26 – Reduction in the percentage of BME staff experiencing harassment, bullying and abuse from staff in the last 12 months, with a view to achieving a score of 'average for acute Trusts' by April 2018 and being in the 'better than average for acute Trusts' by April 2020.	Baseline 2015 = 57% 2016 = 30% 2017 = 27% 2018/19 = 29.6% **(worse than average of 28.6%)** 2020 = 30.1% 2021 = 34.1%	**Not Achieved**	

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
	NHS Staff Survey KF21 – Increase in the percentage of BME staff believing the Trust provides equal opportunities for career progression or promotion, with a view to achieving a score of average by April 2018 and better than average by April 2020.	Baseline 2015 = 73% 2016 = 87% 2017 = 81% 2018/19 = 81.7% **(better than average of 72.2%)** 2019/20 = 78.9% 2021 = 77.0%	**Not Achieved**	
	NHS Staff Survey Q17b – Reduction in the percentage of BME staff who, in the last 12 months, have personally experienced discrimination at work from their manager/team leader or other colleagues, with a view to achieving better than average for acute Trusts for both White and BME staff	Baseline 2015: White 8% BME 16% 2016 = White 6% BME 13% 2017 = White 5% BME 11% 2018/19 = White 6.1% BME 13.2% 2019/20 = White 5.5% BME 14.5% 2020/21 = White 7.3% BME 18.2%	**Not Achieved**	2020/21 national averages: White = 6.7% BME = 17.3%
	The Board meets the WRES requirement on Board membership (ie broadly representative of the population it serves)	Baseline 2015 = No BME rep 2016 = No BME rep 2017 = No BME rep 2018 = BME CMO appointed 2021 6.3% of Board from BME background	**Achieving**	Local population: Hull 10.3% BME East Riding of Yorkshire 3.9% BME (2011 Census)

Key:			
		Not achieved	9
		Partially achieved	4
		Achieving as per plan	1
		Achieved	4
		Total number of measures:	18

Equality Objective One	**To work with our partners and stakeholders to improve health outcomes by developing a better understanding of the local variations in access to and experience of treatment by the Trust.**	**EDS2 Goal(s)** Goals 1 and 2

Context:

Based on the Index of Multiple Deprivation 2019, Hull is the fourth most deprived local authority in England (out of 317). Half of Hull's 166 geographical areas on which the IMD is based, are in the most deprived fifth nationally. There are also large variations in deprivation scores across Hull's 21 electoral wards. Hull has a high percentage of children living in absolute and relative poverty, and the percentages differ markedly across Hull's wards. There is also a high percentage of children who are eligible for free school meals. Life expectancy in Hull is lower than in England, and the inequalities gap has been increasing. The largest contributions to the gap in life expectancy comes from excess deaths from circulatory disease, cancer and respiratory disease.

The health profile for the East Riding of Yorkshire shows that the health of people in the East Riding is generally better than the England average, as is life expectancy. However, this masks a range of inequalities. Some areas, (especially in Bridlington, Goole and Withernsea), have some of the highest levels of poverty in England. These areas are characterised by low incomes, high unemployment, poor health, higher levels of crime and anti-social behaviour and low educational achievement. ERoY residents live in towns which range from the wealthy, with good access to services and opportunities, to those living in relative poverty in remote areas. There is also a large gap between life expectancy and healthy life expectancy. This means a proportion of ERoY residents live with preventable, multiple long term conditions for a large part of their lives.

Waiting for treatment can affect other aspects of people's lives, with impact depending on someone's life circumstances. For example, it can make it harder to maintain independence or continue to work or attend school. Long waits before accessing planned care can have life-long consequences on the development of children and young people, impacting their ability to access education and lead full and active lives. For older people, it can make recovery longer and harder, leading to loss of independence.

Actions:

- Continue to build upon and develop the Trust's Business Intelligence reports which have been established to monitor health inequalities in its patient population.
- Restore NHS services inclusively by:
    - Utilisation of ONS statistical data, data and information within the local JSNAs and health profiles
    - Utilisation of the National Health Inequalities Improvement Dashboard
    - Establishing a clear understanding of the extent to which the elective waiting list is made up of certain groups (eg Black, Asian and Minority Ethnic, top 20% of socially deprived electoral wards) and ensuring that they are not further disadvantaged.
    - Proactive engagement with communities at risk of health inequalities eg: HUTH Bowel Screening Centre work with GP practices, agencies, mental health services, prisons, learning disabilities groups and the homeless to increase opportunities for these groups to participate in the programme.
- Working in partnership with the Integrated Care System, NHSE/I commissioners, Place-based Partnerships and other health and social care providers to develop

integrated care pathways and to deliver an increasing number of services closer to the communities we serve.

- Accelerate prevention programmes that proactively engage those at greatest risk of poor outcomes eg Lung Health Check Programme, AAA Screening Programme.
- Mitigate against digital exclusion - not all patient/service users are digitally mature, or have access to digital communication devices, particularly those in levels of high social and economic deprivation. Actions will be taken to ensure face to face consultations are available and accessible to those who need them.
- Making Every Contact Count – Contribute to improving population health by promoting behavioural changes whenever people interact with our services eg smoking cessation, promoting changes in diet, physical activity.

Expected Outcomes:

- Accurate data is available on the protected characteristics of patients and service users.
- The Trust has a robust source of health inequalities information available to inform operational planning and service delivery.
- Trust is able to provide assurance to commissioners and regulatory bodies that patients and service users have equality of access to services.
- The Trust is able to contribute to the reduction in health equalities across the Humber and North Yorkshire Health and Care Partnership.

Measures:

- Maternity: ensuring continuity of care for 75% of women from minority ethnic backgrounds and from the most deprived groups.

  Baseline (January 2022): % of women from Deprived areas = 8.6%
  % of women from BAME = 10%

- Development and implementation of a Respiratory Exacerbation Service which aims to provide 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) and to prevent those who are experiencing an exacerbation of their condition from being admitted to hospital.

- Reduce variation in outpatient services and waiting times for those from minority ethnic backgrounds and areas of high deprivation.

  Baseline (April 2022):

Month April 2022

IMD Quintile

Most Deprived — Least Deprived

IMD Quintile	Q1	Q2	Q3	Q4	Q5
A&G	27.7%	16.4%	17.4%	19.6%	18.9%
PIFU	20.5%	17.5%	23.5%	20.5%	18.1%
Virtual	29.5%	18.2%	16.5%	19.1%	16.7%
ED Attends	43.2%	17.7%	12.5%	14.2%	12.4%
NEL Admits	33.6%	18.7%	14.4%	18.0%	15.3%
Catchment	39.1%	12.2%	12.9%	16.8%	19.0%
Median Weeks (RTT)	14	13	13	13	13

Ethnicity

Ethnicity	Asian	Black	Mixed	Other	White
A&G	0.7%	0.4%	0.7%	2.5%	95.7%
PIFU	0.0%	0.8%	2.4%	0.8%	96.0%
Virtual	0.8%	0.4%	0.4%	1.2%	97.1%
ED Attends	1.1%	0.6%	1.2%	5.3%	91.8%
NEL Admits	0.9%	0.6%	1.0%	2.3%	95.2%
Catchment	1.8%	0.7%	1.0%	0.5%	95.9%
Median Weeks (RTT)	17	18	13	14	14

- Year on year improvement in the first outpatient DNA (Did Not Attend) rates for those patients and service users from a BAME background when compared to the British % New OP DNA rate.

  Baseline: Q4 2021/22 British 8.3% New OP DNA rate

Ethnic Group

Description	OUTPATIENTS	% of New OP DNA Rate
British	75,867	8.3%
Any other w hite background	2,539	11.0%
Any other ethnic group	1,601	13.7%
African	404	8.0%
Any other Asian background	370	6.6%
Any other mixed background	296	14.5%
Indian	261	5.1%
Pakistani	186	12.7%
White and Asian	180	8.7%
Irish	155	10.6%
White and black African	124	9.6%
Any other black background	138	11.0%
Bangladeshi	128	10.5%
Chinese	120	8.6%
White and black Caribbean	52	26.3%
Caribbean	49	14.7%
Total	**104,805**	**8.9%**

Equality Objective Two	**To build an inclusive, positive environment for all staff, free from discrimination.**	**EDS2 Goal(s)** Goal 3

Context:
The Trust is committed to developing an organisational culture that encourages every member of staff, whatever their role of background to succeed and work in a positive environment free from discrimination.

Actions:

- Actively explore, understand and publish specific outcomes from the National Staff Survey by protected characteristics working with Staff Networks to embed actions which reduce differentials and support the continued development of an inclusive workforce characterised by dignity and mutual respect.
- Reduce inequalities in employment by ensuring clear routes to allow staff to speak up when they face discrimination due to one of their protected characteristics by developing and embedding a zero tolerance reporting and action culture. Ensure robust monitoring arrangements are in place to identify themes to support evidence base for change as well as increasing staff confidence that the organisation will address concerns when raised.
- Continue to build on the partnership approach with already staff networks (BAME, Enabled & LGBTQ+) to ensure the voices and lived experiences of staff are heard and used to influence future change.

Expected Outcomes:

- To have a continual and incremental improvement in the NHS Staff Engagement Score aiming to be equal to or above the national average
- Across all protected characteristics* aim for the staff engagement score to be equal to or above the 2021 Trust average
- To have a continual and incremental reduction in the number of staff reporting that in the last 12 months they have personally experienced harassment, bullying or abuse at work from managers and colleagues across all protected characteristics, aiming to be equal to or below the 2021 Trust average.
- Close the gap of staff reporting that if they spoke up about something that concerned them they were confident that the organisation would address their concern so they are equal to or above the 2021 Trust score

Measures:

<u>Staff Engagement</u>

- To have a continual and incremental improvement in the NHS Staff Engagement Score aiming to be equal to or above the national average

	HUTH	**National Average**
2021	6.7	6.8

- Across all protected characteristics aim for the staff engagement score to be equal to or above the 2021 Trust average

2021	**Score**
Trust Average	6.7
Gender – Male Gender – Female Gender – prefer not to say	6.8 6.8 5.3
Long term conditions	6.4
Ethnicity – Non white	6.9

Sexuality – Gay/Lesbian Sexuality – Bisexual Sexuality – Other Sexuality - prefer not to say	6.8 6.8 5.9 6

People Promise: We are safe and healthy

- To have a continual and incremental reduction in the number of staff reporting that in the last 12 months they have personally experienced harassment, bullying or abuse at work from managers and colleagues across all protected characteristics, aiming to be equal to or below the 2021 Trust average.

2021	**Score**	
	Managers	**Colleagues**
Trust score	13.8%	20.5%
Gender – Male Gender – Female Gender – prefer not to say	13.0% 13.00% 28.00%	19.10% 20.70% 30.00%
Long term conditions	17.90%	27.90%
Ethnicity – Non white	16.60%	26.10%
Sexuality – Gay/Lesbian Sexuality – Bisexual Sexuality – Other Sexuality - prefer not to say	15.70% 14.90% 14.30% 18.70%	24.10% 29.80% 21.40% 28.60%

People Promise: We each have a voice that counts

- Close the gap of staff reporting that if they spoke up about something that concerned them they were confident that the organisation would address their concern so they are equal to or above the 2021 Trust score

2021	**Score**
Trust Score	45.7%
Gender – Male Gender – Female Gender – prefer not to say	48.10% 45.60% 18.10%
Long term conditions	38.40%
Ethnicity – Non white	42.80%
Sexuality – Gay/Lesbian Sexuality – Bisexual Sexuality – Other Sexuality - prefer not to say	54.10% 62.50% 13.30% 27.50%

Equality Objective Three	**To ensure our leaders have the capacity and capability to support, empower and enable staff.**	**EDS2 Goal(s)** Goal 4

Context:

In our Trust Vision of Great Staff, Great Care, Great Future the hidden statement before Great Care is Great Leaders. The Trust has been working for the last three years to embed a compassionate and inclusive leadership approach. All programmes commissioned and delivered both internally and externally are planned to equipped leaders and managers at all levels, to not only develop themselves but to gain the skills that allow them to create a healthy working culture that embraces diversity in all its forms. The COVID-19 Pandemic has seen the need to return to a more command and control style due to the nature of the demands on our people and system. We now need to reset the compassionate and inclusive approach as the norm. As we move to "living with Covid" we are now asking our staff again what are the values of our current culture and do they match what we want here at HUTH? Our 2021 Staff Survey results also show that we can do significantly more to support staff in their careers and make knowing how to success available to all.

Actions:

- A complete review and redesign of our current appraisal systems that ensures our leaders take a talent management approach to managing staff and successful outcomes. This will also aim to include a way to give helpful and development feedback from staff to their managers.
- Development of an effective, helpful and supportive Talent Management approach for HUTH that ensures we have inclusive and positive approach to our succession planning at every level
- Positive action self-development and leadership programmes for our range of protective characteristics. This in partnership with the respective Staff Networks, to co-create programmes that make a difference.
- Compassionate and Inclusive leadership and its approach embedded in all internal and externally commissioned leadership development programmes
- To engage with staff on what matters to them with Focus Groups and wider staff engagement activities
- To review our Trust Values and the Current Culture using Barrett Values Cultural Barometer to understand our staff personal values, the current culture values and the future values they want to see at HUTH. To the review our results
- To adapt our Values and Staff Charter based on the results of our focus groups and Barrett Values Survey and ensure its built into how leadership and personal development activities are role modelled by staff at all levels

Expected Outcomes:

- To see staff reporting a continual and incremental increase in opportunities to develop their careers through having leaders with the skills to support, empower, enable their staff to access, and make great choices.
- To have a continual and incremental increase in the number of staff reporting that we have a compassionate and inclusive culture with leaders and staff role modelling our values and behaviours in all their everyday activities.

Measures:

<u>People Promise: We are always learning</u>

- To have a continual and incremental increase in staff reporting opportunities to develop their career aiming to be equal to or above the 2021 Trust average

2021	Score
Trust Average	52.10%
Gender – Male Gender – Female Gender – prefer not to say	57.20% 52.20% 28.60%
Long term conditions	41.30%
Ethnicity – Non white	62.90%
Sexuality – Gay/Lesbian Sexuality – Bisexual Sexuality – Other Sexuality - prefer not to say	58.80% 77.10% 46.70% 40.10%

People Promise: We are compassionate and inclusive

- To have a continual and incremental increase in the number of staff reporting we are a compassionate and inclusive organisation aiming to be equal to or above the 2021 Trust average (Compassionate Culture Sub-Score)

2021	Score
Trust Average	6.9
Gender – Male Gender – Female Gender – prefer not to say	7 6.9 5.7
Long term conditions	6.7
Ethnicity – Non white	7.1
Sexuality – Gay/Lesbian Sexuality – Bisexual Sexuality – Other Sexuality - prefer not to say	7 7.1 6.4 6.3

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12 July 2022
Title	Trade Union Facility Time Publication Requirements				
Lead Director	Simon Nearney - Director of Workforce and Organisational Development				
Author	Louise Whiting - Employment Policy and Resourcing Manager				
Report previously considered by (date)	This report has been presented to the Workforce, Education and Culture Committee on 13 June 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 Trust Board is requested to note and approve the content of this report. Once approved by the Board, the report will be published on the Trust and Gov.UK websites. It is also referenced in the Trust Annual Report.

Agenda Item	9.2	**Meeting**	Trust Board July 2022	**Meeting Date**	12/07/22
Title	Trade Union Facility Time Publication Requirements				
Lead Director	Simon Nearney, Director of Workforce and OD				
Author	Louise Whiting, Employment Policy and Resourcing				
Report previously considered by (date)	Workforce, Education and Culture Committee on the 13th June 2022				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2022/23**	
Trust Board Approval	Y	Commercial Confidentiality		Safe	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring	Y	High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive	Y	Great Clinical Services	
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

Under the Trade Union (Facility Time Publications Requirements) Regulations 2017, all public sector organisations that employ over 49 full time employees are required to publish annually certain data relating to facility time usage within their annual reports, on their organisation website and also through the Governments reporting service. This year reporting needs to be complete by 31 July 2022.

