Trust Board in Public
Tuesday 8 November 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 previous meeting** **4.1 Minutes of the meeting held 13 September/11 October 2022** Sean Lyons, Chair	Approval		Attached
	4.2 Board Work Programme 2022/23 Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.3 Board Development Framework Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.4 Matters Arising Sean Lyons, Chair			Verbal
	4.5 Action Tracker Sean Lyons, Chair	Approval		Attached
	Patient Story			
5	**Patient Story** Makani Purva, Chief Medical Officer	Assurance	09.10	Verbal
	Governance			
6	**6.1 CEO Report/Covid Update** Chris Long, Chief Executive Officer	Assurance	09.20	Attached
	6.2 Committee in Common Committee Summary Sean Lyons, Chairman	Assurance		Attached
	6.3 Standing Orders Report Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	6.4 Board Assurance Framework Q2 Suzanne Rostron, Director of Quality Governance	Approval		Attached
	6.5 Collaboration of Acute Providers Paper Suzanne Rostron, Director of Quality Governance	Assurance		Attached
	6.6 EPRR Annual Assurance Michelle Cady, Director of Strategy and Planning	Assurance		Attached
	Strategy			
7	**Estates Update** Alex Best, Head of Estates and Facilities	Assurance	09.40	Presentation
	Quality			
8	**8.1 Quality Report** Jo Ledger, Acting Chief Nurse/Makani Purva, Chief Medical Officer/Suzanne Rostron, Director of Quality Governance **8.1.1 Maternity Update** Lorraine Cooper, Head of Midwifery	Assurance Assurance	09.55	Attached Attached

	8.2 Summary from the Quality Committee David Hughes, Quality Chair	Assurance		Attached
	Break		10.45	
	Workforce			
9	**9.1 Our People Report** Simon Nearney, Director of Workforce and OD **9.2 Summary from the Workforce, Education and Culture Committee** Una Macleod, Chair of Workforce, Education and Culture Committee **9.2.1 Responsible Officer Report** Makani Purva, Chief Medical Officer **9.2.2 Guardian of Safe Working Q1 Report** Makani Purva, Chief Medical Officer **9.3 Freedom to Speak Up Report for Q2** Fran Moverley, Head of Freedom to Speak Up	Assurance Assurance Approval Assurance Assurance	11.00	Attached Verbal Attached Attached Attached
	Performance			
10	**Performance Report** Ellen Ryabov, Chief Operating Officer **10.1 Finance Report** Lee Bond, Chief Financial Officer **10.2 End of Life Care Annual Report** Julie Watson, Macmillan Lead Cancer Nurse HUTH/Interim Lead cancer Nurse NLAG	Assurance Assurance Assurance	11.15	Attached Attached Attached
	10.3 Summary from the Performance and Finance Committee Mike Robson, Chair of Performance and Finance	Assurance		Attached
	10.4 – Tier 1 and Tier Elective Recovery Programme – Board Self Certification Ellen Ryabov, Chief Operating Officer	Approval		Attached
11	**Questions from the public relating to today's agenda** Sean Lyons, Chair		11.55	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 14 February 2022, 9am – 12pm			Verbal

Attendance 2022/23

Name	10/	16/06	12/07	03/08	13/09	11/10	18/10	08/11	14/2	14/03	Total

	5										
Sean Lyons	✓	✓	✓	✓	✓	✓					6/6
S Hall	✓	✓	✓	✓	✓	✓					6/6
T Christmas	✓	✓	✓	x	x	✓					4/6
T Curry	✓	x	✓	✓	✓	✓					5/6
U MacLeod	x	✓	✓	✓	✓	✓					5/6
M Robson	✓	✓	✓	✓	✓	✓					6/6
L Jackson	x	x	x	✓	x	✓					2/6
A Pathak	x	✓	✓	✓	✓	x					4/6
D Hughes	✓	✓	x	✓	✓	✓					5/6
C Long	✓	✓	✓	✓	x	✓					5/6
L Bond	✓	✓	✓	✓	✓	x					5/6
M Purva	✓	x	✓	✓	✓	✓					5/6
J Ledger	✓	✓	✓	✓	x	✓					5/6
S Nearney	✓	✓	✓	✓	✓	✓					6/6
E Ryabov	✓	✓	x	✓	✓	x					4/6
M Cady	✓	✓	✓	✓	✓	x					5/6
S Rostron	✓	✓	✓	✓	✓	✓					6/6
S McMahon	✓	x	✓	✓	✓	✓					5/6
R Thompson	✓	✓	✓	✓	✓	✓					6/6

Attendance 2021/22

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

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board meeting
Held on 13 September 2022

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice Chair
	Mr T Curry	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Dr D Hughes	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mr L Bond	Acting Chief Executive Officer/Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Prof M Purva	Chief Medical Officer
	Mrs S McMahon	Joint Chief Information Officer
	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 L Cooper	Head of Midwifery
	Mr D Taylor	Director of Estates and Facilities
	Ms K Rudston	Assistant Chief Nurse
	Ms F Moverley	Head of Freedom to Speak Up
	Mrs R Thompson	Head of Corporate Affairs (minutes)

No	Item	Action
1	**Apologies and Welcome:** Apologies were received from Mr C Long, Chief Executive Office, Mrs J Ledger, Interim Chief Nurse, Mrs T Christmas, Non-Executive Director and Mrs L Jackson, Associate Non-Executive Director	
2	Mr Lyons welcomed everyone to the Board meeting. He asked the Board to observe a 1 minute's silence due to the Queen's passing. He stated that she had set a tremendous example to all and the silence would give time to admire and reflect on her reign. Mr Lyons also welcomed Jessica Haslam and Natasha Abbas (Leadership Fellows) to the meeting.	
3	**Declarations of Interest** **3.1 Changes to Directors' interests since the last meeting** There were no declarations made. **3.2 To consider any conflicts of interest arising from this agenda** There were no conflicts raised.	
4	**Minutes of the previous meeting** **4.1 Minutes of the meeting held 12 July 2022** 6.2 Audit Committee Summary – Mr Bond clarified that the closing stock was from the previous year. Following this change the minutes were approved as an accurate record.	

4.2 Board Work Programme
The Board received the Work Programme.

4.3 Board Development Framework
Mrs Thompson advised that Patient Safety would be added to the December 2022 session. **RT**

4.4 Matters Arising
There were no matters arising from the minutes.

4.5 Action Tracker
The action tracker was reviewed by the Board. All items were on track or completed.

5 Patient Story
Prof Purva introduced the item and advised that the story focussed around the Lung Cancer Health Check service. The patient shared his story regarding the experience he had which was very positive and timely. The only issue raised was regarding obtaining a GP appointment. The patient spoke of his tumour removal by keyhole surgery and how his treatment could not have been better.

The Board discussed the financial constraints of the service and the advantages of the early detection of cancers. The unit was mobile so it could be located in different areas helping with patient attendances.

Mrs Cady advised that she was very proud of the programme which was supported using the latest AI technology. Mr Lyons was hoping that the ICB and the new statutory powers would give more flexibility when setting up health screening programmes in the future.

6 6.1 Chief Executive Officer Report
Mr Bond presented the report and highlighted Lee Ellerker and Dr Andrzej Frygier who were raising money for the Hull 4 Ukraine project.

Mr Bond reported that the Lung Health Check was moving to East Hull and that the organisation had been shortlisted for a 'Towards Net Zero' award.

Prof Andy Beavis had been presented with an honorary degree due to his work in influencing national policy and playing a key role in the future direction of radiotherapy treatment.

6.2 Audit Committee Summary
Mr Robson presented the summary as he chaired the July meeting. He advised that the majority of audits had been given reasonable assurance but there were concerns regarding the Junior Doctor rotas and the Linen Contract.

The Board discussed e-rostering and the difficulties around standardising it. Dr Pathak suggested using middle grade doctors to fill some of the gaps. Mr Nearney advised that the Junior Doctor fill rate was at 96% and work was ongoing with India and Pakistan to recruit new doctors.

6.3 Summary from the Charitable Funds Committee

Mr Curry presented the summary and advised that the majority of the funds had now been transferred to the Wishh Charity and the only funds left were large legacies. Mr Bond advised that work was ongoing with the services to review slow moving balances and how they could be put to best use.

6.4 Standing Orders Report
Mrs Thompson presented the report and highlighted the use of the Trust Seal, a change in the scheme of delegation to allow Mr Bond to sign CNST invoices up to £2.5m and the updated OJEU thresholds.

Resolved: The Board approved the retrospective use of the Trust seal, the change to the scheme of delegation and the updated OJEU thresholds.

The agenda was taken out of order at this point

8 8.1 Quality Report
Mrs Rostron presented the report and advised that there had been 6 Never Events to date, but the majority of them had not caused patient harm. A consultant learning event had been organised to share their experiences and this had been successful with 180 people attending.

The new Patient Safety Incident Reporting Framework, improvement month and Surgery Safer September were all new initiatives to ensure learning was captured and rapidly embedded.

Prof Purva and a team of staff had visited Liverpool to review their SHMI and their approach to the management of Sepsis. It was found that the digital solution being used was key and was available to Trust's across the Country. It was important to understand the financial implications and overall awareness linked to sepsis was robust. Mrs McMahon advised that it was advantageous to review whole pathways strategically from a digital point of view rather than just the gaps.

Mrs Rostron reported that a review of the Complaints service would be carried out to look at the challenges and pressures and if anything could be improved or done differently. She added that the ED complaint figures were 1 in 1000 patients which was very positive.

QSIR training had commenced as well as a Think Tank initiative to capture staff ideas. There had been 135 ideas received to date. Greatix had also been re-launched to recognise staff idea and any learning.

8.2 Maternity Update
Mrs Cooper presented a number of papers relating to maternity.

Avoiding Term Admission into Neonatal Units
The current position for Q1 is 2.6% which is a positive position but work in ongoing to reduce this further.

CNST - Saving Babies Lives Care Bundle
Mrs Cooper stated that the Trust was achieving all 5 standards.

CNST Maternity Incentive Scheme – Year 4
Mrs Cooper advised that the Trust had a fortnightly working group in place to address the training compliance and workforce issues. She advised that there was a comprehensive plan in place for recruitment.

Continuity of Carer
Mrs Cooper advised that work was ongoing to review the programme and it was the view that this would become the default model for all women. Staffing levels and the cost of uplifting staff was being reviewed. Mr Bond advised that this would mean a significant increase in establishment and there had been no further investment yet from Ockenden 2. Mrs Cooper advised that it would be a phased approach aiming to have 2/4 teams ready at the end of next year. Mrs Ryabov added that safe staffing and not putting other services at risk was key.

Ockenden Update
Mrs Cooper advised that the Trust was in a good position with work ongoing regarding audit compliance and digital solutions. Good progress was being made against the 15 actions. Mrs Cooper shared the action plan and progress as part of the report.

CNST – Perinatal Mortality Review Tool/Perinatal Quality Surveillance Tool
Mrs Cooper spoke of 2 cases which resulted in hysterectomies although there were no common themes or a direct link. She added that the team did a great job managing the cases. The Trust was 100% compliant with the standard in Q1.

8.2 End of Life Care Report
The End of Life Care Annual report was deferred to the November meeting.

Ms Rudston jointed the meeting

8.3 Safeguarding Adults and Children Annual Reports
Ms Rudston presented the reports and advised that the small team had been challenged due to Covid from a workforce perspective, but had continued to provide the service well.

Safeguarding Adults – Achievements of the last year included good training compliance, work to introduce community training relating to domestic abuse and working closely with the Police. A mental capacity advocate had been appointed and was working with the Court of Protection cases.

The internal auditors would be reviewing mental health and mental capacity. Mr Hall asked how the Trust was interacting with Humber and Ms Rudston advised that there were good links with the Hull Community Safety Partnership and that she was pushing for a similar model in the East Riding.

Safeguarding Children – Ms Rudston reported that the Trust was compliant in the named roles. The objectives for next year included reviewing the mental health restraint of children and increased referrals

due to the cost of living and cases of neglect.

Mrs Rostron advised that mental health and suicides were increasing and domestic abuse continues to soar. Mr Hall asked if the team had support as they were dealing with very difficult cases and Ms Rudston advised that the role was very difficult and it required positive and resilient people.

Ms Rudston left the meeting

8.4 Summary from the Quality Committee
Mr Hall presented the summary. He advised that the Committee discussed the SHMI, the risks around Sepsis and the number of complaints and extra resources required.

Ms Moverley joined the meeting
9.5 Freedom to Speak Up
Ms Moverley presented her report to the Board and highlighted that she had received 22 contacts in Q1 compared to 6 last year. The common reason was inappropriate behaviours but there was also an increase in Health and Safety issues.

The increase in numbers showed that word was getting out regarding the role and it was positive that staff were coming forward.

Mrs Moverley also advised that the Champions Network was being established and training sessions were in place.

Mrs Ryabov asked what normal looked like and how the Trust compared nationally. Ms Moverley agreed to check this with a similar sized Trust. Mrs Rostron advised caution as some Trusts may have similar numbers but bigger issues.

Mr Hall asked about staff awareness and Ms Moverley advised that she was preparing posters to place around the Trust to compliment the information on the intranet.

Mrs Moverley left the meeting
The agenda returned to order at this point

7 **7.1 Trust Strategy Update**
Mrs Cady presented the update and advised that good progress was being made against the delivery framework. Each member of the Executive Team has a number of areas they are responsible for.

Work was already progressing around Quality Improvement, staff wellbeing and the Acute developments. There had been a change in leadership for the digital objectives from Mr Bond to Mrs McMahon. There had also been environmental progress relating to Zero 30.

Mr Robson asked if progress could be added to a gantt chart to show delivery timescales and Mrs Cady agreed to review this. MC

The Board discussed capital developments and how big business cases and strategic ambitions would be approved within the new ICS. Mr Lyons expressed his concern that the process for approving capital funding was

not emerging.

Action: Mr Bond agreed to raise the issue at the ICB relating to capital funding. LB

7.2 Equality Objectives
The paper had already been received by the Board at the July 2022 meeting.

9 **9.1 Our People Report**
Mr Nearney presented the report and advised that sickness was at 5% and the vacancy rate was at 4.2%.

The Southbank payroll team had joined the Trust's management team and work was ongoing to provide a joint service.

The Covid vaccination programme had been put back due to lack of stock and there was no final date for the Flu vaccination as yet.

There had been 300 managers attend the Executive Briefing relating to people and culture management and staff wellbeing plans were working well.

The Golden Hearts Awards were being held on 30 September 2022 and the EDI Team have launched their rainbow badge initiative.

Mr Hall asked about the pay increase and the A4C pension contributions and Mr Nearney advised that all staff affected would be offered a cash advance to be paid back monthly. Mr Nearney also mentioned the cost of living crisis and the Trust's ideas to provide a food bank, a swap shop and school uniform swaps.

Mr Nearney presented a number of reports for approval by the Board
9.2 Workforce Race Equality Standards
Resolved: The Board approved the report

9.3 Workforce Disability Equality Standards
Resolved: The Board approved the report

9.4 Modern Slavery Report
Resolved: The Board approved the report

9.5 Summary from the Workforce, Education and Culture Committee
Prof Macleod presented the summary and highlighted Talent Management being a challenging opportunity and that the Committee was assured by the People Management discussions held.

Mr Taylor joined the meeting

10 **Performance Report**
Mrs Ryabov presented the report and advised that the 4 hour performance was stable but still poor. She advised that there were a lot more patients staying longer and more patients with high acuity in ED which had led to several incidents.

Mrs Ryabov spoke about the impact on staff after the pandemic and their level of resilience.

Ambulance handover times were increasing but were lower than other Trusts. 12 hour trolley waits were not measured from arrival, there had been 458 in July with the longest wait being 25 hours.

Patients with 'no criteria to reside' ranged from 150 – 180 and the system was not moving as quickly as it should. Work was ongoing with the wider system to try to address the issues.

With regards to RTT Mrs Ryabov had met with Jim Mackey and the Elective Recovery Board. She had presented an overview of HUTH's system deprivation and the types of care delivered. The waiting list continued to grow and there were ITU capacity problems due to levels of sickness in the department. Mrs Ryabov added that referrals had not increased in a major way.

Mrs Ryabov was hopeful that the Trust would get into tier 2 for Cancer due to improved performance and robust planning. Colorectomy, skin, gynae and Cardiology were still challenging and the main areas of concern.

Mr Curry asked about the ground floor pilot and Mrs Ryabov advised that senior decision making, emphasis on non-admission and ensuring correct patient flow was key.

The Board discussed the prognosis of ED performance and Mr Robson advised that he had visited ED yesterday morning and spoken to staff. Processes and pathways were in place but it was taking a long time to move patients on. He was impressed with the doctor triage at the front end, but patients were still waiting 9 hours to be seen. He added that it felt in control and no patients were being misplaced.

Mr Robson had also visited Ward 20 at Castle Hill which was the 'no criteria to reside' ward. He reported that staff were more optimistic as their relationship with social care had improved. Staff were, however, fearful of winter pressures.

Mrs Cady advised that the risk around severe capacity pressures during the winter months was being reviewed and the winter plan would be presented to the Executive Management Board and Performance and Finance at the end of September. She added that drastic measures may need to be taken if nothing changes and it may mean direct contracting with homecare providers. Mr Bond added that challenge had been put in to the local authorities and the Trust was awaiting a response.

Mrs McMahon asked what the role of the ICS and ICB were in putting pressure on the Councils so that all options could be explored.

10.1 Finance Report
Mr Bond advised that the deficit at month 5 was £1.2m which was an improvement on month 4.

There was still a circa £7m risk at year-end which included work with the

independent sector (activity being higher than the original plan), unidentified CRES and bed pressures. Other areas were catering, car-parking and private patients.

The Trust has received £10m from the elective recovery fund and there is a threat that this will be clawed back in the 2nd half of the year. There was still pressure on the Health Groups mainly around Junior Doctor management, bed pressures, drugs and radiology (particularly CT).

Mr Bond advised that he was still forecasting to break-even by the end of the year.

Mr Bond advised that 2 further scanners (MRI and CT) had been leased for mobile work in the East Riding. A speculative bid for a gamma camera was available if the money could be spent in year.

The Day Surgery scheme was awaiting regional assessment and queries were expected in the next 2 weeks.

10.1.1 Premises Assurances Model
Mr Taylor presented the report to the Board and advised that the self assessment scores had dipped in the last year. The self assessment tool was an honest reflection and submission to the centre was required.