The Facility Time Regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.

Once approved by the Board, the report will be published on the Trust and Gov.UK websites. It is also referenced in the Trust Annual Report.

Hull University Teaching Hospitals NHS Trust
Trade Union Facility Time Publication Requirements

1 Purpose of this Report

The purpose of this report is to explain the background to the Trust's reporting requirements in relation to Trade Union Facility Time, provide an overview of the specific annual reporting requirements, together with Trust data for the 2021/22 reporting period.

2 Background

The Trade Union (Facility Time Publications Requirements) Regulations 2017, which came into force on 1st April 2017, implemented the requirement introduced by the Trade Union Act 2016 for specified public-sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time.

The Facility Time Regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.

The percentage of the Civil Service pay bill spent on facility time fell after the implementation of similar reforms, from 0.26% in 2012 to just 0.07% for the 1st quarter of 2015.

It is not however expected that it will result in a significant impact on trade union representatives carrying out their trade union duties for which there is a legal entitlement to reasonable paid time off work.

The Government will assess the information published by public sector employers on facility time before deciding whether regulations to introduce limits on the level of facility time that public sector employers provide, in proportion to their total pay bill, are appropriate.

3 Annual Reporting Requirements

The report (covering the period 1 April 2021 to 31 March 2022) must be published by 31 July 2022 on the Trust's website and referenced in the Trust Annual Report. The information must also be reported via the government portal to the same timescales so that it can be placed on the Gov.UK website.

The reporting requirement applies only where an employer has at least one trade union representative and 50 or more employees for seven months during the reporting period, which is the period of 12 months beginning 1 April each year. As such the Regulations apply to the Trust.

The duty to report covers specific information (set out in detail in Schedule 2 of the Regulations) relating to time off taken for trade union duties, for example negotiations with employers, representing members in the workplace, or the duties of a learning representative and activities, or to carry out duties and receive training under the relevant safety legislation. The Trust's proposed report also contains brief narrative to contextualise the required data (Appendix 1).

Trade union representatives can get paid time off to carry out 'duties' which is set out in legislation. Employers may also grant paid time off for trade union activities for which there is no statutory right to paid time off.

4 Trust Data 2021 – 2022

The Trust's mandatory data for the reporting period 1 April 2021 to 31 March 2022 (detailed in Appendix 2) highlights that the Trust percentage of the total pay bill spent on facility time is 0.01%.

The figures have been calculated using the standard methodologies used in the Trade Union (Facility Time Publication Requirements) Regulations 2017, utilising data submitted from staff side representatives (taken from national NHS Electronic Staff Record, HealthRoster, ABIS, Job Planning systems or paper returns).

Whether in providing support to individual staff members at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas (e.g. Job Evaluation Panels, Joint Negotiating and Consultative Committee (JNCC), Local Negotiating Committee (LNC), Collective Agreements, Policy Sub Group, Junior Doctor's Forum, Health and Safety and Staff Surveys) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

Whilst not included in the return, as they are not Trust employees, the Trust also benefits from the helpful input of fulltime trade union officers supporting the employee relations agenda, as appropriate, and also in the case of Unison caseworkers for occasions no local staff side representative is available.

Many of the Trust's local staff side representatives occupy clinical roles. For obvious reasons their clinical work has been their focus during the Trust's response to the COVID-19 pandemic. It is therefore not surprising that the Trust's percentage of pay bill spend on facility time remains at 0.01%, for the second year. This is lower than the three previous reporting periods, 2017/18, 2018/19 and 2019/20, when it was 0.02%.

5 Comparative Data – Using Data from the Previous Reporting Period

The reforms encourage public sector employers, including the Trust, to monitor and, where appropriate, evaluate the amount of money spent on facility time, in the interests of transparency and accountability.

As part of this assessment the Trust has used the retrospective 2020 – 2021 data published on the Cabinet Office website to compare the percentage of the pay bill it spent on facility time in 2020 – 2021 (0.01%) with comparable NHS organisations both nationally and more geographically based (i.e. with a headcount of 5001 to 9999), as well as with local (non-comparable sized) Trusts.

Analysis of the data of the 80 Trusts nationally (with 5001 to 9999 employees) who formally reported via the national reporting tool by the July 2021 deadline shows:

- the percentage of the pay bill spent on facility time ranged from 0 to 27.34. N.B. the 27.34 appears to be an outlier, the next highest percentage is 1.96%,
- the mode was 0.01% (the percentage value that appears most often, accounting for 23 of the 80 Trusts),
- the median was 0.02% (the middle value in the list of numbers),
- data for Trusts more geographically based are shown in Table 1 below.

Table 1: Comparable Sized NHS Trusts (headcount 5001 to 9999) Data 2020 – 2021

Trust Name	**% of Pay Bill Spent on Facility Time**	**Higher/Lower % than the Trust (0.01%)**
Bradford Teaching Hospitals NHS Foundation Trust	0.01	Same
Calderdale and Huddersfield NHS Foundation Trust	0.01	Same
County Durham and Darlington NHS Foundation Trust	0.01	Same
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	0.01	Same
Northern Lincolnshire and Goole NHS Foundation Trust	0.03	↑
South Tees Hospitals NHS Foundation Trust	0.02	↑
York Teaching Hospital NHS Foundation Trust	0.01	Same

United Lincolnshire Hospitals NHS Trust*	0.04*	↑

**no record of formally reporting, details taken from Annual report*

A further comparison was also undertaken against other (non-comparable sized) local Trusts.

Table 2: Non-Comparable Local NHS Trusts Data 2020 – 2021

Trust Name	**% of Pay Bill Spent on Facility Time**	**Higher/Lower % than the Trust (0.01%)**
Humber Teaching NHS Foundation Trust	3.14	↑
Rotherham, Doncaster and South Humber Foundation Trust	0.04	↑
Leeds Teaching Hospitals NHS Trust	0.01	Same

The analysis provides assurance that, based on the figures for the last reporting year (2020 – 2021), the data for the Hull University Teaching Hospitals NHS Trust was within reasonable limits.

The Trust will again compare the percentage of pay it has spent on facility time for 2021 – 2022 with other similar sized and local NHS Trusts, once they have submitted their data for this reporting period deadline.

6 The Proposed Report for 2021 – 2022

Attached for the Workforce, Education and Culture Committee approval (as Appendix 1 and 2), is the proposed report to meet the Trade Union Facility Time Publication Requirements for the reporting period 1 April 2021 to 31 March 2022.

7 Recommendation.

The Trust Board asked to note and approve the content of this report, once approved by the Board, the report will be published on the Trust website, prior to the 31 July 2022. It will also be placed on the Government portal.

Simon Nearney
Director of Workforce
May 2022

Appendix 1

Hull University Teaching Hospitals NHS Trust

Trade Union Facility Time Publication Requirements
Reporting Period; 1 April 2021 to 31 March 2022 Inclusive

1 Introduction

The Trade Union (Facility Time Publications Requirements) Regulations 2017, which came into force on 1st April 2017, implemented the requirement introduced by the Trade Union Act 2016 for specified public sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time.

2 Background to the New Reporting Requirements

The Facility Time Regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.

3 Annual Reporting Requirements

The duty to report covers specific information (set out in detail in Schedule 2 of the regulations) relating to time off taken for trade union duties, for example negotiations with employers, representing members in the workplace, or the duties of a learning representative and activities, or to carry out duties and receive training under the relevant safety legislation.

Trade union representatives can get paid time off to carry out 'duties' which is set out in legislation. Employers may also grant paid time off for trade union activities for which there is no statutory right to paid time off.

4 Trust Data 2021 – 2022

The Trust's data for the reporting period 1 April 2021 to 31 March 2022 is attached as Appendix 2.

Whether in providing support to individual members of Trust staff at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas (for example: Joint Negotiating and Consultative Committees, Job Evaluation Panels, Collective Agreements, Policy Sub-Group, Junior Doctor's Forum, Health and Safety and Staff Surveys) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

Whilst not included in the return, as they are not Trust employees, the Trust also benefits from the helpful input of fulltime trade union officers, as appropriate, and also for one union, caseworkers for occasions where no local staff side representative is available.

The Trust will continue to monitor and evaluate the amount of money spent on facility time, in the interests of transparency and accountability.

Appendix 2

Hull University Teaching Hospitals NHS Trust

The Trade Union (Facility Time Publication Requirements) Regulations 2017
Reporting Period; 1 April 2021 to 31 March 2022 Inclusive

Table 1: Relevant union officials

Total number of Trust employees who were relevant union officials during the relevant period, 1 April 2021 to 31 March 2022:

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number (of trade union representatives)
55	46.32

Table 2: Percentage of time spent on facility time

Hull University Teaching Hospitals NHS Trust's employees, who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	34
1%-50%	21
51%-99%	0
100%	0

Table 3: Percentage of pay bill spent on facility time

The percentage of the Trust's total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period:

	Figures
Total cost of facility time	£56,755.14
Total pay bill	£446,211,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.01%

Table 4: Paid trade union activities

As a percentage of total paid facility time hours, the number of staff hours spent by employees who were relevant union officials during the relevant period on paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	0%

The figures have been calculated using the standard methodologies used in the Trade Union (Facility Time Publication Requirements) Regulations 2017.

Report to the Board in Public
Workforce, Education and Culture Committee June 2022

Item: Staff Survey – Quarter One	Level of assurance gained: Limited

Work has been completed to understand the results in greater detail which has resulted in four themes being identified;

- Command and Control / Process Driven / Bureaucracy
- Improvements - No clear way to raise ideas, suggestions and projects.
- Recruitment and Retention – need to do more to encourage and retain.
- Strategy - Greater Steer on the future strategy. Trust strategy and a clear clinical strategy.

There was an acknowledgement that the pandemic has an ongoing impact on staff and that the staff want a greater understanding on how the situation is going to improve.

Item: Freedom to Speak Up Guardian	Level of assurance gained: Reasonable

The Freedom to Speak Up Guardian has improved awareness across the organisation and has developed an effective network over the past 12 months. With regular attendance a variation of forums. Contacts have tripled over the last year and this will continue to be tracked over the next 12 months, despite the increase this was felt to be as result of the increased awareness of the role.

It was noted that there was still a gap in certain areas and staff groups that has been discussed with Human Resources and would be monitored.

The guardian will now focus on establishing a Freedom to Speak Up champion network across the organisation and recruitment and training will be begin later in the year.

Item: Trade Union Facility Time Publication Requirements	Level of assurance gained: N/A

Paper was submitted to the committee for approval.

- The Trust's reporting period 1 April 2021 to 31 March 2022 highlights that the Trust percentage of the total pay bill spent on facility time is 0.01%.
- It was noted that changes have occurred in the disciplinary process which have improved the process and saves time.

The committee approved the paper.

Item: Board Assurance Framework (BAF)	Level of assurance gained: Reasonable

The final 2021/22 BAF was approved by the Board in May, and the committee agreed with the 2022/23 BAF proposal and ratings.

- Regular meetings will be held to ensure the controls, gaps and actions are captured throughout the year.
- Car parking charges were raised at the meeting and concerns raised that it was poorly timed with the cost of living increases and further risked staff morale.

Item: People Management Performance Report	Level of assurance gained: Reasonable

The report shared key figures for the committees information and narrative was shared.

- The Trust's vacancy rate is low at 2.4%
- Turnover was 9.3% on investigation at health group level for turnover there were no significant issues raised.
- Sickness rate is 5.96%
- Job plans, appraisals and mandatory training are all on an upward trajectory as things continue to move towards business as usual.

Item: Terms of Reference and Effectiveness Review	Level of assurance gained: N/A

The committee received their annual terms of reference and effectiveness review, 7 out of 11 responses were received.
The effectiveness review results scored the committees as a mixture of 4's and 5's and comments but mainly focus on the volume of papers and the meeting content;

- The committee functioned well around staff wellbeing issues during the pandemic
- The quality is always good from all colleagues.
- It is a massive agenda and sometimes the volume of issues is hard to stick to the time. Maybe presentations vs Formal papers might assist the board members on the committee to get a better overview.
- EDI, Compassionate Culture work and Wellbeing could do with being standard items with a verbal update and more formal maybe 1-2 times per year.

Amendments to the terms of reference were agreed as;

- Network chairs to be included in the memberships
- Staff side representatives to be included in the membership

Item: Nursing and Midwifery Staffing Report	Level of assurance gained: Reasonable

The Trust continue to have a robust recruitment strategy for nursing staff and vacancy levels are low at for nursing staff with recruitment processes for newly qualified and international nursing well established.

- 22 midwifery students have been successfully recruited for appointment in September.

The apprenticeship programmes continue with;

- 35 Registered Nurse Degree Apprentices
- 23 Apprentice Health Care Support Worker
- 43 Trainee Nursing Associates.

Care Hours per Patient Day continues to be reviewed, with manual data collection being run alongside the system calculations to identify any issues with the automated calculations.

Item: Learning & Development Update	Level of assurance gained: Reasonable

The paper was received to update the committee on progress within the department;

- Structure, the department has seen an updated structure following the departure of the deputy head of learning and organisational development.
- Succession planning is being looked at within the department
- Statutory and mandatory training is being focused on and recruitment is in progress for a band 5 to support.
- Suite 22 is now functional and is being officially opened in July.
- Learning pods are being relocated to into clinical areas to increase access to training.
- Mediation service has expanded and is a diverse network with 13-15 people available.
- The Trust 213 colleagues (both substantive and apprentices) on apprenticeship programmes worth approx. £3m
- Utilising over 44 apprenticeship standards procured from 22 different learning providers
- Work experience model is being delivered to share what is available and develop engagement with schools.
- The Surgical Skills has continued to successfully deliver training with a face to face provision. National Royal College courses are running under normal conditions now outside of the NHS, but ours are still being delivered to COVID-19 safety measures.
- The centre is currently working towards a Human Tissue Licence application which has been submitted and currently under review waiting for audit.

Item: Guardian of Safe-Working Report with Rota Gaps	Level of assurance gained: N/A

The Guardian for Safe-Working presented the report to the committee;

- Phlebotomy issues have been escalated to Health Education England. A business case has been completed but approval has not yet been received.
- Allocate is due to roll-out shortly across the Trust, the team have now completed recruitment so progress is expected of the next few months and feedback later in the year.
- All foundation doctors are receiving Self Development Time, which would like to be expanded to all trainee's.
- Summary of gaps was provided, no recruitment issues were noted.

Item: Leadership for a collaborative and inclusive future	Level of assurance gained: N/A

NHS providers on the day briefing was received for information. The final report was published on the 8th June on the review of leadership and management in the health and social care sector, as commissioned by the Secretary of State for Health and Social Care in October 2021.

It was noted that the Director of Workforce and Organisation Development was comfortable with where we were as an organisation against the 7 recommendations although acknowledged that some areas needed strengthening.

Agenda Item	9.4	**Meeting**	Trust Board	**Meeting Date**	12th July 2022
Title	Freedom to Speak Up Guardian report – 2021/2022 annual report				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Frances Moverley, Head of Freedom to Speak Up				
Report previously considered by (date)	Audit Committee April 2022 Workforce and Culture Committee June 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	X
Assurance	X	Staff Confidentiality		Caring		High Quality Care	X
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	
				Well-led	X	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
• The Trust Board are asked to receive and accept this annual report of the work and activities of the Trust's Freedom to Speak Up Guardian. • The Trust Board are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian 2021/2022 annual report – July 2022

1. Purpose of the paper

The National Guardian's Office requires Freedom to Speak Up Guardians (FTSUG) in NHS Trusts to report directly to their Trust Board.

This report provides the annual update on the concerns raised by staff through HUTH's Freedom to Speak Up Guardian, including an overview of themes and the activities undertaken by the Trust's FTSUG.

Furthermore, the report aims to provide assurance to the Board on promoting a 'speaking up' culture at the Trust for staff and complying with Key Line of Enquiry 3 as part of the CQC Well-Led domain.

2. Introduction

Following the Francis Review, all Trusts are required to have a Freedom to Speak Up Guardian (FTSUG) in place. This role acts impartially and provides staff, students, trainees and volunteers with an option to raise concerns in a confidential manner.

There are a number of processes in place that allow staff to raise concerns. These include:

- Formal Raising Concerns and Whistleblowing Policy
- Anti-fraud service
- Through their line manager
- Through the Staff Conflict Resolution and Professionalism in the Workplace Policy or the Grievance Policy
- Freedom to Speak Up Guardian

There are other routes as ways in which staff can receive support if they are experiencing difficulties at work, for example Occupational Health and other staff support services.

In addition, professional organisations such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) also issue guidance which sets out the GMC's expectations that all doctors will, whatever their role, take appropriate action to raise can act on concerns about patient care, dignity and safety.

This report provides an update on the concerns raised by staff, students, trainees or volunteers through the Trust's FTSUG from 1st April 2021 to 31st March 2022.

3. Current FTSUG arrangements 2021/2022

The FTSUG post was previously part of Carla Ramsay, Director of Corporate Affairs role. Following a change in role and Suzanne Rostron commencing in post as the new Director of Quality Governance and incorporating FTSU as part of the Executive portfolio, the FTSUG role was temporarily undertaken by Fran Moverley, Quality Safety Manager from April 2021 as an interim arrangement.

In June 2021 following a recruitment process, Fran Moverley was appointed as the substantive Head of Freedom to Speak Up and has ring fenced time as the FTSUG as part of a wider role in the Quality Governance team.

The new FTSUG has completed the mandatory training required by the National Guardian Office and continues to participate in CPD. The FTSUG is a part of the active Yorkshire and Humber regional network which consists of sharing best practice with other Guardians and participating in monthly regional meetings and peer support sessions.

4. FTSUG Activities during 2021/2022

The FTSUG had the aim of re-launching the role to further support and encourage a culture of speaking up. During April 2021 to March 2022, a summary of the activities of the FTSUG are detailed below:

- Increased the content on Pattie including creating of a dedicated FTSU intranet page, Frequently Asked Questions and creation of blog articles.
- Ways to contact the Guardian refreshed on Pattie, including the provision of a new confidential mobile telephone to encourage staff to make contact.
- Continued the 'buddy' partnership with the FTSUG at Northern Lincolnshire and Goole NHS Foundation Trust, previously established by Carla Ramsay.
- New buddy partnerships established with other Trusts - Rotherham Doncaster and South Yorkshire NHS Foundation Trust and York and Scarborough Teaching Hospitals NHS Foundation Trust.
- Established working relationships with the Chairs of the BAME Staff Network, Enabled Staff Support Network and LGBTQ+ Staff Network, and where appropriate, attended Network meetings to promote speaking up.
- Attended other key meetings to provide information on FTSU, raise awareness of the role and how to contact the FTSUG. This included the Junior Doctor Forum, Pastoral and Spiritual Care Team, Pharmacy Senior Leadership Team meeting and Pharmacy Huddle.
- Met with the Director of Workforce, Head of HR and Head of Organisational Development and Learning to begin partnership and joint working.
- Linked in with the Head Chaplain and Staff Support Psychologist to promote mutual referrals.
- Regular meetings with the Non-Executive Director and Executive Sponsor for Speak Up. Meetings with the Chief Executive and Chairman have also commenced.
- Introductory meeting and regular discussions established with the UNISON branch secretary and local representatives.
- The FTSUG presented and led a Just Culture and Speak Up workshop at the Trust Patient Safety Conference in September 2021.
- Established joint working with the Primary Care Dean at Health Education England to promote the Guardian role to GP Trainees and support and promote the anti-racism work currently underway.
- Provided training to the FY1s as part of the Foundation Training programme and to the newly qualified Midwives induction.
- Promoted the National Speak Up month during October 2021 including:
    - Increased communications across the Trust serving as a reminder about FTSU including news articles, emails and a joint blog supporting Black History Month.
    - The FTSUG, Chair of the BAME Network, Director of Workforce and Director of Quality Governance (Executive Sponsor for FTSU) recorded videos for inclusion on Pattie.
    - Attendance at various team meetings including the Chaplaincy Team.
    - Promotion of the Health Education England e-learning modules.
    - Conducted several face to face and virtual drop in sessions, including evening sessions to assist the accessibility of the FTSUG to night workers and clinical staff members.
- Continued to increase the accessibility of the FTSUG through further drop in sessions, virtual and face to face at both HRI and CHH and within and outside of office hours.
- Met with the Volunteers Manager to include FTSU as part of the volunteer's induction and completion of the e-learning Health Education England Speak Up e-learning modules.
- Attendance at the HR Business Partner, HR Manager and HR Advisor meeting across all Health Groups to share learning and partnership working.
- Joint working with the Well-Being Champion network meeting to start to promote the FTSU Champion future network.
- Commenced work on a Board assurance gap analysis and review of current speaking up processes at the Trust.
- Participating in the stakeholder event for the recruitment of the new Chairperson.
- Provided a CQC Assurance presentation to the Director of Quality Governance and Compliance Team.
- The FTSUG is a member of the Zero Tolerance to Racism working group and Equality, Diversity and Inclusion Committee.
- Proposal drafted and accepted by the Executive Team to disband the Staff Advice and Liaison service (SALs) due to the low numbers of contacts and the duplication with the FTSUG role.

5. Trust contacts during 1st April 2021 to 31st March 2022

The FTSUG reports on contacts received from members of staff to the Trust Board each quarter in the public board meeting. The data is also required to be reported to the National Guardian Office. The Trust's figures are as follows:

From 1st April 2021 to 31st March 2022, the FTSUG has been contacted as follows, in comparison to 1st April 2020 to 31st March 2021:

Route of contact	Number of contacts 2020 to 2021	Number of contacts 2021 to 2022
Contacted directly by the member of staff	21	43
Requesting advice for a colleague	0	0
Contacted via SALS	1	1
Signposted by manager	0	1
Signposted by Occupational Health	0	0
Signposted by a FTSUG in another Trust	0	0
Signpost by Trust's Guardian of Safe Working Hours	2	0
Signposted by Trade Union contact	0	7
Signposted by Multi-faith team*	0	2
Signposted by Staff Support Networks*	0	3
In line with the Raising Concerns (whistleblowing) policy*	0	7
Other	0	7
Total	**24**	**71**

**new codes for 2021/2022*

From 1st April 2021 to 31st March 2022, the FTSUG has been contacted for the reasons below, in comparison to 1st April 2020 to 31st March 2021:

Route of contact	Number of contacts 2020 to 2021	Number of contacts 2021 to 2022
Concerns about bullying behaviour	8	11
Concerns about HR process involving the member of staff – concerns about fair treatment	0	11
Concern about patient safety	1	8
Concern about worker safety*	0	3
Concerns about workload	0	2
Concerns about inappropriate behaviour	0	13
Concerned about role within the Trust	0	6
Concerned about issues directly relating to Covid-19	3	1
Concerns about service delivery	5	4
Concerned about poor working relationships within team	5	4
Unspecified – contacted for general support	2	8
Total	**24**	**71**

**new code for 2021/2022*

Please note the routes of contact and type of concern codes will be refreshed from 1st April 2022 onwards, following changes to the national guidance and internal changes at the Trust.

Comments and observations:

- There was a significant increase in the number of individuals contacting the FTSUG – from 24 to 71. Of the 71, this reflected 62 standalone concerns. NB – the national guidance requires Trusts to report on numbers of *individuals* approaching the Guardian.
- This increase may reflect the renewed communications and reminders of the FTSUG role and offering varying ways of accessibility.
- The most common reason raised with the FTSUG was inappropriate behaviour (13). Followed by reports of bullying behaviour (11) and HR processes with concerns about unfairness (11).
- Many of the concerns raised are on a 'local' level, and specific to individuals. Many cases remain ongoing and there have been specific examples where issues have been raised and quick action has been taken. When the FTSUG has approached a senior manager to request resolution of issues, leaders have welcomed the feedback and asked for thanks to be passed onto the individual who initially raised the concern.
- One individual further contacted the FTSUG to report they had been subject to detriment as a result of speaking up. The FTSUG with consent from the individual, escalated this matter to a senior manager to take action.

6. Planned future activities during 2022/2023

The FTSUG will be focusing on the following areas of work:

- Creating and training a network of FTSU Champions, in line with the guidance from the National Guardian Office. Champions will perform a sign posting and supportive role, but will not handle cases. The Champion network has previously been delayed due to the further surge of Covid-19 and the cancellation of training across the Trust.
- Supporting the Board to finalise the NHS England and Improvement 'Freedom to Speak Up review tool for NHS Trusts and Foundation Trusts'.
- Working in partnership with the HR team to complete the National Guardian Office 'Policy Review Framework'.
- Creation and implementation of a Trust wide FTSU Strategy.
- Launching a feedback survey of individuals approaching the FTSUG.
- Comprehensive review and analysis of the 2021 Staff Survey results.

7. Freedom to Speak Up national Index

In May 2021, the National Guardian's Office released a report providing a 'Freedom to Speak Up' index measurement for all NHS Trusts. This is calculated on scores from specific questions within the 2020 NHS Staff Survey questions, as follows:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 16b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 17b)

The report provides an index score for each organisation, as well as a national average for same kind of NHS Trust. The national average has risen from 75% in 2015 to 79.2% in last year's survey results.

Hull University Teaching Hospitals NHS Trust's Freedom to Speak Up 2021 index score is **79.1%,** against a national average score for acute trusts of 82%. Therefore, the Trust is performing slightly below the national average against all and acute NHS Trusts.

The highest score nationally is 87.6% (Cambridgeshire Community Services NHS Trust) and the lowest being 66.6% (East of England Ambulance Service NHS Trust).

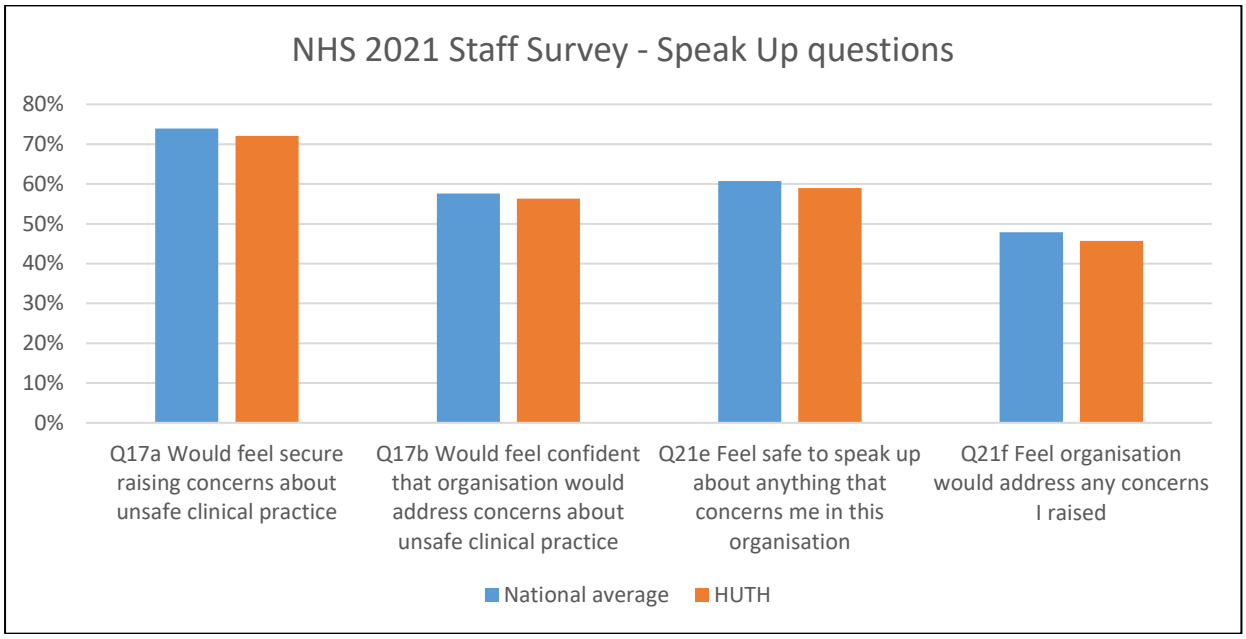
Nationally the Staff Survey questions have been changed in line with the People Plan and as a result some of the questions that comprised the Index have been removed. In light of this the National Guardian Office will no longer publish the Index.

8. Staff Survey 2021

The Staff Survey has continued to have a question asking whether workers feel safe to speak up and is accompanied by a new follow up question *"If I spoke up about something that concerned me, I am confident my organisation would address my concern".*

The National Guardian Office has invited Trusts to consider using this question as an indicator of their speaking up culture and arrangements.

The HUTH average, in comparison to the national average, is shown below for each of the four questions relevant to speaking up. Each Health Group Governance Committee has been provided with a Health Group specific breakdown of each question.



9. Conclusions

The Trust continues to support the FTSUG role and has reinforced this further through the recruitment to a substantive Head of Freedom to Speak Up position, in which there are ring fenced hours to proactively and reactively perform the role.

It is positive that the number of individuals approaching the FTSUG has significantly increased. The new FTSUG has worked extensively to build working relationships with key individuals and teams across the Trust, and referrals between the FTSUG and other staff support services have been positive.

The majority of cases are isolated and on an individual level and the key reasons for raising concerns has included inappropriate behaviours, bullying behaviours and perceived unfairness in respect of HR processes.

10. Recommendation

The Trust Board is asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

Fran Moverley
Head of Freedom to Speak Up
July 2022

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING 2020-2021

Workforce, Education and Culture Committee	13th June 2022	**Reference Number**	
Director	Makani Purva – Chief Medical Officer	**Author**	Mahmoud Loubani – Guardian of Safe Working
Reason for the report	This paper provides an annual summary of gaps and vacancies among junior medical staff and the exception reports received at Hull University Teaching Hospitals NHS Trust.		

Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Board is asked: • to note the findings of this report, which should be regarded as a baseline for future reports • to support the development of a coherent strategy for the medical workforce and its support by non-medical practitioners and other staff.					
2	**KEY PURPOSE:**					
	Decision	✓	Approval		Discussion	✓
	Information	✓	Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): **W2 – Governance Framework – Quality, performance and risks are understood**					
	Assurance Framework Ref: BAF 2 Staffing	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		

5	**Ongoing Issues:** • The usage of e-roster across the Trust • Increased workload for junior doctors due to lack of support from Phlebotomists and having to perform ECG's • Aim to rollout Self Development Time (SDT) for all trainees in the Trust
6	**BOARD/BOARD COMMITTEE REVIEW** The report is received annually by the Trust Board.

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Executive summary

This paper provides an annual summary of gaps and exception reports received by the department for each quarter from April 2021 to March 2022 at Hull University Teaching Hospitals NHS Trust, together with a plan to improve these gaps.

Professor Mahmoud Loubani started in the role as Guardian of Safe Working from September 2020 and is responsible for monitoring the safe working of junior doctors within the Trust. This relates to their working hours, service support available and education/training opportunities.