Resolved: The Board approved submission to the centre.

Mr Taylor left the meeting

10.2 Summary of the Performance and Finance Committee
Mr Robson advised that the assurance levels for performance and finance were still limited due to the performance levels and risks to delivery.

11 Questions from the public relating to today's agenda
There were no questions asked.

12 Chairman's Summary of the meeting

13 Any other Business
Mrs Cady advised that the Trust Strategy would be received in September and March and that the EPRR and Winter plans would be received in October 2022.

14 Date and time of the next meeting:
Tuesday 8 November 2022, 9am – 12pm

Hull University Teaching Hospitals NHS Trust
Minutes of the Board Meeting
Held on 11 October 2022

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice Chair
	Dr D Hughes	Non-Executive Director
	Mrs J Ledger	Interim Chief Nurse
	Mr C Long	Chief Executive Officer
	Mr P Walker	Deputy Chief Operating Officer
	Prof M Purva	Chief Medical Officer
	Mrs S Rostron	Director of Quality Governance
	Prof U Macleod	Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mrs S McMahon	Joint Chief Information Officer
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
In attendance:	Mrs J Railton	Deputy Director of Strategy and Planning
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

1 Apologies

Apologies were received from Mr L Bond, Chief Financial Officer, Dr A Pathak, Non-Executive Director, Mrs M Cady, Director of Strategy and Planning and Mrs E Ryabov, Chief Operating Officer

2 Declarations of interest

There were no declarations of interest received.

3 EPRR Approval

Mrs Railton presented the statutory annual assurance process and advised that the core standards had changed again. A peer review was scheduled for 14 October 2022 and a confirm and challenge session set with the Local Health Resilience Partnership.

Out of the 64 standards the Trust was fully compliant with 57 and partially compliant with 7. Evacuation and shelter arrangements were being reviewed as was risks around oxygen supplies.

There had been national changes regarding command and control training for on-call staff so this training had commenced. Also an audit of EPRR training was being carried out to ensure all on-call staff have the relevant training, including communications and social media training.

On-call arrangements were being considered in relation to loggists as 24hr access was required.

Work was also ongoing to review and update SITREP reports.

Mrs Railton also mentioned the Data Protection Tool-kit, business continuity particularly following the latest Lorenzo outage and the requirement to be compliant in these areas.
The EPRR action plan was in place to address the partially compliant actions.

Mr Curry asked about the Data Protection compliance and Mrs Railton advised that regulations had changed in year so the Trust was ensuring

actions and evidence was up to date.

Mrs McMahon reported that cyber security and digital system down-time needed robust plans in place to ensure systems were up and running quickly and working correctly.

Mr Lyons asked if EPRR risks were on a risk register and Mrs Railton advised that they were an monitored at the Non-Clinical Quality Committee.

Resolved: The Board endorsed the findings of the EPRR self-assessment, agreed the action plan and approved the ratings presented.

4 Winter Plan 2022/23 Approval

Mrs Railton presented the Winter Plan 2022/23 which had already been to the Performance and Finance Committee for endorsement. She advised that the document was live and was evolving due to Covid and flu numbers as well as other respiratory viruses. The plan was based on the Health and Social Care planning principles.

The Trust had been given non-recurrent funding for 6 months and 2 'no criteria to reside' wards had been identified giving an additional 45 beds. This would mean a full establishment and staff being put back to their original areas.

Funding had also been received for an inpatient Frailty Team who's expertise could reduce patient's length of stay.

Priority 1 bids had been reviewed and additional HCA's will be added to ED and ambulance areas to support staff.

Impact statements had been received from the Health Groups and the surge plan was in place and had already been used. Other areas included in the plan were; escalation plan, changes in the vaccination policy and increasing 7 day services to cope with demand. The Winter planning and delivery group was in place to monitor delivery.

Mrs Railton also stated that business continuity plans were in place due to the issues around electricity/gas/fuel supplies. Mr Lyons asked about 'black outs' and how the Trust was prepared for them and Mrs Railton advised that further generator tests would be carried out.

Mr Robson advised that the Performance and Finance Committee had endorsed the plan for approval by the Board. Mr Robson added that the Trust was working to capacity and working with system partners was key.

Resolved: The Board approved the Winter Plan 2022/23

5 Date and time of the next meeting:

Tuesday 13 December 2022, 9am – 12pm

Item	Sponsor	Lead	Jan	Mar	May	EO June	Jul	Sept	Nov	Fequency	Purpose of the report	Considered by another Committee	Why is this report required to go to Trust Board	Action
Opening Items														
Declarations of Interest	Chair	Chair	✓	✓	✓	✓	✓	✓	✓	Every Board Meeting	To declare any interests the Board may have	No	Statutory	Nothing
Minutes of the last meeting	Chair	Chair	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure an accurate record of the meeting is kept	No	Statutory	Nothing
Action Tracker	Chair	Chair	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure actions are completed	No	Statutory	Nothing
Trust Board work programme	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure all statutory items are received	No	Statutory	Nothing
Trust Board Development Framework	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To aprise the Board of future Development sessions	No	Statutory	Nothing
Chief Executive Briefing	Chief Executive	Chief Executive	✓	✓	✓		✓	✓	✓	Every Board Meeting	To update Board members on Trustwide matters	No	The report covers a wider remit of what is happening around the Trust and the wider health economy	Nothing
Regulatory, Compliance and Corporate Governance														
Board Assurance Framework and Corporate Risk Register	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓		✓	Three times per year	To receive assurance in relation to the management and mitigation of the risks as 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
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	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					Health Inequalities				Dementia Update
13 December 2022				Patient Safety IPC End of Life Care			BAF 6: Research and Innovation		
April 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 (November 2022)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
September 2022						
01.09	Trust Strategy Update	Gantt chart to show delivery timescales to be presented with the next Strategy update	MC	March 2022		
02.09		Capital development and business case approval - ICS process – Mr Bond to raise and clarify	LB	November 2022		
COMPLETED						
01.07	Board Work Programme	Health Inequalities to be added to the Board Development programme	RT	October 2022		On programme
02.07	Covid Update	Winter pressures to be discussed at August Board Development session	RT	August 2022		Discussed
03.07	Board and Committee Review	Board and Committees to be removed from January/August 2023 – Terms of reference to be changed	RT	November 2022		
04.07	Trade Union Facility Time reporting	Approved reported to be published on the Trust's website	SN	July 2022		Completed
05.07	Performance and Finance Summary	BAF assurance to be changed to reasonable	RT	July 2022		Completed

Actions referred to other Committees

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

Hull University Teaching Hospitals NHS Trust

Trust Board

9th NOVEMBER 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:	Group structure engagement, extended stroke service, national awards for Zero30 and RSV research project	

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 9 NOVEMBER 2022

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

Priority areas 2021-2025:
- Compassionate care of patients and staff
- Equality, diversity and inclusion
- Research, development and innovation
- Sustainability – Zero30

1. KEY MESSAGES FROM JULY/AUGUST 2022

COMPASSIONATE CARE

Group Structure Proposal

HUTH and NLaG have a strong track record of working together to ensure the stability and sustainability of clinical services. Most recently we have seen this in our region-wide Integrated Care System Humber Acute Services (HAS) programme, which aims to transform the way we deliver acute hospital services.

The boards of both trusts are keen to extend and enhance this partnership more formally and have developed a proposal that will deliver significant benefits for both organisations, staff and, most importantly, patients across the Humber region.

We want to develop a group leadership model for our hospitals, where both trusts maintain their individual sovereignty. This means we would continue to have separate boards, CQC registrations, financial accounts and accountability for performance but we would have shared governance and a single executive team, with one Joint Group Chief Executive, leading both organisations. This is a model, which is being adopted across the country, it has the backing of our regulators and we believe that this is a good way to maximise the benefits of joint working.

For the past three weeks we have been engaging with key stakeholders to get their feedback on the proposals.

Life-Saving Service Extended To Help More Patients Having Strokes

The Trust has been offering a Regional Mechanical Thrombectomy Service to patients since 2018 at its Comprehensive Stroke Centre, based at Hull Royal Infirmary.

This year, on Stroke Awareness Day (27th October) we announced that the service would be extended to run from 8am to 8pm, Monday to Friday, to help more patients.

Patients having strokes are "blue lighted" by ambulance from all over North and East Yorkshire and North Lincolnshire for minimally invasive Mechanical Thrombectomy in the Interventional Radiology Theatres.

Performed under local anaesthesia or sedation, the Interventional Radiology team gains access to the blocked artery in the brain via a small puncture made in an artery in the groin or arm. Various devices known as guide wires, catheters, stent retrievers and suction devices are used to remove the blood clot and restore blood flow to the affected part of the

brain thus enabling patients to recover mobility, speech and other faculties damaged by an acute ischaemic stroke.

Improvements can be dramatic, Mechanical Thrombectomy has been called a “Lazarus procedure” because of its ability to reduce the risk of long-term disability or death.

The long-term aim is to extend the service to weekends before rolling it out to 24/7.

ZERO30

National Recognition For Zero30 Project

The Trust is a finalist in two national awards for a project to help staff travel to work.

The Trust launched its Getting to Work project in May as part of its Zero Thirty campaign to tackle climate change, introducing three free park-and-ride services and discounted bus and rail travel for staff.