From April 2021 to March 2022 the most common reason for submission of exception reports was due to staff shortages and high workload meaning trainees were working over their rostered hours. There was also exception reports submitted for missed education or training opportunities again this was commonly from a high workload and working for the interest of patient care and safety. On some occasions trainees felt unsupported in their role subsequently completed a report to highlight this.

Introduction

This report provides a summary of information from April 2021 – March 2022.

High level data (As of 31 March 2022)

Number of doctors / dentists in training (total): 562 (March 21 – April 22)

Number of doctors / dentists in training on 2016 TCS (total):561.4 (March 21 – April 22)

Annual average fill rate among this staff group: 93.40% (March 21 – April 22)

Annual data summary

The following table shows the rota establishment rate in comparison to how many trainees are in post from April 2021 to March 2022. This is a combined summary of the data from the previous four quarterly reports.

Summary of Rota gaps and vacancies.

The board has received quarterly updates throughout the year on the gaps across the different specialties and grades.

There are consistent gaps in the following departments:

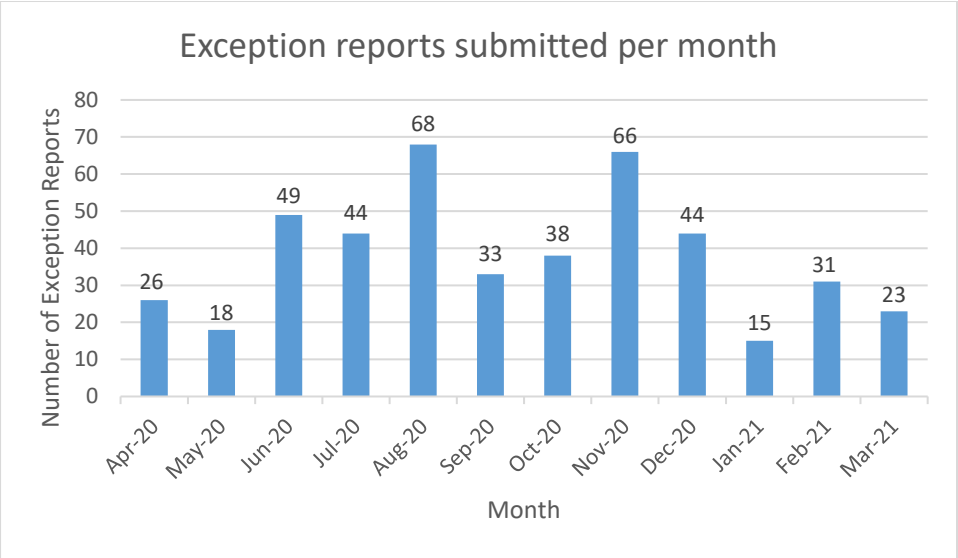
- General Surgery – There are known gaps across all grades as they are difficult to recruit.
- Histopathology – They only have 4 trainees and they don't recruit for vacancies.
- Immunology – There has been a vacant post for a number of years at ST3+ level, the department hasn't recruited for the positions.
- Stroke Medicine – There has been a vacant post for a number of years at ST3+ level, the department hasn't recruited for the positions.

	Quarter 1		Quarter 2		Quarter 3		Quarter 4		
Department	Rota Establishment	In Post	Rota Establishment	In Post	Rota Establishment	In Post	Rota Establishment	In Post	Average
Academic, GP, Psych & Community	111	96.6	125	115.8	125	115.8	125	115.8	91.36%
Acute Medicine	25	46.27	27	31	27	31	27	31	131.39%
Anaesthetics	64	65.075	48	54.3	48	54.3	48	54.3	109.60%
Breast Surgery	7	5.675	7	6	7	6	7	6	84.55%
Cardiology	20	13.675	20	23	20	23	20	23	103.34%
Cardiothroacic Surgery	12	11	12	12	12	12	12	12	97.92%
Chemical Pathology	2	1	1	1	1	1	1	1	80%
Colorectal Surgery	-	-	16	14	16	14	16	15.8	109.59%
Dermatology	2	2	2	2	2	2	2	2	100%
Elderly Medicine	28	26.9	26	24.4	26	24.4	26	24.4	94.43%
Emergency Medicine	32	45.92	45	43.8	45	43.8	45	43.8	106.18%
Endocrinology	9	10	11	11	11	11	11	11	102.38%
ENT	13	12.68	13	10.6	13	10.6	13	10.6	85.54%
Gastroenterology	10	14.68	12	12	12	12	12	13.4	113.22%
General Surgery	39	17.74	1	1	1	1	1	1	49.38%
Haematology	10	4.68	12	12.6	12	12.6	12	12.6	92.35%
Histopathology	4	1	4	3	4	3	4	3	62.50%
Immunology	-	-	2	1	2	1	2	1	50%
Infectious Diseases	14	14	15	12.8	15	12.8	15	12.8	88.81%
Neurology	14	14.96	14	11.6	14	11.6	14	11.6	88.86%

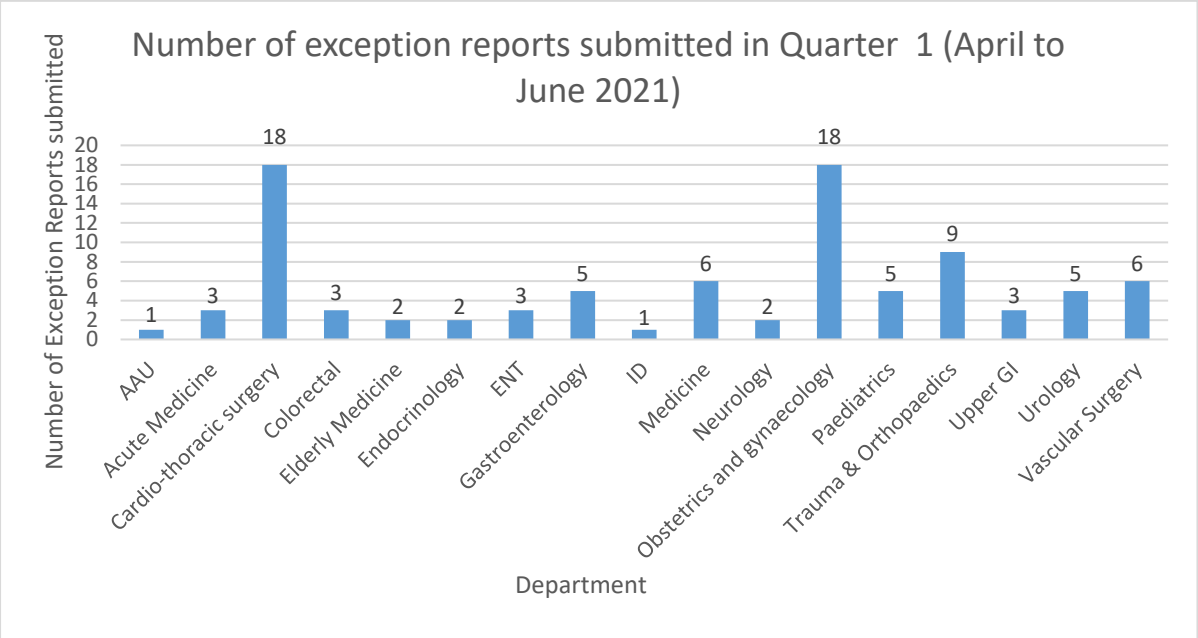
Neurosurgery	19	19.6	20	17.8	20	17.8	20	18.8	93.67%
Obstetrics & Gynaecology	24	25.46	22	22.6	22	22.6	22	22.6	103.62%
Oncology	26	23.6	23	22	23	22	23	22.4	94.74%
Ophthalmology	9	6.6	11	11	11	11	11	11	94.29%
Oral & Maxillofacial Surgery	20	12	16	13	16	13	16	13	133.34%
Paediatric Neonatal Medicine	14	17.25	18	14.4	18	14.4	18	14.4	88.90%
Paediatric Surgery	6	7	6	4	6	4	6	4	79.17%
Palliative Care	2	2.54	2	2	2	2	2	2	106.75%
Plastic Surgery	11	11	12	8.6	12	8.6	12	8.6	78.29%
Paediatrics	28	14.57	25	22.1	25	22.1	25	23.1	79.49%
Radiology	25	24.6	25	25.5	25	25.5	25	25.5	101.10%
Renal Medicine	10	11	11	11	11	11	11	11	102.33%
Respiratory Medicine	20	19	21	21	21	21	20	20	98.78%
Rheumatology	9	8.8	11	13	11	13	11	13	113.81%
Stroke Medicine	1	0	1	1	1	1	1	1	75%
Trauma & Orthopaedics	30	31.9	31	29	31	29	31	29	96.67%
Upper GI	-	-	20	18.8	20	18.8	20	17.8	92.34%
Urology	12	12	12	11	12	11	12	11	93.75%
Vascular Surgery	13	10.89	12	9	12	9	12	8	75.29%
Total	**695**	**661.665**	**712**	**679.7**	**712**	**679.7**	**711**	**682.3**	**93.40%**

Summary of exception reports.

There have been a total of 455 exception reports submitted between March 2021 and April 2022.

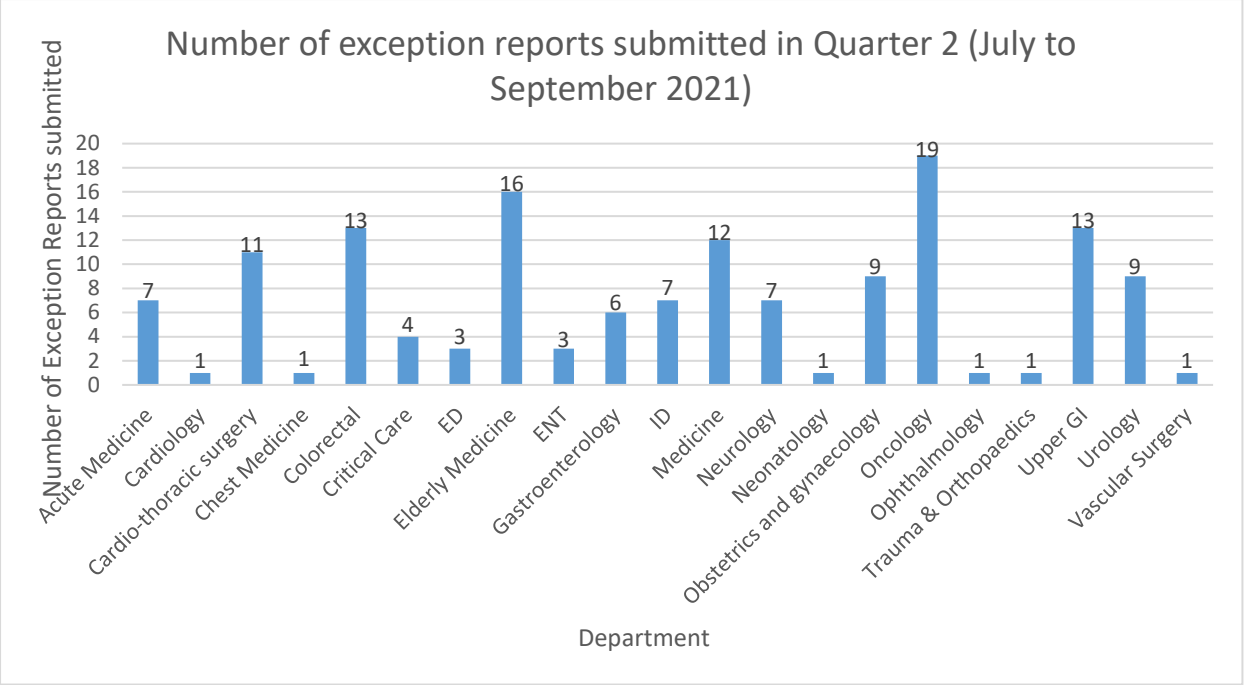


The most common type of exception report received was in relation to trainees working over their rostered hours due to staffing shortages and an increased workload while maintaining patient interest and safety. Exception reports have also been submitted for lack of support and missed educational or training opportunities as well as a change in their working pattern. Some exception reports have been noted as an immediate safety concern this highlights issues that are cause for concern towards the safety of the patients. These are discussed by educational supervisors prior to exception reports being submitted, once they have been submitted the review takes place within 24 hours. The most common grade to submit exception reports are F1 and F2 then decreasing as the grade rises.

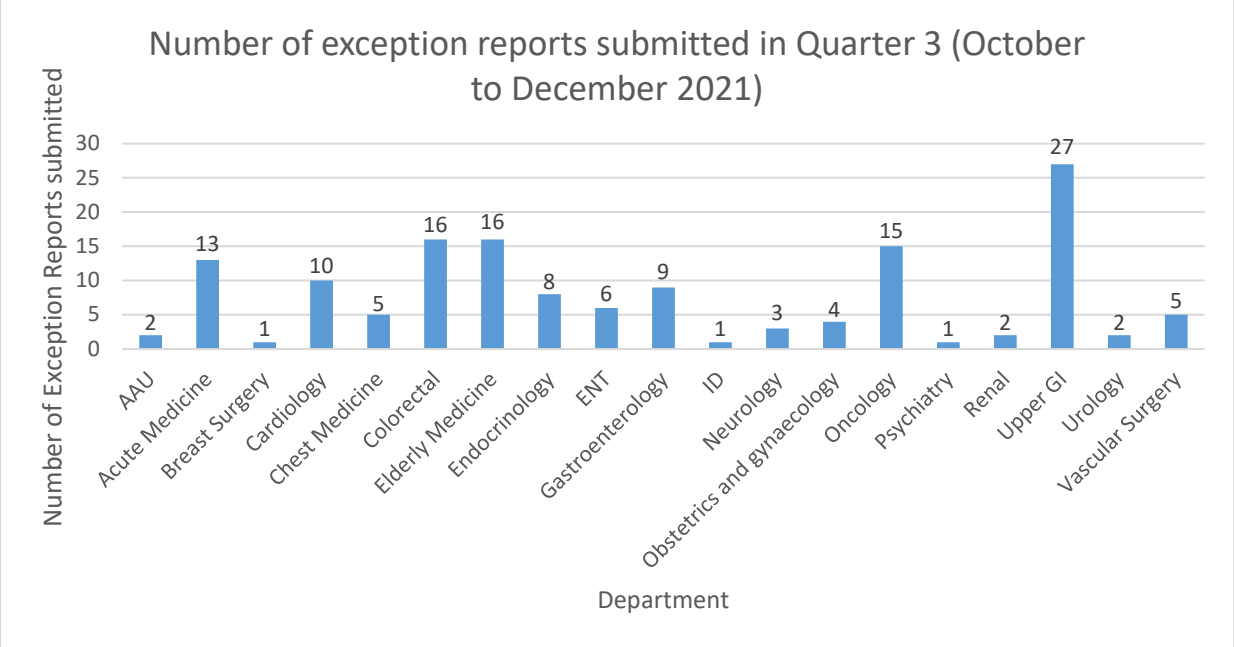


Within the first quarter from April to June 2021 the Cardio-Thoracic Surgery department as well as the Obstetrics and Gynecology department received the highest number of exception reports submitted from trainees within the department.

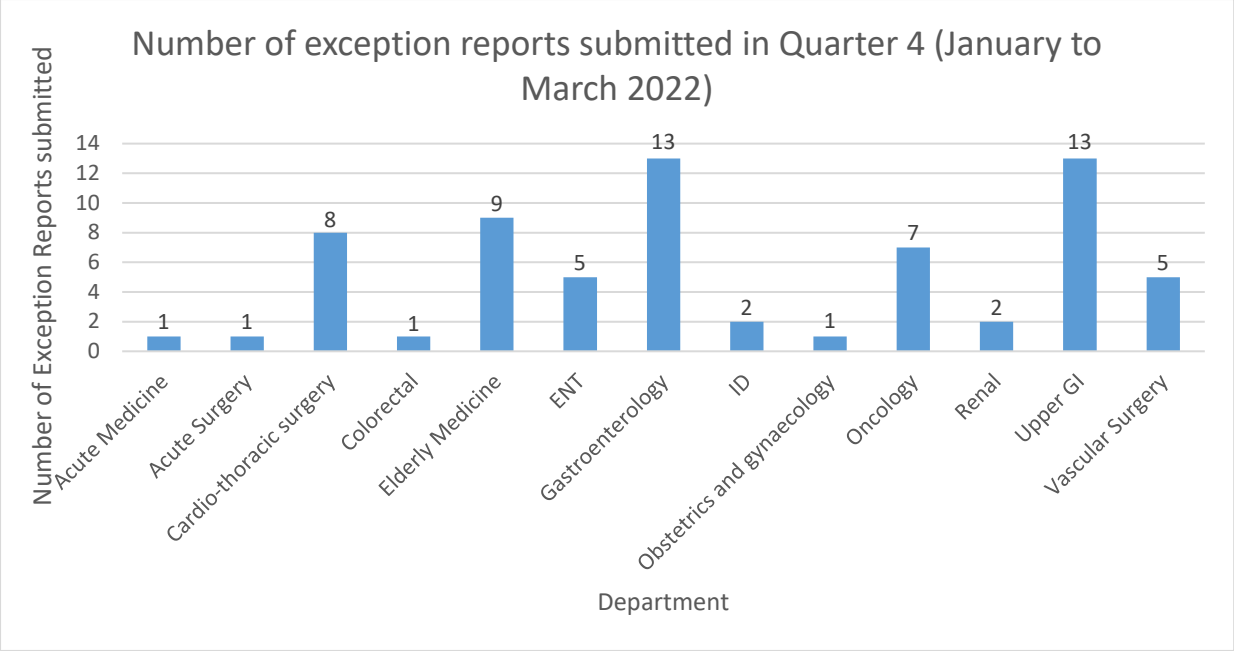
A particular trainee submitted several exception reports retrospectively while rotated in the Obstetrics and Gynecology department. They were in relation to self-development time being missed due to the department giving trainees self-development time on an ad-hoc basis rather than it being rostered it. Similarly in the Cardio-Thoracic Surgery department another trainees was unable to attend teaching days due to workload demand and short staffing issues. As many of the exception reports were submitted weeks or months after the occurrence the trainees are unable to be compensated with payment or time owing in lieu after being agreed in the review. It often becomes more difficult to resolve issues as rotas may be required to be changed and catching up on missed self-development time becomes increasingly difficult.



During the second quarter Oncology received the highest amount of exception reports. Again most of these were in relation to staying beyond their rostered hours to complete ward rounds as well as additional workloads due to staff shortages. In August a higher amount of exception reports were submitted due to the junior doctors rotation, some trainees reported fewer doctors working as the new trainees were completing their induction. As some of the new trainees were unfamiliar with the systems and handovers at the Trust these processes took longer than normal.

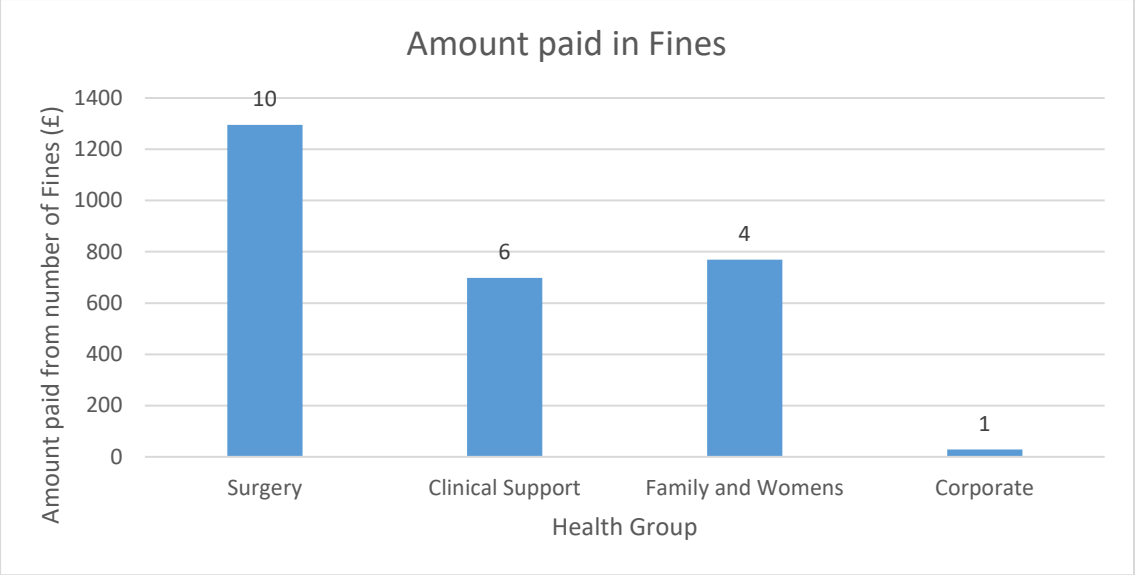


There was a combination of different types of exception reports submitted for the third quarter although most of them were related to low staffing levels particularly FY1 trainees. Also there was a higher level of sickness and Covid related absences further decreasing staffing and problems finding locum cover meant there was very few trainees covering upper GI. Any other time such as self-development time was used for ward rounds and it is also apparent that the trainees health became affected due to the huge workload and pressures.



In the fourth quarter it followed the same pattern as previously seen in the third quarter with the Upper GI department receiving some of the highest amount of exception reports. Again this was due to lower numbers of FY1 in the department and further affected by sickness and Covid related absences.

Gastroenterology also experience an increased amount submitted in comparison to the other departments. These were mainly based around additional hours worked and missed educational opportunities from a large workload due to a shortage of trainees specifically of FY1. The exception reports highlight that there is a shortage of phlebotomists meaning that the trainees workload was increased.



Summary of Fines

The Trust has incurred 21 fines which totals to the amount of £4,148.66. This includes £1602.91 which was paid to the trainees and £2545.75 to the Guardian of Safe Working.

During the JDF the Guardian of Safe Working budget is discussed and decisions are agreed on how it should be spent.

Below are examples of some of the fines issued (April 21 – March 22):

- An FY2 trainee working in Urology worked and 2.5 hours over on 28th May 2021 due to staff shortages and an increased workload. There were two breaches of the maximum 13 hour rule as well as the less than 11 hours rest rule being broken.
- An FY2 trainee working in Oncology worked 2.75 hours over from 10th to 13 August 2021 due to handovers being completed late and therefore breaking the 13 hours shift and 11 hour rest rule.
- The Upper GI department received a fine due to an FY1 breaching the maximum 72 hour week rule as they stayed late for patient care reasons.
- There were five exception reports submitted in November by a particular FY1 trainee meaning that the maximum 72 hour week rule was broken as they had a high workload and a shortage of staff so stayed beyond their rostered hours.

The most common reason seen for rules being breached were high workload, staff shortages, late handovers and staying late for patient safety. Multiple fine were issued for multiple breaches of Junior Doctor Contract T&C's. In order to issue a fine the trainee must have submitted an exception report as evidence to highlight the breaches or unsafe working.

Junior Doctors Forum (JDF)

The Junior Doctors Forum takes place on the second Friday of each month. Representatives for each grade attend as well as any other trainees that want to attend. There are different members of staff from all across the Trust that attend the JDF to provide support for the trainees. The purpose of the meeting is to allow junior doctors to raise and highlight any concerns or issues that they have experienced in addition to this the Guardian of Safe Working is able to provide feedback on trends that have been recognised through exception reporting. Since Covid the JDF has been held virtually through WebEx invites are sent out the week prior with the link to attend. All information regarding the JDF is available on the staff intranet with information on how to receive the invitation link. Each month the JDF Chair works through the agenda and action tracker receiving from feedback and updates from the members of the JDF. They then get updated monthly allowing the progress to be tracked and continue addressing arising problems.

Actions taken to resolve issues

One of the current actions being taken, to ensure that the Trust is compliant with the Junior Doctors Terms and Conditions, is working to ensure all departments are using the E-Roster system fully. This allows the Guardian of Safe Working to monitor the working hours of trainees, it will automatically flag an issue if a rule has been broken and it is no longer practicing safe working. When an exception report is submitted in relation to a difference in hours worked, E-Roster is able to be updated with the hours actually worked and it will highlight if any rules have been breached. The Medical Staffing Team are now responsible for the e-Rostering of Junior doctors within the Trust amd are working through a project aiming to get more departments using E-Roster, allowing us to identify and resolve issues quicker ensuring compliance with the T&C's.

A reoccurring issue seen to be highlighted through exception reporting is the lack of support seen from the Phlebotomy services. Due to this trainees are then having to perform bloods increasing their workload and taking them away from training or educational opportunities. This as well as trainees being asked to perform ECG's is addressed at the Junior Doctors Forum. It has been added to the deanery's risk register and Executives have been informed of the risk to the Trust.

From April 2021 to March 2022, 108 exception reports were submitted in relation to missed education or training opportunities. This continues to be an issue as trainees workloads in combination with staffing problems meaning that they are unable to take their rostered self-development time within the working week to complete their ARCP. Currently negotiations are happening with senior management with the aim of all trainees receiving self-development time however due to contractual agreements it is currently only available to foundation trainees. As the approval of SDT was only recorded from August 2021 the data is not available to show many trainees had approved SDT prior to this. From August 2021 to March 2022 49.55% of all rostered SDT was taken.

After recommendation from a recent audit report, previous exception reports which remain on the systems as live after having come to a resolution or without a review are being actioned. This allows our trainees to have their review undertaken in a timely manner compliant with the T&C's and be compensated as necessary as soon as possible. We have also changed the time from which supervisors are chased to respond to their trainee's exception reports. Supervisors are automatically sent an email when the exception report is submitted however there is no automated chasing process. We have shortened the time frame of chasing the

supervisors via email so the reviews can be undertaken as close as possible after the occurrence.

Questions for consideration

The Workforce, Education and Culture meeting has requested to receive this report and decide if the report provides sufficient information and assurance and decide if any further information / actions are required.

Agenda Item	10	**Meeting**	Trust Board July 2022	**Meeting Date**	12/07/2022
Title	Performance Report				
Lead Director	Ellen Ryabov – Chief Operating Officer				
Author	Louise Topliss – Assistant Director of Operations (Operational Performance)				
Report previously considered by (date)	Trust Board 27th June 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 Trust Board members are asked to receive, discuss and accept this update on key performance issues.

Performance and Activity Report

May 2022 Performance

April 2022 for Cancer data

Produced June 2022

Table of Contents

1. Executive Summary

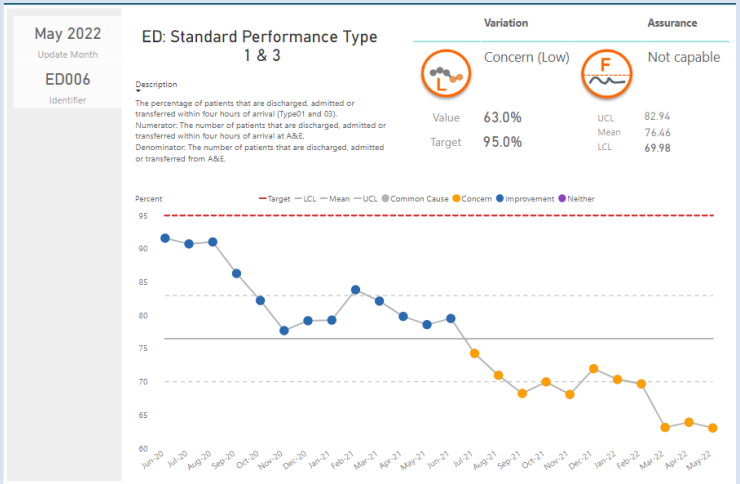
Areas requiring improvement	
Urgent Care performance – ED and Ambulance handovers	• Ambulance handover position continues to deteriorate with increasing numbers of lodged patients within ED, routinely between 25 and 30 patients at the start of the day. • YAS and HUTH have agreed a Cohorting procedure that uses the fracture clinic space out of hours to enable Ambulance crews to be released to support the community. The decision to implement Cohorting lies with YAS as if required YAS staff the area. • The number of patients in May with No Criteria to Reside remains the single largest factor affecting performance with approximately 167 patients per day remaining within the Hospital who have no medical need for acute services.
Cancer performance	• Overall cancer performance remains comparable with previous months, and whilst 2ww referrals have increased by 6% compared to previous years, there is no significant increase in confirmed cancers for any tumour site. • 0 of 9 cancer waiting times' national standards were achieved. • The number of patients on the 62 day from referral to treatment pathway has started to reduce (at its highest it was ~1,800) with the latest PTL number ~1,500. • The Two Week wait cancer PTL has four high volume tumour sites (colorectal, gynae, skin and urology); as part of the internal assurance processes, an internal validation of those PTLs has been completed in order to be confident that the patients were genuine. The outcome of the exercise was that overall, the PTL is clean and the patients are valid. Minor discrepancies allowed a small number to be removed with little impact to the overall size of the PTL; some internal actions are underway to further improve systems/processes. • The Trust performance, with regards to the 62 day treatment pathways and overall cancer PTL have flagged as an outlier through the NHSE assurance processes. In line with the on-going review of patients on an RTT pathway over 104 weeks, and with effect from May 2022 cancer performance has been added to the weekly assurance and recovery meetings with National & Regional NHSE leads and HNY ICS colleagues. Updated slides are presented each week to the

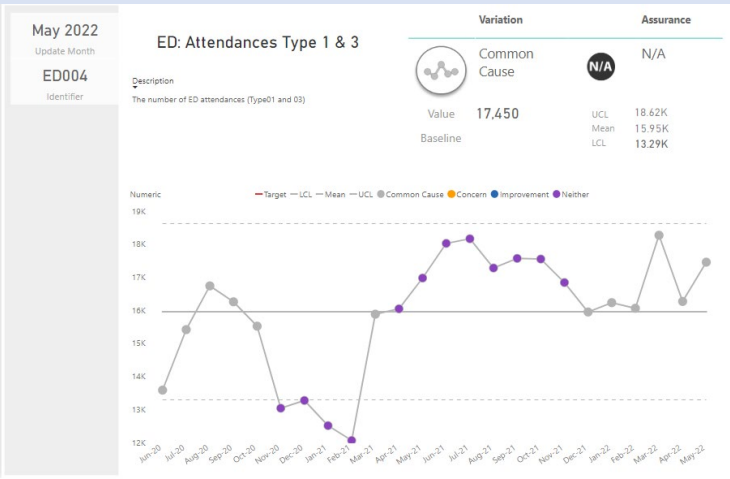
	meeting providing action and progress where indicated. Good progress was noted at the meeting on 17 June 2022 as a result of the actions being taken. • The Trust Cancer transformation programme is beginning to tackle some of the diagnostic waiting time issues for colorectal patients, as a result additional capacity has been secured which will come on line in July which should improve the waiting times for CTC request to test • Specific additional performance meetings and support from the Operational Improvement Team has been directed to support recovery of CT waiting times. These meetings continue and some progress is being realised (e.g. CTC additional capacity)
Recovery of elective activity	• Recovery of elective activity in May 2022 against the operational plan was broadly in line with the submitted activity numbers except for Ordinary elective at 82% of plan. The indicative activity requirement of 110% of 19/20 baseline was not delivered in any of the PODs. • The operational plan also includes a reduction of outpatient follow-ups by 25% by March 2023. In May 2022 follow up activity was 101% of baseline and 107% of plan; further work is required to transform outpatient pathways to support this operational requirement. There has been a counting change in Clinical Support Services HG for Radiotherapy which has shifted approximately 17,000 new outpatients per year to follow up activity which in part accounts for this. • The on-going capacity required to support Covid+ patients is reducing however, the number of patients with No Criteria to Reside (NCTR) across HRI and CHH continues to restrict the ability to deliver further increases in elective work with circa 38 beds lost at CHH during May 2022. A further 12 beds are not in use due to staffing vacancies within the surgical nursing teams. Changes from the end of May 2022, including reconfiguration of the CHH NCTR/elective capacity will reduce this to a net 35 beds lost (23 NCTR and 12 due to vacancies) to elective inpatient capacity for surgical specialities (mainly orthopaedic & neurosurgery & ENT/Plastic Surgery) patients. • Mutual aid continues to progress focussing on any provider with shorter waiting times inside and out with the HNY to not only improve waiting times but to support the reduction of the overall size of the Trust's PTL.