HUTH has also worked with East Riding of Yorkshire Council to host regular cycling events such as “Be Safe, Be Seen” events, safer route planning and tips on security to encourage staff to leave their cars and cycle to work.

Now, we have been named finalists in two awards – Business Engagement Project of the Year for its Getting to Work project and Best Project Under £1000 for an event run with East Riding of Yorkshire Council to offer staff the chance to try an e-bike.

The national awards are run by Modeshift, the UK’s leading sustainable transport organization, and the winners will be announced at a black tie event in Leicester on Thursday.

RESEARCH DEVELOPMENT AND INNOVATION

Hull Team Leads Study To Reduce Serious Illness In Babies

A research team from Hull is taking part in an international study that investigates whether it’s possible to reduce the chance of babies becoming seriously unwell with Respiratory Syncytial Virus.

Commonly known as RSV, this common virus causes cold-like symptoms in older children and adults, but can cause inflammation in the lower airways (bronchiolitis) in babies, which makes them short of breath. They can also have difficulties feeding and develop a rattly cough and /or wheezing.

Many areas of the country saw a notable rise in RSV associated hospitalisations of babies and children last year, thought to be linked to restrictions put in place to limit the spread of Covid-19. Fewer infections in young people meant they were unable to build up as much immunity, leaving them more susceptible to viruses such as RSV, and this may still be the case to some extent this year.

In Hull, doctors normally expect to see over 130 children hospitalised with RSV each year during the winter months.

Through the HARMONIE study, a dedicated paediatric research team from our Trust is now assessing the benefits of giving a drug – called Nirsevimab – to healthy babies aged under 1 year during the winter, when RSV is most common.

Study To Assess Alcohol Habits Before, During And After Pregnancy
Our maternity department is working in alliance with the University of Hull's research department to support midwives in their efforts to assess alcohol habits before, during and after pregnancy. The research study is called the CHAMPION study.

Some women attending antenatal appointments are being asked to complete a short questionnaire asking about their alcohol habits. They complete the questionnaire with their midwife at the appointment.

The questionnaire will go to our research midwife who is inputting data into a confidential database for analysis by the University's research team. This information will help the team identify any need for staff training, clinical needs (more appointment time, more staff, more resources) and any issues from the participating clinical team.

2. MEDIA/SOCIAL MEDIA ACTIVITY

In September 2022 there were 18 articles published about the Trust:

- 12 positive (67%)
- 5 neutral (28%)
- 1 negative (5%)
- 0 factual (0%)

Social media
Facebook
Total "reach" for Facebook posts on all Trust pages in September – 170,965

- Hull Women and Children's Hospital – 57,872
- Castle Hill Hospital – 58,282
- Hull Royal Infirmary – 41,678
- Hull University Teaching Hospitals NHS Trust – 13,133

Twitter @HullHospitals

- 65,800 impressions in September 2022
- 10,461 followers

Tweets with highest number of impressions related to the Trust hosting the CWIS Modern Management of Chest Wall Injury conference and the Golden Hearts Awards.

In October there were 55 articles published about the Trust:

- 40 positive (73%)
- 2 neutral (4%)
- 8 negative (14%)
- 5 factual (9%)

Social media
Facebook
Total "reach" for Facebook posts on all Trust pages in October – 204,691

- Hull Women and Children's Hospital – 61,469
- Castle Hill Hospital – 70,463
- Hull Royal Infirmary – 54,100
- Hull University Teaching Hospitals NHS Trust – 18,659

Twitter @HullHospitals

- 95,900 impressions in October 2022
- 10,521 followers

Tweets with highest number of impressions related to high levels of pressure on ED/requests to use alternatives and the extension of the regional mechanical thrombectomy service.

Report to the Board in Public
Humber Acute Services Development Committee held on 11 October 2022

Item: Director Overview Report P2/P3 Update	Level of assurance gained: Reasonable
Work was ongoing regarding the programme and changes to clinical models and the economic and social impact of moving services was being reviewed. Finance and out of hospital services were key to the programme. The consultation period would now take place in June 2022 Key risks: Loss of staff engagement and momentum due to delays and the need to sustain safe services during the next year	
Item: Integrated Care Programme Update	Level of assurance gained: Reasonable
Service strategies had been received for Haematology, Oncology , Neurology, ENT and Dermatology and were on trajectory. The Humber Neurology Service was now operational and had been taken out of the ICP programme and would be supported by the Joint Development Group. An assessment of Pharmacy home deliveries on the North and South Bank is being undertaken. Terms of Reference and governance arrangements have been agreed for the JDB.	

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	08.11.22
Title	Standing Orders				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The report was previously considered at the September 2022 Trust Board				

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

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

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders November 2022

1 Purpose of the Report

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

2 Approval of signing and sealing of documents

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

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2022/27	Hull University Teaching Hospitals NHS Trust and Compass Contract Services (UK) Ltd – Agreement for lease with landlords – refurbishment works. Ground floor premises, unit 2 and 3, HRI	21/09/22	Suzanne Rostron, Director of Quality and Governance
2022/28	Hull University Teaching Hospitals NHS Trust and WHSmith Hospitals Ltd – Licence for alterations (minor works) relating to unit 4, HRI	06/10/22	Chris Long, Chief Executive Officer/ Suzanne Rostron, Director of Quality and Governance
2022/29	Hull University Teaching Hospitals NHS Trust and WHSmith Hospitals Ltd – Lease relating to ground floor premises known as unit 4, HRI together with ancillary storage space within unit 5	06/10/22	Chris Long, Chief Executive Officer/ Suzanne Rostron, Director of Quality and Governance
2022/30	Humber NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust – Counterpart/Lease of Rights of Way, land at Willerby Hill, Willerby	18/10/22	Chris Long, Chief Executive Officer/ Suzanne Rostron, Director of Quality and Governance
2022/31	Hull University Teaching Hospitals NHS Trust and Healthcare Solutions (Hull) Ltd and Shepherd Construction Ltd – Second water mains settlement and variation agreement	18/10/22	Chris Long, Chief Executive Officer/Lee Bond, Chief Financial Officer

3 Recommendation

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Rebecca Thompson
Head of Corporate Affairs
November 2022

Agenda Item		Meeting	Trust Board	Meeting Date	08/11/22
Title	Board Assurance Framework 2022/23 Q2				
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: • Review and agree the ratings for Quarter 2.

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 Q2 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.

   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.

   The Board Assurance Framework was approved at the July 2022 Board meeting.

3. **Current Status of the Board Assurance Framework**
   An overview of the new 2022/23 Q2 Board Assurance Framework risks are highlighted in the 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
4 - Performance There is a risk to access	5x5=25	4x5=20	4x4=16	Low

Risk	Inherent Risk (L x I)	Current Risk (L x I)	Target Risk (L x I)	Risk Appetite
Trust Services following the residual impact of Covid				
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 of critical 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	4x4=16		3x4=12	
2	4x5=20	4x4=16	4x4=16		3x4=12	
3.1	4x4=16	3x4=12	3x4=12		2x4=8	
3.2	5x5=25	4x4=16	4x4=16		3x3=9	
4	5x5=25	5x4=20	5x4=20		4x4=16	
5	3x4=12	3x4=12	3x4=12		2x3=6	
6	4x4=16	3x4=12	3x4=12		2x4=8	
7.1	5x4=20	5x4=20	5x4=20		3x4=12	
7.2	4x5=20	4x5=20	4x5=20		3x5=15	
7.3	4x5=20	3x5=15	3x5=15		2x5=10	

Each of the BAF risks excluding BAF risk 5 have been discussed at the relevant Board Committees. No changes to risk ratings are recommended in this quarter. The Board is reminded that for strategic risks, it is not of concern that the risk ratings do not move in the first half of the year. Many only change in quarter 4. Assurance ratings are included in Appendix 2. 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.

New programmes for 2022/23 include Board to Ward walkrounds, Management Briefings, NED visits, re-implementation of the Greatix scheme and internal assurance programmes. The Zero Tolerance to racism policy has also been launched.
It is recommended that this risk rating remain the same.

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.

Sickness levels reported in clinical services was 7.5%, Estates 5.5% and Nursing and Midwifery 4.3% all above the Trust target.

The vacancy rate reported in October was 516.9 WTE (6.2%).

The Trust is not meeting its turnover target. In total 18.9% of all leavers left the Trust with less than 1 years' service.

It is recommended that this risk rating remain the same.

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 align with the Nursing Strategy and include collaborative working where possible. The Medical QI leads continue play a significant part in supporting improvement programmes. One of these is the work in relation to Sepsis, following a visit to Liverpool University Hospitals NHS Foundation Trust to learn from their focused work and good outcomes in this area.

In June the Trust launched its 2022-2025 Quality Strategy which outlines the Trust's direction of travel to become a regional centre of excellence and to be an overall CQC rated 'Outstanding' organisation by 2026.

There are new Quality Improvement Programmes relating to Falls, Pressure Ulcers and Antimicrobial Stewardship as part of the Quality Strategy.

The Trust is in a strong position in its preparation for implementing the Patient Safety Incident Response Framework, which was published in August 2022. Training has been commissioned and new tools are being developed and trialed to promote earlier improvements following patient safety events.

It is recommended that this risk rating remain the same.

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 how ICB governance processes can replace the enhanced surveillance measures introduced in 2021.