Improving treatment times for long waiting patients	• For 2022/23 Quarter 1, the starting position was 794 patients to treat, who have breached/or are at risk of breaching 104-weeks 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. • At the end of May 2022, there were 181 (-211 on last month) patients who had waited over 104 weeks for treatment. • The National aspiration was to have zero patients waiting over 104 weeks by the end of June 22, the current risks to delivery of this plan for HUTH is circa 74 patients (a reduction from the previous forecast of 160 and 127). There is no definitive plan for this group of patients at this point, however the speciality level teams continue, where possible, to identify opportunities to deliver an increase in activity which is often set against the demands of acute/trauma, P2 and cancer requirements. • Enhanced internal governance processes are in place, daily monitoring against the trajectories and on-going work to identify capacity internally and seek/take up offers of mutual aid from other providers. • There are 4,706 (-326 on last month) patients who have waited more than one year, and this number has reduced significantly in the last 12 months. • The Elective National Intensive Support Team visited the Trust on 26th and 27th May 2022 as part of the Tier 1 support/assurance process. Draft feedback has been received which identifies several areas of good practice. • Source Group have completed the validation of the Trust's PTL and shared the end of project report. PTL removals was 7.2% (compared to the Source Group average of 18%), with the Trust's PTL being described as "clean".
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 May 2022 there were 167 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.

	• East Riding CCG are providing a senior manager to support the progression of all patients who have had 'no criteria to reside' (NCTR) for 20+ days. All patients over 30 days NCTR are discussed weekly between the System Chief Operating Officers and Directors of Adult Social Services.

2. Emergency Care Standards – 4 hour Performance





What the chart tells us

4 hour performance has been relatively stable for the last three months, albeit that it is significantly below the required standard and in May 2022 was 63% for all Types. ED attendances are increasing and were above the mean at 17,450 (mean 16,000) in May 2022.

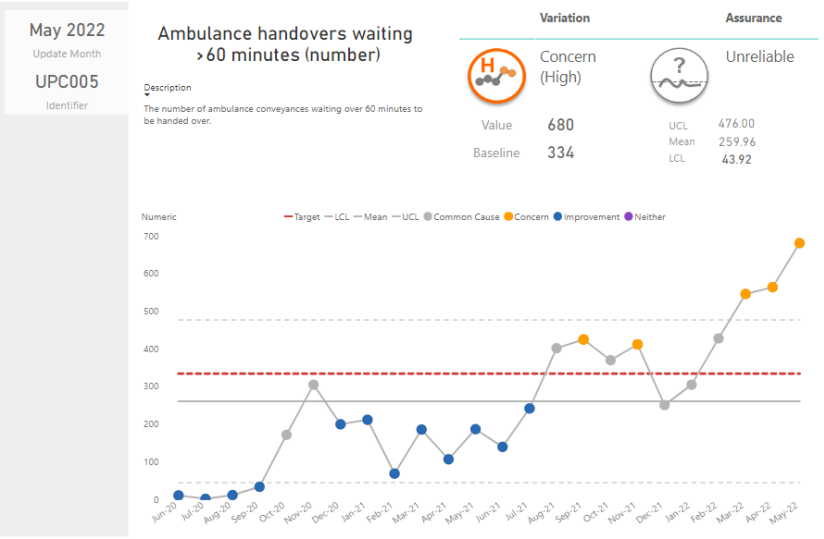
Intervention and Planned Impact

- A planned intervention in ECA to be led by the clinical teams to improve processes and timeliness of patients being seen which will start in June 22.
- A multi-clinical workshop to be held in June 2022 with all Health Groups to redesign our emergency pathways a d line up a PDSA cycle for change in July 22.
- ED to be able to book pts directly into Specialty Hot clinics will begin rolling out towards the end of June 2022.
- ED to review the staffing model for the ambulatory Emergency Care Area (ECA) to reduce discharge breaches.

Risks / Mitigations

- Continued delays in flow and discharge delays are a significant impediment to improvement in the majors area
- Poor processes and staffing allocations are impacting timeliness of treatment in ECA which are to be reviewed
- Further recruitment of staff/GPs has been achieved and will be ongoing to support minor illness in ECA
- Ring fencing of Elective capacity has reduced the ability outlie into the surgical bed base and relieve non-elective pressure.

3. Ambulance Handovers waiting over 60 minutes



What the chart tells us

There were 680 over 60 minute ambulance handover delays in May 2022 which equated to 22.7% which is broadly similar to April of 20.9% but a significant deterioration in the position of January 12.5% which highlights the ongoing challenge.

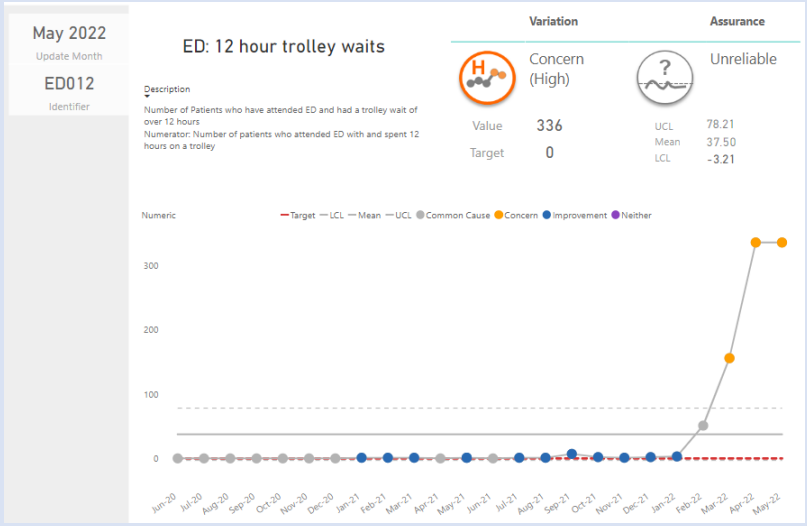
Intervention and Planned Impact

- The Paediatric pathway has been reviewed and a test of change was delayed until W/C 20th June 2022, the delay was it is anticipated to achieve an average reduction of 6 minutes based on entry to the Paediatric area via alternative route.
- A further test of change in initial assessment will begin in June 2022 with crews 'pinning out' in the cubicle rather than having to go to a separate screen this will act as the intermediary step while awaiting the EPR interface to automate the data capture.
- Specific weekly review of all long waiting delays in hospital are expected to speed up and reduced occupied bed days thereby providing potential for improved flow out of ED.

Risks / Mitigations

- No Criteria to reside patients continue to occupy 167 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.

4. 12 Hour Trolley Waits (from DTA to Depart)



Date
01/05/2022 31/05/2022

Day of Week Number	1 Mon	2 Tue	3 Wed	4 Thu	5 Fri	6 Sat	7 Sun	Total
ED Departures (Type 01)	1,879	1,851	1,442	1,489	1,399	1,275	1,679	11,014
ED 12 Hour Trolley Breaches	60	45	23	48	37	40	82	335
ED 4 Hour Standard Performance (Type 01)	52.8%	47.6%	45.0%	44.7%	47.6%	50.6%	52.9%	48.9%

What the chart tells us

There were 336 x12 hour trolley wait breaches in May 2022 with the longest wait from Decision to Admission (DTA) of 27 hours. In May 2022, Sunday was the highest daily figure for trolley waits.

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 May 2022 was that 10.8% of patients (1,188 patients) waited over 12 hours against a tolerance of 2%.

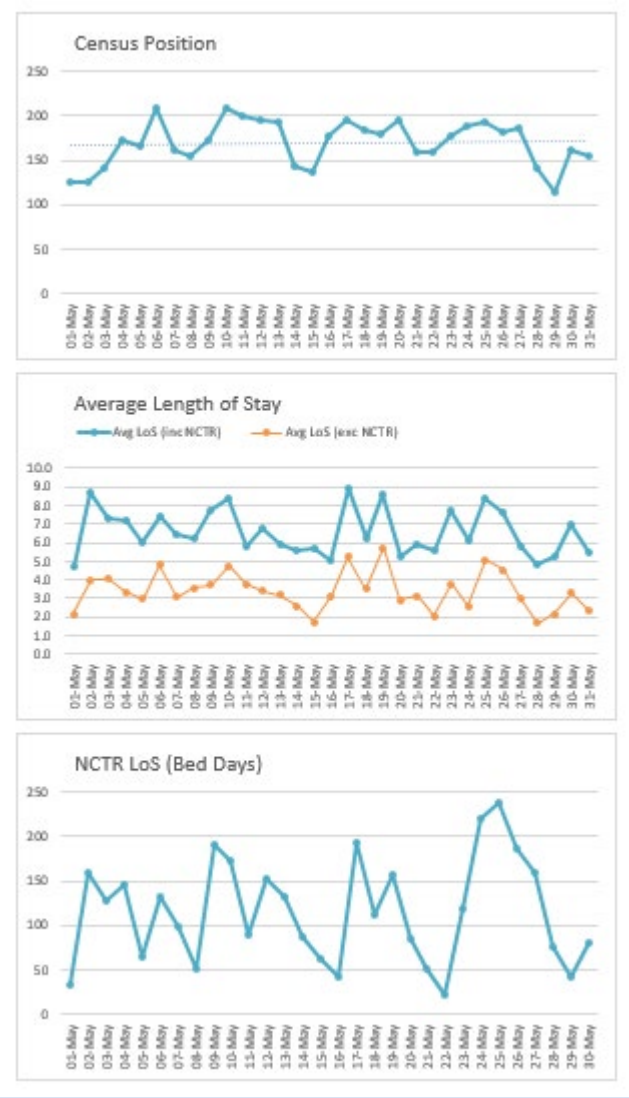
Intervention and Planned

- Additional CCG support to be provided in June 2022 to work across all system partners and initially focus on patients with 20+ days of having 'No Criteria to Reside'
- To commence in middle of June 2022, all patients referred via GP after contact with a speciality will be streamed directly to the specialty assessment area away from ED
- Workshop to be held in June 2022 with all health groups to redesign the emergency pathways and improve experience for our patients

Risks / Mitigations

- No Criteria to reside patients continue to occupy 167 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.

5. No Criteria to Reside



What the chart tells us

On average, there were 167 patients per day with No Criteria to Reside in May 2022. There was an average impact of 4.5 days increase on Length of Stay due to the NCTR.

The NCTR accounted for 3,560 lost bed days in May, which is an increase of 481 on April 2022.

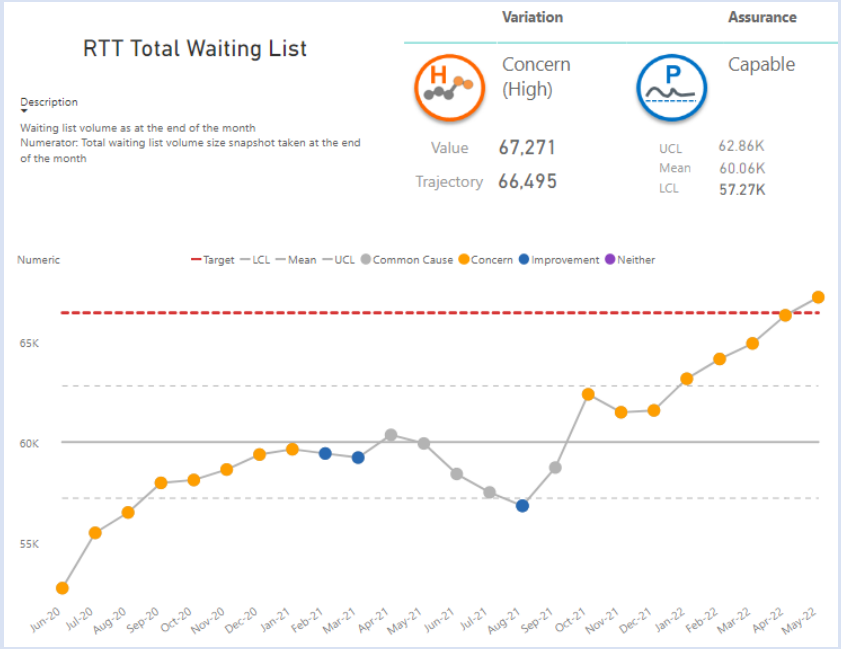
Intervention and Planned Impact

- Single Point of Access for discharge became operational from mid-April 2022 this has reduced the rejection rate from 16% to 11% in May2022; work continues to improve this further.
- Focus on Hospital only Discharge (Pathway 0) any patients not discharged same day are escalated. At the start of the HOD improvement programme we were recording around 40 patients per day. In May 2022 we reported an average of 20 patients per day; improvement work with Health Groups continues with a thematic review at the end of June 2022.

Risks / Mitigations

- East Riding Social Services were particularly challenged with staffing throughout May 2022 leading to increasing volumes of patients and time to assessment.
- Continued Covid outbreaks closing community capacity with predicted increase in prevalence June and July 2022.
- Domiciliary capacity remains lower than demand.

6. Referral to Treatment – Total Waiting List Volume



What the chart tells us

The Trust's total waiting list volume (WLV) continues to increase; with 8 data points above the mean. At the end of May 2022, the position is 67,271 (+901 on last month). The sustainable list size to achieve 92% incomplete performance is circa. 36k. The total WLV is currently above the 2022/23 trajectory for May 2022; the final submission is due on 21 June 2022.

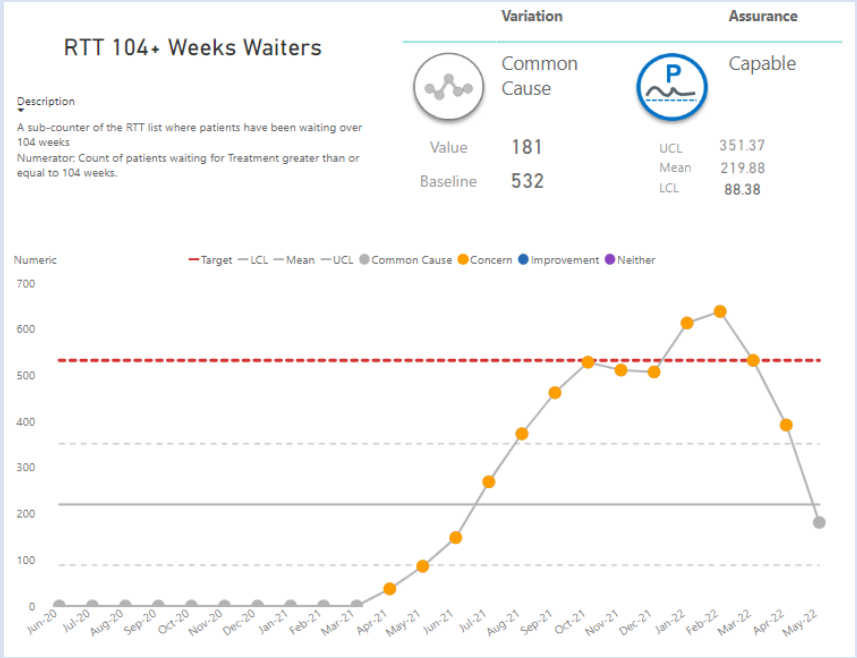
Referrals in May 2022 were 9% higher than the previous year (May 2021) (+1,601). The decrease in referrals in 2020/21 was due to the Covid pandemic. The operational plan for 2022/23 assumes no further increase in referrals.