There have been 6 Never Events to date. The Serious Incident backlog has almost been cleared with around 12 incidents older than 100 days at the end of Quarter 2. The open SIs have reduced from over hundred in March 2022 to 37 now, which is a manageable case load. Never Events investigations have all been completed in line with guidance, with on investigation concluded within 5 days and another within 12. These have all been chaired by the Chief Medical Officer using clinical simulation to positively engage those involved in the incident.
There has been an increase in Serious Incidents in the emergency department due to poor patient flow. Ambulance handovers continue to be challenged which also increases risk to patients both in and out of hospital. The patients with 'no criteria to reside' continue to be between 170-200 patients, which directly impacts on the ability to provide harm free care.

The 104 week wait patients have dramatically reduced and work is ongoing to reduce long waiters further. Patients with 'no criteria to reside' remains an issue and a priority for the Trust.

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.

The revised position for August 2022 was 16 breaches of the 104-week target after validation. The September position was improved again with only orthodontic patients remaining which is a national issue.

Enhanced internal governance processes continue to support the daily monitoring against the trajectories and on-going work to identify capacity internally, add capacity alerts (to reduce GP referrals) to a number of very pressured specialities and seek/take up offers of mutual aid from other providers.

The ambulance handover position remains challenged with high numbers of lodged patients within ED.

The Trust's performance regarding the 62 day treatment pathways is much improved and NHS E have rated it as a lower risk as part of their assurance process.

Although the excellent work relating to the 104 week waits should be noted it is recommended that the risk rating remain the same.

BAF 5 – Partnerships
An ICS Emergency Care summit had been held and well attended by acute and community partners. The four key themes discussed were avoiding ambulance conveyances, avoiding hospital admissions, well managed discharges and the cost of living increases.

Close partnership working with Northern Lincolnshire and Goole Foundation Trust continues.

The Humber Acute Services Review consultation would be deferred to May 2023 after the local government elections had taken place.

The Integrated Care Plan is being finalised and monitored at the Joint Delivery Board.

It is recommended that this risk rating remain the same.

BAF 6 – Research and Innovation
The success of COVID research activity means the Research Team will have an 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 staff have worked incredibly hard to ensure recovery from a 'COVID legacy' is ahead of trajectory.

It is recommended that this risk rating remain the same.

BAF 7.1 – Finance
The Trust is reporting a deficit of £0.3m at month 5, which is £1.2m worse than the plan. This is an improvement of £0.3m in month.

It is recommended that this risk rating remain the same.

BAF 7.2 – Underlying Financial Position
CRES shortfall is £0.8m at month 5, an improvement of £0.3m from month 4.

It is recommended that this risk rating remain the same.

BAF 7.3 - Capital
The reported capital position at month 5 shows gross capital expenditure of £5.4m against a plan of £7.9m.
The planned capital expenditure for 2022/23 (incl PFI/IFRIC12 impact) is £34.9m.

The planned capital expenditure includes an assumption on the Trust receiving a Salix Grant of £10m. This is being reviewed, as it is possible that we will not receive any funding for this in 2022/23. The bids will now be for 2023/24.
It is recommended that this risk rating remain the same.

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

5. **Recommendation**
The Board is asked to:

- Review and agree the ratings for Quarter 2.

Rebecca Thompson
Head of Corporate Affairs
November 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 Zero Tolerance Policy Established BAME network Diversity in recruitment implemented	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 Disability Network established	**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	Series of virtual exec-led focus groups x 10 (March/April) Staff survey results presented at HG business meetings (March) Launch bi-monthly staff forum (Link Listeners – from April) Run Barrett Values survey (late March) Exec-led manager briefing/feedback sessions (May/June) BAME networking event (June) Zero tolerance policy launch WDES Action Plan which is based on the outcomes from the technical data results and is intended to address disparities in the experiences of disabled staff compared to non-disabled staff	Q1 Barratt Values Survey rolled out Executive-led manager briefing sessions held Staff Survey Board Development Session in June 2022 Q2 Zero Tolerance Policy Launched Management Briefing sessions continued Appointment to EDI Role Introduced Diversity in Recruitment scheme The 'Our Voices' project has now concluded, the project asked staff, volunteers and trainees to share their voices and lived experiences to improve staff experiences as measured by the national Staff Survey / feedback forums.
Risks from Risk Register:			**Metrics** Performance against People Strategy Quarterly and National Staff Survey Results People Report monitoring/ Board and Workforce committees **Independent / semi-independent:** NHSE/I CQC Internal Audits	**Outcomes:** Staff survey issues – Bullying and harassment and team working –-the Trust is below average on the following indicators -we are compassionate and inclusive -we are recognized and rewarded -we each have a voice that counts -we work flexibly -we are a team -staff engagement		

Inherent risk			Risk as at 30.09.22 (Q2)			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: Workfor	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 International nurse PINs due by the end of August New University registrants on last placement & will start Sept, with their PINs being gained by the end of October	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 Nurse staffing – 3 additional wards open (Ward 1, Winter Ward H5 and C20) July/August - Peak holiday season for nurse staffing and resilience low post covid Continuity of Carer – challenges around pay uplifts, number of midwives required, upskilling of midwives.	**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 Nurse safe care briefings held 4 times per day Late Matron pastoral role now in post to support staff and help on wards, Mon-Fri Task and finish group set up to facilitate Ward Sisters being involved in staffing decisions Trust wide Same Task and finish group also reviewing how we can facilitate Sisters to work weekend shifts on a rota basis, to support and carry out wellbeing checks with staff	**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. Q2 The Trust has successfully recruited 129 adult nursing students and 14 child branch students, conditional offers have been given to commence employment with the Trust September 2022. 19 Midwifery students have also now been successfully recruited for appointment in September 2022. Registered Nurse Degree Apprentices (RNDA) -there are currently 31 in post, 8 of which are due to complete their programme in September 2022. The Trust has successfully recruited a further 12 RDNA due to commence employment with the Trust in September 2022.

	Risks from Risk Register: 3990 - Shortage of staff is a serious issue in the department of cardiothoracic surgery 3044 – Consultant Pathologist shortages (Breast Pathology)			**Metrics** Staff Survey People Performance Report **Independent / semi-independent:** CQC NHS England/Improvement Internal Audits	**Outcomes:** Reported in October – 516.9wte (6.2%) includes temp staffing Sickness levels Clinical services 7.5%, Estates 5.5% Nurse and midwifery 4.3% all above Trust target 18.9% of all leavers left the Trust with less than 1 year's service		

Inherent risk			**Risk position as at 30.09.22 (Q2)**			**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

S t r	**Strategic Objective:** We will achieve a rating of 'Outstanding' in the next 5 years (2019-2024) **Assurance Committee: Quality Committee** **Executive Lead: CMO/CN/DQG** **CQC Domain: All/Well-led** **Enabling Strategies/Plans: Quality, Patient Safety, Improvement**						
	Risks to objective	**Controls**	**Gaps in controls**	**Sources of Assurance**	**Assurance outcomes / gaps**	**Action plan**	**Progress / Timescales**

	Strategic risk: Taken from the Trust's strategy: *The Trust has a well embedded approach to monitoring and improving the fundamental standards of nursing and midwifery care in its inpatient and outpatient areas* **Condition:** There is a risk that the 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 NCTR wards – extra staffing required	**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 Falls Improvement Programme implemented Purpose T implementation with an emphasis on staff awareness of individualizing the skin integrity plan of care	**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 Q2 Nursing safety huddle now electronic. Insights audits carried out every 1st Friday of the month Anti microbial stewardship task and finish group established Roll out of QSIR Training PSIRF steering group and implementation team set up. Training commissioned.
	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 & actioned by the requester 3450 - There is a risk of increased pressure damage to patients due to failing or lack of pressure relieving mattresses			**Metrics** National Audit Benchmarking Harm Free Care Patient Experience Survey **Independent / semi-independent:** CQC inspections Internal audits External reviews (e.g. NHSEI)	**Outcomes:** 1 Never Event reported in Q1 5 Never Events reported in Q2 No Regulation 28 reports in Q1 or Q2 Reduction in open Serious Incidents =75 in June 2022, 65 in July, 54 in August, 44 in September, 38 in October 7.1 inpatient falls per 1000 bed days – August 2022 Pressure Ulcers – 1.48 hospital acquired per 1000 bed days in August 2022		

Inherent risk	Risk position as at	Planned target risk position by 31/3/2023

			30.09.22 (Q2)					
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

S t r	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, Patient Safety			
	Risks to objective	Controls	Gaps in controls	Sources of Assurance	Assurance outcomes / gaps	Action plan	Progress / Timescales

	Strategic risk: Taken from the Trust's strategy: *The Trust is the only local provider of secondary emergency and elective healthcare services for a population of 600,000. These people rely on us to provide timely, accessible, appropriate care and look after them and their families at times of great vulnerability and stress.* **Condition:** There is a risk that patients suffer unintended or avoidable harm 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 Complaints Introduction of the Role of Patient Safety Partners & Patient Safety/Experience Champions Learning from 'lived experience' across a number of different platforms including the Patient Councils	**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 PSIRF 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 Q2 A further 8 QSIR candidates booked onto the programme in September/October Serious Incident investigation numbers reducing – aim 35-40 cases open from 30 September 2022
	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 **Independent / semi-independent:** CQC inspections Internal audits – Waiting	**Outcomes:** 12 hour Trolley Breaches – 404 in August ED – 62.6% performance for all types RTT list size 69556 (May 2022) 71,310 (July 2022), 71,855 (August 2022) ED risk rating has been increased to 25 (5x5) due to the increase in Serious		

			lists, recovery included in schedule Positive feedback from ECIST visit May 2022	Incidents reported No Criteria to Reside continues to be the single largest factor affecting performance with a daily average of 179 (August 2022)			

Inherent risk			Risk position as at 30.09.22 (Q2)			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 Objective: Great Clinical Services Executive Lead: Ellen Ryabov – Chief Operating Officer CQC Domain: Effective				Assurance Committee: Performance and Finance Committee Enabling Plan: Operating Plan			
Strategic Risks	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 handover position remains highly challenged with numbers of lodged patients within ED, routinely between 20 and 30 patients at the start of the day. 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 71855 (August 2022) 104 week wait expected performance no worse than	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 primarily involved with pathway	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' Q2 104 week waits reduced to 20 in July 2022, 16 in August YAS/HUTH cohorting procedure agreed Focused support on 62 day RTT pathway in Q2 ICS Summit held to review a system response to the patients with NCTR – August 2022

					127 (June 2022) 20 (July 2022), 16 (August 2022) Patients with no criteria to reside = 169 July 2022, 179 August 2022 2 out of 9 cancer waiting times national standards were achieved in July 2022 and August 2022	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 Ground floor PDSA cycle commenced 11 July 2022 for a four week period; early evaluation is to continue with new ways of working, embed the elements where successful as Business As Usual (BAU) before winter, and continue to refine other aspects in order to maximise the potential benefits for flow and patient turnaround	

Inherent risk			**Year-end risk position as at 30.09.22 (Q2)**			**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
Executive Lead: Michelle Kemp
CQC Domain: Well Led/Effective/Safe

Assurance Committee: Trust Board
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)	Q1 - Wide ranging engagement programme in place including: models of care design, travel and access, workforce, out of hours and digital Q2 – Consultation process for HASR postponed until April 2023 due to political situation and local elections ICP Programme – Nurse Lead recruitment programme implemented Continued development of clinical pathways Finalisation of a joint IPR Quality Impact Assessment workshop to be held
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 Single Humber Neurology Service is now operational		

Inherent risk			Year-end risk position as at 30.09.22 (Q2)			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:	**Strategic Objective: Research and Innovation** **Executive Lead: Prof M Purva** **CQC Domain: Safe**			**Assurance Committee: Quality Committee** **Enabling Plan: Research and Innovation Strategy**		
Risks to objective	**Controls**	**Gaps in controls**	**Sources of Assurance**	**Assurance outcomes / gaps**	**Action plan**	**Progress / Timescales**
Strategic risk: Research and Innovation There is a risk that R&I support service is not delivered operationally to its full potential due to lack of investment	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	**Management assurance:** Successful portfolio of Covid studies managed in 2020/21 2316 patients involved in clinical research as at August 2021	**Gaps:** Scale of ambition vs deliverability Current research capacity hampered due to the recovery plan Funding availability Reconfigurations and the	(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	Q1/Q2 – continue to risk-assess the balance of investment in R&I capacity and other competing priorities. Continue to support research

	Cause: Funding is unavailable Consequence: Impact on R&I Investment Impact on R&I capacity Risks from Risk Register: No risks highlighted		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.	Continuing working with HYMS and the ICS **Metrics** Recovery Activity R&I Capacity **Independent / semi-independent:** NHS E/I HASR CQC ICS	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. Continued 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 and local strategies have been engaged throughout Q1 and into Q2. The Trust must continue to risk-assess the balance of investment in R&I capacity against that of other competing priorities, taking into account the reputational momentum that has accrued over the last two years in relation to the delivery of a comprehensive and highly effective COVID-19 research programme. Capitalising on this momentum with additional investment should be seen as a priority for the organisation to accelerate the goals of the R&I Strategy. Consideration of the development and implementation of an agreed R&I investment strategy covering the next 3 years (protected research time for staff, providing core budgets for increased admin and other costs) is critical in taking the next step on this journey of development and supporting the research collaborations as a leading partner in the Humber and North Yorkshire Health and Care Partnership. Major risk is that without investment we will reach a ceiling point in our capacity which in turn will limit new activity from collaborators and this could spark a decline in activity in the coming years as we are forced to decline participation in studies. This is not the current position in Q2 but is something we are monitoring closely. **Outcomes:** Number of consultants with protected R&I time	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	Collaborations as a leading partner in the Humber and North Yorkshire Health and Care Partnership Q2 The current position for the first half of the 2022/23 year: •Recruited 3,229 participants to NIHR Portfolio research (across 93 studies – ranked 4th in Yorkshire) – we have achieved 75% of our year-end recruitment target after 23 weeks. •Recruited 84 participants to commercial trials since 1st April 2022 (ranked 3rd in Yorkshire) and recruited at least one new patient to 20 new commercial studies since 1st April 2022 (ranked 3rd in Yorkshire). • Delivered feedback from nearly 200 research participants as part of the annual NIHR Participant Research Experience Survey (PRES) – (currently achieving 50% of our yearly target of 368). •Delivered an ongoing COVID-19 and Urgent Public Heath legacy workload. •Delivered a diverse portfolio of research activity that ensures research is seen as a treatment option in many specialties in our organisation – transforming the culture in operationally challenging times.

Inherent risk			Risk position as at 30.09.22 (Q2)			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 Objective: Financial Sustainability Executive Lead: Chief Financial Officer CQC Domain: Effective			Assurance Committee: Performance and Finance Committee Enabling Strategy: Financial Plan 2022/23			
	Risks to objective	**Controls**	**Gaps in controls**	**Sources of Assurance**	**Assurance outcomes / gaps**	**Action plan**	**Progress / Timescales**
S T F	**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 £7.5m of uncovered risk within Health Group	**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	Q1 No national reporting at month 1 due to the plans being finalised Month 2 - £3.4m deficit due to the non-delivery of the ERF and unidentified CRES Q2 Confirmation has been given that, there will be no clawback of Elective Recovery Funding (ERF) in the first six months of the financial year. This removes the risk of the Trust losing up to £6m in the first half

	Risks from Risk Register:		expenditure plans. ERF target of 104% activity value is delivered or funding is not clawed back in second half of the year.	**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:** The Trust is reporting a deficit of £0.3m at month 5, which is £1.2m worse than the plan. This is an improvement of £0.3m in month. Achieve financial control total at Trust and system level		of the year due to activity value being below 104% target. The rules on clawback are expected to commence from month 7. CRES shortfall is £0.8m at month 5, an improvement of £0.3m from month 4. The Trust is currently reporting that it will deliver its financial plan for 22/23.

Inherent risk			**Year-end risk position as at 30.09.22 (Q2)**			**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 Objective: **Financial Sustainability** — **Assurance Committee: Performance and Finance**

Executive Lead: Lee Bond

CQC Domain: Effective — **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 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 Q2 Work is ongoing to confirm the underlying deficit. A full analysis will be carried out in Month 6

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	Risks from Risk Register:			**Metrics** 1. Run rate 2. I&E position 3. CRES position 4. Activity performance against plan 5. Cash flow	**Outcomes:** Risk on elective recovery income Deficit of £0.4m at month 2 mainly driven by unidentified CRES		
				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 30.09.22 (Q2)			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 Themes

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	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 The planned capital expenditure for 2022/23 (incl PFI/IFRIC12 impact) is £34.9m, although this does not include any assumptions on the Trust receiving PDC allocations. The Trust has recently submitted PDC Capital bids in relation to a CT scanner; Gamma Camera and NICU development and we are currently developing a business case for Phase 2 of the Day Surgery scheme (TIF2).	Q1 Month 2 Capital expenditure position is £0.96m against a plan of £1.91m Q2 The main areas of expenditure relate to the Digestive Disease Scheme; Day Surgery Scheme and PFI lifecycle costs. The variance from plan is a profiling issue on the Salix grant scheme as the forecast capital spend for the year is in line with the annual plan.

	Lack of investment impacting on patient and staff safety							
	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:** The reported capital position at month 5 is £0.3m which is £1.2m away from plan. Front Entrance Build Day Surgery Theatres CHH		

Inherent risk			**Year-end risk position as at 30.09.22 (Q2)**			**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)	Q2 Zero Tolerance Policy Launched Management Briefing sessions continued Appointment to EDI Role Introduced Diversity in Recruitment scheme The 'Our Voices' project has now concluded, the project asked staff, volunteers and trainees to share their voices and lived experiences to improve staff experiences as measured by the national Staff Survey / feedback forums.			

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	The Trust has successfully recruited 129 adult nursing students and 14 child branch students, conditional offers have been given to commence employment with the Trust September 2022. 19 Midwifery students have also now been successfully recruited for appointment in September 2022. Registered Nurse Degree Apprentices (RNDA) - there are currently 31 in post, 8 of which are due to complete their programme in September 2022. The Trust has successfully recruited a further 12 RDNA due to commence employment with the Trust in September 2022. Apprentice Health Care Support Worker (AHCSW) - there are currently 23 in training, with 14 currently finalising their course. 10 of the (AHCSW) have successfully been appointed to the RDNA programme due to commence in September 2022. A further 5 AHCSW have been successfully recruited and are due to commence employment with the Trust September 2022. There are currently 43 Trainee Nursing Associates (TNA), 14 of which have recently completed their programme and are awaiting their NMC PIN and a further 3 who will finish in September 2022. In addition the Trust has successfully recruited a further 23 TNAs due to commence employment with the Trust in September 2022.			