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 127 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 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 70-weeks at 31 March 2023
- Validation by Source Group has been completed with 7.2% overall removal rate; the PTL has been consistently described as "clean".
- 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 at the end of June 2022 delivered by Healthcare Communications. This process will focus on patients confirming whether they still require treatment.
- Elective Intensive Support Team (IST) visit on 26 and 27 May 2022 with draft report received. Several good areas of practice were noted. The recommendations and suggested actions are being reviewed and an action plan will be implemented.
- Progressing transfers to Independent Sector Providers
    - St Hugh's (Gynaecology, Orthopaedics)
    - Spire Hull & East Riding (Orthopaedics, Pain, Plastics)
    - One Health (Neurosurgery, Interventional Radiology)
    - Modality (Cardiology New outpatients & Diagnostics, Dermatology)
- Continued Insourcing from

	○ Pioneer (Paediatric Gastro, Cardiology, Plastic Surgery, ENT, Urology, UGI, Vascular, Neurosurgery) ○ Medinet (Endoscopy)
	Risks / Mitigations • Further increase in GP referrals – referral triage and A&G in place to mitigate • Patients with No Criteria to Reside does not reduce • Covid and Covid Contacts does not start to increase • Increase in non-elective demand displacing elective capacity

7. 104 Week Waits & Planned Trajectory to June 2022



What the chart tells us

At the end of May 2022 there has been a decrease in actual 104 week waits to 181 (-211 on previous month).

Risks in Quarter 1 have reduced from a starting position of 794 to 98 at 20th June 2022, 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 which is delivering improved performance.

- Revised Trust trajectory agreed with NHSE on 17 June 2022:
  - 30 June 2022 no worse than 74 (was 127)
  - 31 July 2022 x 21 (was 36)
  - 31 August 2022 x 14 (was 25)
  - 30 September 2022 x 5 (was 9)
  - 31 November 2022 x 0 (was December 2022)

- Clinical Admin Service continue to proactively contact patients with TCIs/appointments to check they are attending/if treatment is still required – 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
- Progressing mutual aid support from providers within and without of H&NY
  - NLAG (Orthopaedics, Urology & Upper GI)
  - York (Orthodontics, Plastic Surgery, Dermatology)
  - HCA London (Complex Spine)
  - Rotherham (Colorectal Surgery)
  - Mid Yorkshire (Oral Surgery)
  - South Tees (Cardiac Surgery)

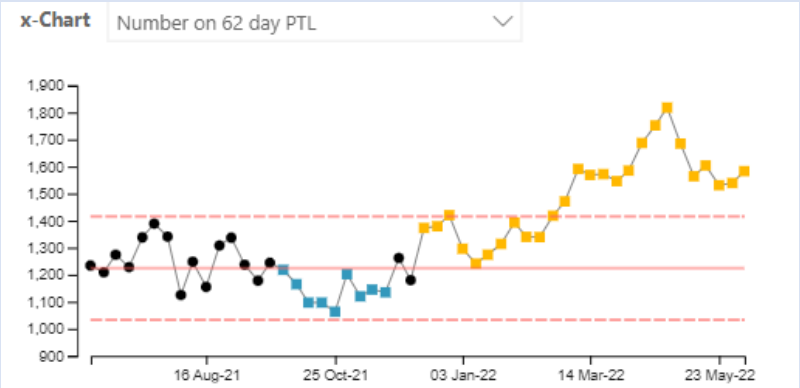
Risks / Mitigations

- Covid (staff absence & patient numbers), Monkey Pox and/or NCTR numbers (still average of 167 vs. 50 baseline)
- Staff absence increases or does not reduce
- Non-elective demand increases – impacting on elective bed base
- Priority 2, cancer and trauma demand – including ICU capacity & delays in repatriation (in & out of network)
- 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 has been received – to be managed at HUTH)
- 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, however much reduced at 213 (-209 on last month) at 20/6/2022 – and being tracked).
- Mutual aid offers - patients do not meet criteria to transfer to alternative provision
- **Risk** – Speciality capacity: Colorectal (cancer demand & HOB bed requirements), & ENT (surgeon/complex operating time), Plastic Surgery (ward based enhanced monitoring requirements), Neurosurgery (P2/acute demand, theatres & bed base), Orthodontics (clinical capacity) and Oral Surgery (surgeon capacity)
- Procurement issues (global and nationally)

Week Commencing	28/03/2022	04/04/2022	11/04/2022	18/04/2022	25/04/2022	02/05/2022	09/05/2022	16/05/2022	23/05/2022	30/05/2022	06/06/2022	13/06/2022	20/06/2022	27/06/2022
Trajectory	794	750	706	662	618	574	492	410	328	246	164	160	160	127
Target Clock Stops	44	44	44	44	44	82	82	82	82	82	82	82	82	82
Actual Position	794	718	642	604	548	472	419	358	291	222	190	146	98	
Removals Required (straight line)	61	60	58	60	61	59	60	60	49	44	48	49	49	
Actual Removals	76	76	38	56	76	53	61	67	69	32	44	48		

Planned Trajectory to June 2022

8. Cancer 62 day Waiting List Volume



What the chart tells us

The number of patients waiting to start treatment on a 62-day pathway has decreased over the last month from a peak of 1,818 to 1,539 at the end of May 2022. However, this remains significantly above the sustainable list size of c.900.

At week commencing 13 June 2022, Colorectal, Gynae, Skin and Urology are the tumour sites that continue to make up the largest percentage of the overall PTL.

The tumour sites with the largest proportion of the PTL are:

- Colorectal (639/40%) with 22% over 63 days (which is a 6% reduction)
- Urology (193/12%) with 26% over 63 days
- Skin (234/14%) with 12% over 63 days
- Gynaecology (199/12.5%) with 24% over 63 days (5% increase)

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:

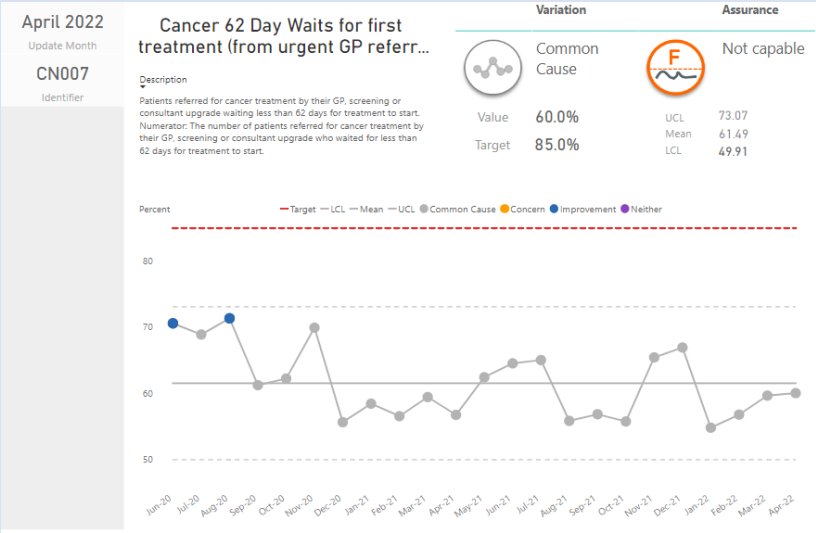
- Administration process review in Radiology department (CTC); this has now been completed and actions are being explored for implementation
- CTC demand and capacity analysis: additional capacity will come on line in July 2022 and is intended to significantly reducing the backlog
- CTC mutual aid being provided by NLAG (4 slots per week); the Spire is yet to come on line
- There is some evidence to support shorter waiting times for CT following the radiology department intervention
- Colonoscopy waiting times - have increased and will form part of the colorectal transformation improvement plan

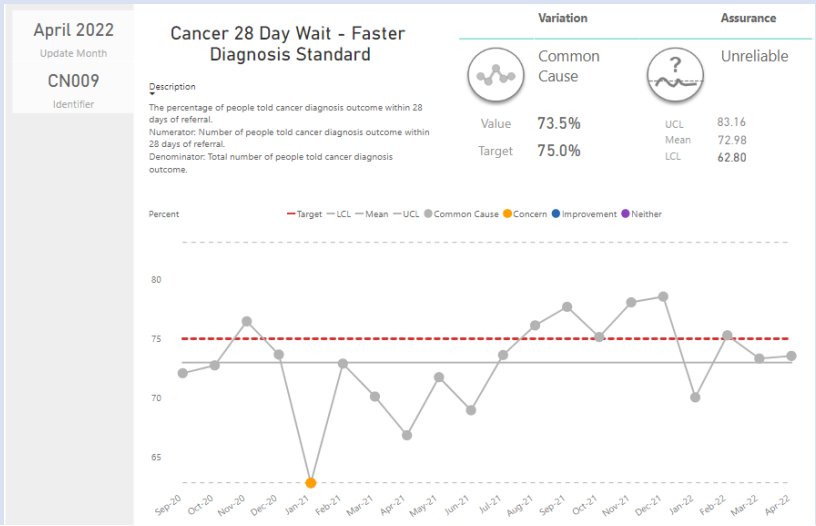
Histology capacity/delays – continue to be significant for gynae and skin in particular the following actions remain current

- Daily results file has been made available to tracking staff

	• Escalations to the SHYPS manager will be initiated where results remain outstanding • Support to identify mutual aid for histology through the NEY Regional Clinical Leads Tracking capacity and decision making • Additional tracking resource has made a positive impact on the colorectal PTL • Internal in-house validation of the PTL has been completed with assurance that with the exception of a very small number that could be removed by applying CWT guidance, the PTL numbers are valid **Radiotherapy capacity/delays** • Staffing vacancies and long term sickness continue to be a considerable challenge • Increased workload since the recovery plan was developed and implemented during COVID-19 (2021/22) • Clinical Oncology workforce shortages remains a challenge The result of these challenges is that Radiotherapy and Chemotherapy waiting times for treatment have declined to a point where the Cancer Waiting Times performance is adversely affected. Performance is not expected to improve for the remainder of the calendar year.
	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 • Histology tracking systems implemented locally to prioritise long-wait patients • Mutual aid sourced for CTC with some success • Additional internal CTC capacity has been secured going forward • Mobile CT capacity continues to be provided by the IS

9. Cancer 62 day Performance





What the chart tells us

Performance for April 2022 was 60% and common cause is being displayed as the mean is 61.5%; performance has not been achieved for some time.

The Faster Diagnosis Standard (combined) April 2022 did not achieve the target with performance of 73.5%. 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 PTL has been validated; additional CTC capacity has been secure to address the backlog of patients ~200
  - Administration processes have been reviewed and actions being explored/implemented
  - Mutual aid from NLAG at x4 per week per hospital site in in progress; the Spire has yet to come on line
- Access to timely CT scans are having an impact across a number of cancer pathways; the wait was 4-weeks – the radiology department are now prioritising 2WW patients to provide earlier slots. Early indications show the waiting time is reducing.
- Improved access to CTC towards the end of August 2022 should have a direct impact on FDS performance for colorectal which in turn will support the overall Trust performance

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
- Histology tracking systems implemented locally to prioritise long-wait patients
- Mutual aid sourced for CTC with some success
- Additional internal CTC capacity has been secured going forward
- Mobile CT capacity continues to be provided by the IS

10. Elective Recovery Fund

		Target	104%	104%		
HG	POD	DATA	Apr-22	May-22	Q1 Total	Grand Total
Trust	01 Day Case	2019-20 M10 FOT Baseline	3,971,246	4,153,426	8,124,672	8,124,672
		22-23 Baseline Plan	3,817,574	4,137,310	7,954,884	7,954,884
		Actuals	3,458,112	4,455,948	7,914,060	7,914,060
		Baseline 19/20 %	87%	107%	97%	97%
		Baseline 22/23 %	91%	108%	99%	99%
		Indicative Gain/Loss	(503,988)	102,289	(401,699)	(401,699)
	02 Elective	2019-20 M10 FOT Baseline	5,261,478	5,385,385	10,646,863	10,646,863
		22-23 Baseline Plan	5,589,982	5,990,510	11,580,492	11,580,492
		Actuals	3,996,518	4,574,380	8,570,898	8,570,898
		Baseline 19/20 %	76%	85%	81%	81%
		Baseline 22/23 %	71%	76%	74%	74%
		Indicative Gain/Loss	(1,106,564)	(769,816)	(1,876,380)	(1,876,380)
	05 Outpatient Firsts	2019-20 M10 FOT Baseline	3,326,125	3,490,995	6,817,120	6,817,120
		22-23 Baseline Plan	3,359,698	3,194,396	6,554,094	6,554,094
		Actuals	3,325,995	3,326,532	6,652,528	6,652,528
		Baseline 19/20 %	100%	95%	98%	98%
		Baseline 22/23 %	99%	104%	102%	102%
		Indicative Gain/Loss	(99,881)	(228,077)	(327,958)	(327,958)
	06 Outpatient Followups	2019-20 M10 FOT Baseline	3,179,731	3,488,704	6,668,435	6,668,435
		22-23 Baseline Plan	3,293,344	3,618,227	6,911,570	6,911,570
		Actuals	3,465,953	3,997,594	7,463,546	7,463,546
		Baseline 19/20 %	109%	115%	112%	112%
		Baseline 22/23 %	105%	110%	108%	108%
		Indicative Gain/Loss	0	-	-	-
Trust Overall		2019-20 M10 FOT Baseline	15,738,579	16,518,511	32,257,090	32,257,090
		22-23 Baseline Plan	16,060,598	16,940,443	33,001,040	33,001,040
		Actuals	14,246,579	16,354,453	30,601,032	30,601,032
		Baseline 19/20 %	91%	99%	95%	95%
		Baseline 22/23 %	89%	97%	93%	93%
		Inicative Gain/Loss	(1,710,432)	(895,605)	(2,606,037)	(2,606,037)

What the chart tells us

Overall, financial income for May 2022 was below the 104% based on the early income position.

Intervention and Planned Impact

Risks / Mitigations

-

Agenda Item	10.1	Meeting	Trust Board	Meeting Date	12.07.22
Title	Finance Report – 2022/23 - Month 2				
Lead Director	Lee Bond, Chief Finance Officer				
Author	Stephen Evans, Deputy Director of Finance				
Report previously considered by (date)					

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

Key Recommendations to be considered:

a) The agreement to submit a balanced ICB plan, with each organisation within the ICB also showing a balanced position, through funding smoothing adjustments.

b) The reported deficit of £0.4m at month 2, which is £0.8m away from plan chiefly driven by unidentified CRES.

c) The risk on elective recovery income if value of activity is below plan and NHSEI enact the clawback.

d) The underlying deficit of £41.4m

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD: TUESDAY 12th JULY 2022

FINANCIAL UPDATE 2022/23 – MONTH 2

1. Purpose of Paper

To update the Trust Board on the latest financial planning position and the financial position at month 2.

2. 2022/23 Financial Planning Update

The Trust submitted a financial plan on 28th April 22 with a £19.1m deficit. This was part of an overall Humber and North Yorkshire Health and Care Partnership ICB (HNY ICB) position of £56.2m deficit. Subsequent review of the ICB submission identified that some commissioner expenditure items needed updating and the revised ICB deficit increased to £60.8m. A large element of the Trust deficit (£14.2m) linked to expected high levels of inflation for both utilities and general non-pay costs.