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	Nursing safety huddle now electronic. Insights audits carried out every 1st Friday of the month Anti microbial stewardship task and finish group established Roll out of QSIR Training Falls Improvement programme implemented Pressure Ulcer Improvement programme implemented			

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	A further 8 QSIR candidates booked onto the programme in September/October Serious Incident investigation numbers reducing – 38 cases open September 2022 Patient Safety Incident Response Framework launched in Q2			

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	104 week waits reduced to 20 in July 2022 YAS/HUTH cohorting procedure agreed Focused support on 62 day RTT pathway in Q2 ICS Summit held to review a system response to the patients with NCTR – August 2022			

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)	Consultation process for HASR postponed until April 2023 due to political situation and local elections ICS/ICB Established ICP Programme Nurse Lead recruitment programme implemented Continued development of clinical pathways Finalisation of a joint IPR Quality Impact Assessment workshop to be held			

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	Q2 - The current position for the first half of the 2022/23 year: •Recruited 3,229 participants to NIHR Portfolio research (across 93 studies – ranked 4th in Yorkshire) – we have achieved 75% of our year-end recruitment target after 23 weeks. •Recruited 84 participants to commercial trials since 1st April 2022 (ranked 3rd in Yorkshire) and recruited at least one new patient to 20 new commercial studies since 1st April 2022 (ranked 3rd in Yorkshire). • Delivered feedback from nearly 200 research participants as part of the annual NIHR Participant Research Experience Survey (PRES) – (currently achieving 50% of our yearly target of 368). •Delivered an ongoing COVID-19 and Urgent Public Heath legacy workload. •Delivered a diverse portfolio of research activity that ensures research is seen as a treatment option in many specialties in our organisation – transforming the culture in operationally challenging times.			

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	The Trust is reporting a deficit of £0.3m at month 5, which is £1.2m worse than the plan. This is an improvement of £0.3m in month. Confirmation has been given that, there will be no clawback of Elective Recovery Funding (ERF) in the first six months of the financial year. This removes the risk of the Trust losing up to £6m in the first half of the year due to activity value being below 104% target. The rules on clawback are expected to commence from month 7. CRES shortfall is £0.8m at month 5, an improvement of £0.3m from month 4. The Trust is currently reporting			

	that it will deliver its financial plan for 22/23.			

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	Work is ongoing to confirm the updated underlying deficit, including in-year pressures and full year effect of CRES delivery. A full analysis will be provided at Month 6.			

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	The reported capital position at month 5 shows gross capital expenditure of £5.4m against a plan of £7.9m. The main areas of expenditure relate to the Digestive Disease Scheme; Day Surgery Scheme and PFI lifecycle costs. The variance from plan is a profiling issue on the Salix grant scheme as the forecast capital spend for the year is in line with the annual plan			

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

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

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

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

Agenda Item		Meeting	Trust Board	Meeting Date	19/10/22
Title	Collaboration of Acute Providers				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Hill Dickenson LLP				
Report previously considered by (date)	This report has not been considered 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:

Summary:
The Director of Quality Governance and the Head of Corporate Affairs attend the CAP Governance meetings. At the last meeting a Provider Leadership Board with Committees in Common structure was proposed and this is supported by the Chief Executive Officer.

The Board is asked to:

- Review the briefing and the recommendation of a Provider Leadership Board and Committee in Common structure

Board Briefing for the Collaboration of Acute Providers: An Introduction

Purpose of this paper

The purpose of this paper is to provide an introduction to provider collaboratives under the Health and Care Act 2022 ("the **Act**"), an explanation regarding the relationship between providers, Integrated Care Boards ("**ICB**s") and where statutory accountability sits within this system.

What is a Provider Collaborative?

The Act required that, by July 2022, all acute trusts had to become part of a Provider Collaboratives, which are simply arrangements between two or more trusts. Provider Collaboratives have been described as "*a key component of system working, bringing together NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.*"

Provider Collaboratives are not legal entities. Rather they consist of member organisations working together. There is no prescribed form of a Provider Collaborative and members are free to determine what model is best suited to their local area to achieve integration. There is some limited guidance from NHS England available to assist in making these decisions, and there are some existing models in operation from which lessons can be drawn.

What is the relationship between Provider Collaboratives and ICBs and how does accountability work?

ICBs are statutory bodies which have taken on the statutory functions of the CCGs (and some of NHS England's) for the populations which they cover. They are ultimately responsible for the delivery of these functions and making decisions about how they achieve this.

ICBs generally look to how to deliver those functions through contracting and delegation to providers (including in collaboratives and at place) rather than directly through the ICB itself. ICBs however can only delegate to another legal body and, as stated above, Provider Collaboratives have no legal or statutory basis; accountability for performance therefore remains with the individual members of the Provider Collaborative for the functions that are delegated to them via the Provider Collaborative.

Although individual trusts therefore continue to function within the system and they remain accountable for their individual performance, *"[…] the success of individual Trusts and Foundation Trusts will increasingly be judged against their contribution to the objectives of the [Integrated Care System], in addition to their existing duties to deliver safe and effective care. This will include delivering their agreed contribution to system financial balance, improving quality and outcomes and reducing unwarranted variation and inequalities across the system as a whole, in the context of the new 'triple aim' duty to promote better health for everyone, better care for all and efficient use of NHS resources.*" (Design Framework).

The question therefore arises as to what form a Provider Collaborative should take, such that functions can be delegated/contracted to its members to deliver through a collaborative route? There needs to be a proper governance arrangement in place to do this.

Guiding principles for deciding on the form of Provider Collaborative

The guidance sets out several guiding principles for deciding on the form for a Provider Collaborative:

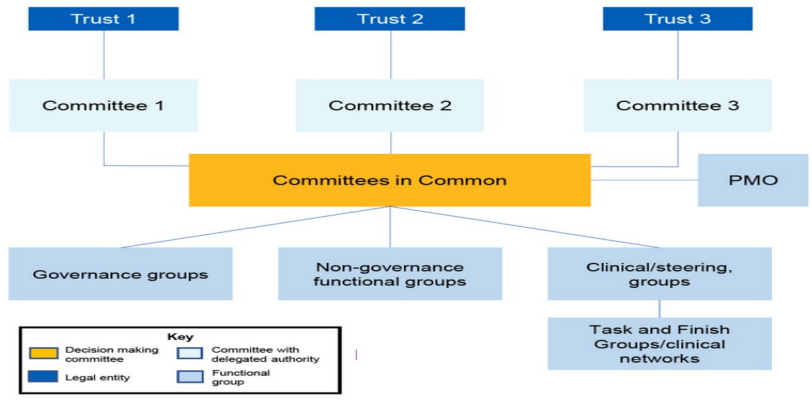
- Agreeing a shared vision and a commitment to collaborate
- Building on and enabling existing successful governance arrangements
- Reaching decisions efficiently – with each organisation committed to upholding these decisions
- Developing strong mechanisms for holding each other to account
- Needs and voices of local communities must be a key consideration
- Embedding of clinical leadership
- Clarity around how decisions are made, disagreements resolved, how funding flows and how the collaborative is resourced
- The PC should help streamline ways of working across systems

There is no one-size-fits-all model of collaborative. Established provider collaboratives have used a variety of arrangements based on local objectives and context. These tended to fall within three broad types of collaboratives which are set out in the guidance. These are not exclusive, and alternatives/combinations could be permissible. The three suggested forms are described below:

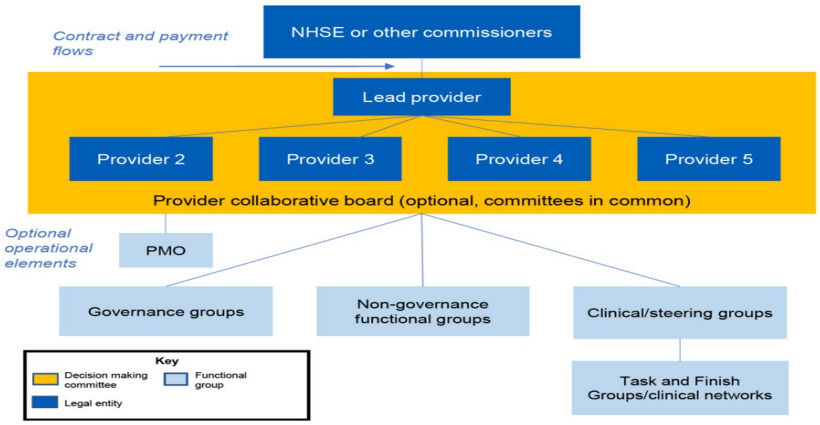
Provider Leadership Board	Lead Provider	Shared Leadership
• Directors / Chief Executives with common delegated responsibilities • Deliver shared agenda on behalf of collaborative / system partners • Committees in common to take aligned decisions • Providers to involve non-executive directors for scrutiny and challenge	• Single Trust / Foundation Trust with contractual responsibility for commissioning on behalf of collaborative • Subcontracts to other providers • Also partnership agreement between lead provider and other collaborative members	• Shared defined leadership structure • At least one joint Chief Executive • Achieved by appointing same person / people to leadership posts • Each provider board remains accountable for decisions (even aligned) • Shared governance e.g. committees in common to support aligned decision-making

The most common forms being used currently are the Provider Leadership Board and the Lead Provider as the shared leadership model requires a greater degree of integration and transformation to implement effectively. We have set out examples of these below:

Provider Leadership Board



Lead Provider



Please contact Rob McGough at Hill Dickinson (Robert.mcgough@hilldickinson.com) if you have any queries on this briefing paper.