NHSEI have reviewed the NHS financial position and have looked to release further funding into the system. This is not new funding but a re-allocation of centrally held funds. This is broken down as:

Additional Inflation Funding	£680m Recurrent
Ambulance Funding	£180m Recurrent
Commissioner Side Pressures	£345m Recurrent
Target Specific Issues	£400m Non-Recurrent
Total	£1,605m

NHSEI expect systems to submit balanced financial plans as part of the agreement for receiving a share of this funding.

HNY ICB has an indicative share of the above funding at £36.3m, reducing the planned deficit to £24.5m.

The CFOs within the ICB have worked through the potential options and have agreed to submit a balanced plan with receipt of the above funding. This has been achieved by release of additional funding from within the overall ICS position and further use of technical flexibilities. It is recognised that some of these assumptions may be challenging and will need further work (for example £3m assumption on Commissioner Independent Sector baselines, transfer of funding between different ICBs).

The CFOs also agreed that if the system was in balance then every organisation within the system should submit a balanced plan to ensure cash problems did not arise. Smoothing adjustments would be used to transfer funding between organisations.

For HUTH this means that the following adjustments have been made to the previously submitted plan:

Planned Deficit at 28th April	(£19.1m)	
Additional Inflation Funding	£3.9m	Recurrent
Share of Specific Issues Funding	£6.0m	Non-Recurrent
Technical Flexibilities	£4.3m	Non-Recurrent
Smoothing Funding	£4.9m	Non-Recurrent
Revised plan submission	£0.0m	

It must be noted, that of the plan to reach break-even, £15.2m of the additional actions are non-recurrent and will not improve the underlying position.

The underlying position is currently forecast to be:

2021/22 Financial Plan	£0.0m

Add back Non-Recurrent Items

Initial Balance Sheet flexibility in plan	(£8.0m)
Additional Non-Recurrent items above	(£15.2m)
Covid19 Income	(£8.0m)
Recharge to NLAG for Consultant Time	(£0.9m)
ERF Productivity Gain	(£4.6m)
Full Year Effects of Investments	(£4.7m)
2022/23 Underlying Position	(£41.4m)

The above position assumes that the Trust develops a recurrent CRES plan in 2022/23 to deliver the full CRES requirement of £17.3m.

The run rate will be refined and updated on a monthly basis.

The revised plan was submitted to NHSEI on 20th June 22.

3. Month 2

The table in appendix 1 shows the month 2 reported position against the revised NHSI plan, at health group level. The Trust is reporting a deficit of £0.4m at month 2, which is £0.8m worse than the plan.

Income

The Trust plan includes £19.7m of Elective Recovery Funding (ERF), that is, £1.6m per month. Activity numbers for months 1 and 2 are below the 104% requirement. The value of that activity determines the final calculation. The potential shortfall is valued at £2.5m, but this is currently identified as a risk rather than a confirmed shortfall. There is discussion ongoing nationally as to whether the clawback will happen in Q1. The shortfall is primarily because of the loss of inpatient beds due to the number of No Criteria to Reside (NCTR) patients and continuing higher levels of sickness.

The Trust has received £0.1m additional income through Injury Recovery Unit.

Expenditure

Health groups and corporate areas are reporting that they have a deficit of £1.9m at month 2.

The biggest driver of the deficit is the current level of unidentified CRES, currently standing at £4.9m, which is showing a shortfall in Month 2 of £0.85m. The breakdown by Health Group is as per the following table:

	YTD CRES Plan £'k	YTD CRES Actual £'k	YTD CRES Variance £'k	% Achieved YTD
Medicine	304	66	-238	22%
Emergency Medicine	58	37	-21	64%
Surgery	498	358	-140	72%
Family & Womens Health	254	130	-124	51%
Clinical Support Services	329	134	-195	41%
Corporate	285	203	-82	71%
Estates, Facilities & Development	110	81	-29	74%
Energy	858	834	-24	97%
Central	60	60	0	100%
TOTAL	**2,756**	**1,903**	**-853**	**-31%**

Surgery Health Group has the biggest pressure excluding CRES delivery with a further £0.6m overspend. The main areas are the pressures on Junior Doctors (£0.3m) which is under review, Anaesthetic Consultant sessions (£0.2m) and loss of private patient income (£0.1m).

Clinical Support Health Group has £0.2m overspend excluding CRES, chiefly due to non-pay pressures and use of locums in Oncology.

Family and Women's Health Group is £0.2m over-spent with main driver the high level of Wet AMD cases in first two months.
Excluding CRES, Medicine Health Group is under-spent with the level of vacancies offsetting pressures due to additional wards being open to support NCTR patients and winter ward remaining open in May.

EF&D have shortfalls on Catering (£0.2m) and car parking income (£0.1m), which have not returned to pre-Covid19 levels. Funding for new Allam building at HRI and new ICU is to be finalised.

The Trust has reserves available, which it expected to use to offset some of these pressures, as they were included in the initial plan. This amounts to £0.85m.

In summary the month 2 position is:

Unidentified CRES	(£0.85m)
Other Health Group Pressures	(£1.03m)
Reserves and other areas	£1.05m
Total shortfall	(£0.83m)

The key actions needed are identifying plans to reduce the level of unidentified CRES and the need to increase in house productivity to ensure the Trust delivers the ERF income.

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

The SOFP and SOCF for will be included from Month 3 onwards.

Capital

The reported capital position at month 2 is gross capital expenditure of £0.96m against a plan of £1.91m. The main shortfall on expenditure is due to delays on the Day Surgery Unit, resulting in spend being below plan. The other main items of expenditure are backlog maintenance and PFI lifecycle costs.

The planned capital expenditure for 2022/23 (incl PFI/IFRIC12 impact) is £33.9m; this excludes the impact of IFRS16 for which the Trust is expecting CDEL cover totalling £0.97m.

Cash

The Trust's liquidity position remains healthy with a cash balance of £89.6m at the end of May 22. This will reduce gradually in the year, as balance sheet flexibility is released into the SOCI position, in support of plan delivery.

To date the Trust has paid 96.4% by volume and 84.2% by value of non-NHS invoices within best practice terms. In May, the figures were 95.6% and 73.3% respectively.

Stocks

Stock levels are at £16.0m, an increase of £0.1m since year-end. The table below shows how stock has moved since March 19 with the value increasing by £3.5m. Work is to be under-taken to review the level, to determine if levels can be reduced down to pre-pandemic levels, or even further below.

As part of the 2021/22, audit recommendations there will be a review of the Trust stock-take procedures during the year.

Health Group	Mar 19 £000	Mar 20 £000	Mar 21 £000	Mar 22 £000	May 22 £000	Change £000
Clinical Support	5,981	6,655	7,460	7,178	7,180	2
Surgery	4,017	4,738	4,247	4,489	4,611	122
Medicine	851	1,014	1,026	2,326	2,395	70
F & WH	732	1,722	1,174	1,096	1,014	(82)
Other	947	470	439	434	436	2
PPE Stock	-	-	635	345	345	0
Total	12,528	14,599	14,981	15,867	15,982	114

Debtors

The Trust currently has £4.0m of debt that is over 90 days. This has increased £0.3m from month 1. The main debtors are as follows

	April 22	May 22	Change
Debtors over 90 Days	**£**	**£**	**£**
Northern Lincolnshire And Goole Nhs Ft	592,561	545,782	-46,778
York & Scarborough Teaching Hospitals Nhs Ft	352,017	491,258	139,242
Alliance Medical Ltd	140,941	277,485	136,543
City Health Care Partnership	357,765	272,271	-85,495
Humber Teaching Nhs Foundation Trust	162,109	164,601	2,492
East Riding Of Yorkshire Council	107,945	122,307	14,362
East Riding Fertility Services Ltd	96,171	98,041	1,870
Fresenius Medical Care Renal Services Ltd	77,505	77,505	0
Crawford & Company Adjusters (Uk) Ltd	70,320	70,320	0
University Of Hull	59,823	59,823	0
Nhs Scotland	35,913	53,468	17,555
Ge Healthcare	51,962	51,962	0
Others	1,588,916	1,669,437	80,521
Total	3,693,949	3,954,262	260,313

NLAG invoices relate mainly to Oral & Maxillofacial services and is being worked through with the teams. It will be resolved shortly and will require a credit note of £0.2m. This was provided for in the 2021/22 accounts. There is a further invoice for £97k relating to NLAG share of the ICS costs in 20221/22. A copy invoice has been sent and is expected to be paid shortly. York have paid £0.5m on 1st June 22 so will reduce some of the over 90 days balance. The main issue relates to Radiology services and is being worked through. Alliance have confirmed they will pay the outstanding balance week commencing 20th June 22. East Riding Fertility, Fresenius, Crawford and GE Healthcare have all been chased for an update on when payment will be made.

5. Recommendations

The Trust Board is asked to note the following:

e) The agreement to submit a balanced ICB plan, with each organisation within the ICB also showing a balanced position, through funding smoothing adjustments.

f) The reported deficit of £0.4m at month 2, which is £0.8m away from plan chiefly driven by unidentified CRES.

g) The risk on elective recovery income if value of activity is below plan and NHSEI enact the clawback.

h) The need to increase in-house productivity and to continue to identify CRES opportunities to reduce the unidentified balance.

i) The underlying deficit of £41.4m

Stephen Evans
Deputy Director of Finance
June 2022

APPENDIX 1

Financial Year 2023 Month 2

	Annual Budget £000	Budget £000	Actual £000	Variance £000
Nhs Contract Income	650,852	108,666	108,674	8
ERF income	19,718	3,286	3,286	(0)
Nhs Other Clinical Income	209	35	39	4
Education + Training Income	21,138	3,523	3,521	(2)
Other Income	12,780	387	456	69
Total Income	**704,697**	**115,897**	**115,976**	**79**
Surgery	(143,492)	(24,232)	(24,959)	(727)
Medicine	(86,896)	(14,733)	(14,889)	(156)
Clinical Support Services	(97,387)	(16,442)	(16,813)	(371)
Pass Through Drugs	(68,159)	(11,360)	(11,339)	21
Family + Womens Health	(86,020)	(14,740)	(15,063)	(323)
Corporate Directorates	(76,842)	(12,969)	(13,030)	(60)
Reserves	(23,417)	(2,595)	(1,746)	849
Other Operating Expenditure	(6,475)	(1,078)	(1,070)	8
Emergency Care Health Group	(18,428)	(2,991)	(2,927)	64
Estates Facilities & Developmt	(51,688)	(8,450)	(8,790)	(339)
Total Operating Expenditure	**(658,804)**	**(109,590)**	**(110,626)**	**(1,034)**
Donated Asset Income	(10,460)	0	0	0
EBITDA	**35,433**	**6,307**	**5,350**	**(955)**
Depreciation	(22,161)	(3,688)	(3,695)	(7)
Interest Payable	(6,235)	(1,027)	(1,027)	0
Interest Receivable	17	3	94	92
Pdc Dividends	(8,195)	(1,366)	(1,366)	0
Total Non Operating Expenditure	**(36,574)**	**(6,078)**	**(5,994)**	**85**
Net Surplus/Deficit	**9,320**	**227**	**(644)**	**(870)**
Donated Asset Adjustment (NEW)	(9,320)	190	232	40
Adjusted Financial Performance before Profit/Lo	**0**	**417**	**(412)**	**(830)**
Profit/Loss Disposal Assets Adjustment	0	0	0	0
Adjusted Financial Performance Surplus/Deficit	**0**	**417**	**(412)**	**(830)**

Report to the Board in Public
Performance and Finance Committee
June 2022

Item: Board Assurance Framework	Level of assurance gained: Limited

The committee agreed the 2022/23 proposal;

- Discussions were held over the future plans for replacement of core structure and the risks to the future capital programme.
- Agreement was made to divide BAF 7.3 to reflect the future capital programme
- Current capital programme would be added to the Corporate Risk Register
- BAF 4 to capture the residual impact of covid.

Item: Performance Report	Level of assurance gained: Limited

The performance report was provided in the new format and covered the key performance areas;

- Urgent care performance remains fairly static. The different types of reported activity was explained and comparable figures from other organisations discussed.
- Ambulance handover and ED performance are still significant issues. A workshop was held in June with senior clinical staff and managers with a view to implement changes in the way the ground floor works through July.
- System capacity remains a challenge with a fairly static high number of no criteria to reside patients impacting increased length of stay and occupancy levels.
- Following the national change in standards we continue to see a rise in 12 hour waits, these are now reported from arrival in ED.
- Waiting lists continue to increase with a sustained increase in referrals seen.
- Mutual aid continues and 104 weeks waits were predicted to be no more than 74 at the end of June with expectations to be around 50. Teams were congratulated on the hard work so far to reduce numbers.
- Validation work is completed, with data management commended within the Trust.
- Work to increase non face to face consultations continues as this has dropped following the end of lockdown.
- Cancer waiting list continues to reduce, but is still above sustainable levels.
- Work to reduce follow-ups and increase patient initiated follow-ups across outpatients continues.

Item: Screening Programme Update	Level of assurance gained: N/A

Report was provided to the committee as a quarterly update on the Trust's screening programmes which are public health funded and were suspended during covid. The report covered;

- Humberside Diabetic Eye Screening
- Humberside Breast Screening
- Humber & Yorkshire Coast Bowel Cancer Screening
- North Yorkshire and Humber AAA Screening

Item: Finance Report	Level of assurance gained: Limited

Following the submission of the financial plan, the ICB had identified additional funds, which has been distributed between organisations to ensure a break even position for all Trusts within the ICB.

- Following the submission of the financial plan, funding was subsequently reviewed and released and smoothing adjustments made across the ICS to ensure that all organisations within the ICB would balance.
- The reported deficit of £0.4m at month 2, which is £0.8m away from plan chiefly driven by unidentified CRES.
- The capital, cash and stock position for the organisation was also discussed.

- Level of debtors remain the same although should start to see an improvement as some of the issues have been resolved.
- The underlying deficit remains a concern.

Item: CRES Delivery 2022/23	Level of assurance gained: Limited

The committee received a breakdown in cost savings identified along with areas in which cost savings were still required to be identified.

- Cost savings were being seen following the installation of the solar panels and this would be a recurrent cost saving and further energy savings were planned.
- It was noted that cost savings would be a challenge without being able to reduce our length of stay.

Item: Licensing Costs Paper	Level of assurance gained: N/A

The licencing costs paper was presented following a request by the committee. Last year when the contract for licensing costs was submitted it was noted that it had increased substantially.

- Microsoft is embedded within the organisation and needs to remain.
- The option presented to the committee was to renew the licences again this year whilst scoping transition to Microsoft 365 through the national procurement.

The following reports were shared for information:

- Capital Resource Allocation Committee Minutes

The following contracts were approved;

- Contract Recommendation Paper For Supply Of Endoscopy Consumables
- HEY/20/263 - Contract Extension Recommendation Paper For The Supply Of Products For The Treatment of Haemophilia A

Report to the Board in Public
Performance and Finance Committee
May 2022

Item: Performance Report	Level of assurance gained: Limited
The Committee agreed limited assurance due to the underperformance; however, the committee was clear on the mitigations and acknowledged the work being undertaken to improve the position.	
Item: Finance Report	Level of assurance gained: Limited
Mr Robson confirmed the committee had limited assurance, although acknowledged the progress in reducing the deficit.	
Item: CRES Delivery 2022/23	Level of assurance gained: Limited
Mr Robson confirmed the committee had limited assurance. There were some challenges across the health groups in identifying efficiencies that they are working through, and that some efficiencies identified as we progressed through the year would start being seen.	
The following presentation was shared with the committee for information; • Outpatients	
The following contracts were approved; • Recommendation Paper for the Provision of Service Maintenance for Scopes and Associated Equipment • The Supply of Infusion Pumps & Associated Consumables	