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	08.11.22
Title	**Emergency Preparedness Resilience and Response Annual Assurance Process 2022/23**				
Lead Directors	Michelle Cady, Accountable Emergency Officer				
Authors	Jackie Railton, Deputy Director, Strategy and Planning				
Report previously considered by (date)	Verbal update at Trust Resilience Committee 29.9.22 Trust Board Meeting 11.10.22				

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: • Acknowledge the EPRR self-assessment finding of 'Substantially Compliant'.

Hull University Teaching Hospitals NHS Trust

Trust Board

Emergency Preparedness Resilience and Response
Annual Assurance Process 2022/23

1. Purpose

The purpose of this document is to request the acknowledgement of the Public Trust Board of the finding of 'Substantially Compliant' following the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Process for 2022/23.

2. Background

The October 2022 meeting of the Trust Board received a report on the outcome of the Trust's self-assessment against the NHS core standards for EPRR.

A total of 64 EPRR core standards are applicable to the Trust as an acute provider. The Trust achieved full compliance against 58 of the 64 standards and is therefore reporting a 91% compliance rate, resulting in an overall assessment of 'substantially compliant'. A summary of the compliance against the core standards is provided below.

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	1	1	0
Training and exercising	4	2	2	0
Response	7	6	1	0
Warning and informing	4	3	1	0
Cooperation	4	4	0	0
Business continuity	10	9	1	0
CBRN	14	14	0	0
Total	**64**	**58**	**6**	**0**

The detail of each standard and the Trust's self-assessment rating is available in the embedded document below.

The areas of partial compliance were in relation to:

Domain	Standard	Requirement	Action Required
Command and Control	Trained on call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Ongoing training of on call staff in the new Principles of Health Command training. Audit of training records

Domain	Standard	Requirement	Action Required
			to ensure all on call staff trained/booked for training in accordance with training programme
Training and exercising	EPRR training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Training needs analysis to be undertaken to inform 2023/24 training plan. Audit of training records and encouragement of key staff to maintain training portfolios.
Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Audit of training records to be undertaken to provide assurance
Response	Decision logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Ongoing recruitment of loggists to increase pool of staff. However no on-call arrangements for loggists in relation to 24/7 availability - Trust to consider necessity.
Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Incident Communications Plan to be developed Plan to be tested both in and out of hours.
Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Compliance rating of 'Approaching Standards'. Improvement Plan in place Regular downtime exercise programme to be developed

An EPRR action plan has been developed to address areas where attention is required and to strengthen areas where the Trust is already compliant (see embedded document below).

In addition to the assessment against the core EPRR standards, the Trust is required to undertake a Deep Dive into the resilience of evacuation and shelter arrangements. The domains included up-to-date plans, activation, patient triage, movement, transportation, dispersal and tracking, partnership working, communication and exercising. .

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant
Evacuation and Shelter	13	12	0	1
Total	**13**	**12**	**0**	**1**

The self-assessment identified that the Trust was fully compliant with 12 out of the 13 applicable standards but was not compliant with one standard – equality and health inequalities. This standard requires the organisation to undertake an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities. It is proposed to undertake detailed impact assessments and this action has been included in the EPRR Action Plan, the progress against which will be monitored by the Trust Resilience Committee and Non-Clinical Quality Safety Committee.

3. EPRR Self Assessment Sign Off Process
It is a requirement that the final overall EPRR assurance rating for the Trust should be:

- formally reported to, and signed off by, the organisation's board/governing body/senior management team *(Trust Board meeting of 11th October 2022)*
- presented at a public board meeting *(8th November 2022)*
- published in the organisation's annual report within the organisation's own regulatory reporting requirements.

The EPRR self assessment rating of 'substantially compliant' is therefore presented to today's Public Board for formal acknowledgement of the assessment rating.

4. Recommendation
The Trust Board is asked to acknowledge the EPRR self-assessment finding of 'Substantially Compliant'.

Michelle Cady
Accountable Emergency Officer
Director of Strategy and Planning

21 October 2022

Hull University Teaching Hospitals NHS Trust

2022/23 EPRR Annual Assurance Action Plan

Core Standard Description	Requirement	Compliance	Action	Timescale	Lead Manager
No. 13 – New and Emerging Pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	**Fully Compliant** - Trust has a pandemic flu plan. It provides the framework and operational guidance for the Trust to plan for, prepare for, respond to and recover from an influenza pandemic, alongside existing preparations and plans to manage COVID-19. This plan aligns with the 2011 National UK Influenza Preparedness strategy that reflects the learning from the H1N1 (2009) Influenza pandemic response, and is based on the 3 key principles that underpin planning and response: Precautionary, Proportionality and Flexibility. Due to the unpredictable nature of the pandemics, this approach allows for adaptability of response in light of emerging knowledge about the virus, proportionality of impact according to the capability and characteristics of the virus and whether the impact on the Trust and local services is low moderate or high. This plan is a "live" document and subject to regular updates in response to further guidance, refinement of planning and response procedures following regular testing and exercises and in collaboration with partners and the local community. The principles can be applied to other, non-influenza based, emerging pandemics	Non-influenza pandemic plan to be developed	November 2022	Director of Infection Prevention and Control
No. 15 - Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass	**Fully Compliant** - The Trust's response to an incident involving mass casualties is included within its Major Incident plan. The Trust has a paper-based, safe identification system in place for unidentified patients. Work is	Non-sequential electronic ID system for mass casualties on work plan with	Subject to suppliers of Lorenzo and development of software	Head of Emergency Planning / Head of Clinical Admin

Core Standard Description	Requirement	Compliance	Action	Timescale	Lead Manager
	casualties.	ongoing to develop into an electronic based system within Lorenzo EPR	suppliers of Lorenzo EPR and clinical admin		
No. 16 – Evacuation and Shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	**Fully Compliant** - The Trust has a full and partial evacuation plan in place. This was subject to table top exercises during development and will be tested further as part of the national Floodex in November 2022 and on an ongoing basis	Testing of the plan through a series of table top exercises. Training of staff in evacuation techniques was paused during Covid. Education and development team working on new programme of training	March 2023	Head of Education and Organisational Development / Head of Emergency Planning
No. 18 – Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	**Fully Compliant -** Trust VIP Visitor Access & VIP Patient Poilcy approved in February 2020. In process of being refreshed.	Refresh of VIP Policy	February 2023	Director of Communications and Engagement
No. 19 – Excess Fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	**Fully Compliant -** The Trust works in partnership with the Local Resilience Forum in relation to excess deaths and mass fatalities. The Trust increased its mortuary capacity during the Covid pandemic. The Trust currently has measures in place to manage rising tide events.	Stocktake of current mortuary capacity	October 2022	Head of Emergency Planning / Head of Bereavement Services

Core Standard Description	Requirement	Compliance	Action	Timescale	Lead Manager
No. 21 – Trained on call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	**Partially Compliant -** Section 8 of the EPRR Policy outlines the training and exercising requirements which are in line with the national minimum occupational standards. The Trust has a fully training programme for on call staff. On call staff also have access to the On Call Toolkit available on the Trust's intranet with links to key documents including the MIP and the On call SOP.	Ongoing training of on call staff in the Principles of Health Command training. Audit of training records to ensure all on call staff trained/booked for training in accordance with training programme	December 2022	Head of Emergency Planning
No. 22 – EPRR training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	**Partially Compliant -** Training and exercising contained within Section 8 of the EPRR Policy. Major incident awareness training available on HEY247 (Trust's education and development website) Table top exercises held in relation to adverse weather, intruder, cyber security, CBRN incident, lockdown, site evacuation. Planning undertaken for live CBRN event in 2023. Recent training needs analysis not undertaken. Evidence of personal training records poor	Training needs analysis to be undertaken to inform 2023/24 training plan. Audit of training records and encouragement of key staff to maintain training portfolios.	December 2022	Head of Emergency Planning
No. 23 – EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	**Fully Compliant -** Live exercise - response to Covid-19 pandemic. Learning used to inform response to future waves of admissions. Comms test completed - June 2022 Table top exercises undertaken on evacuation, cyber security, adverse weather, intruder, lockdown, CBRN event ICC - has been stood up on numerous occasions as a result of Covid-19 pandemic. Exercise undertaken with site team regarding setting up of ICC.	Planning ongoing for live CBRN exercise in 2023/24 Programme of table top exercises planned for 2023/24	December 2023	Head of Emergency Planning

Core Standard Description	Requirement	Compliance	Action	Timescale	Lead Manager
No. 24 – Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	**Partially Compliant** - HEY247 is the Trust repository for capturing records of learning, whether in-house or external. Where training is organised by HUTH, the attendance can be automatically recorded. HEY247 can be updated by individuals. Audit of personal training recording required.	Audit of training records to be undertaken to provide assurance	December 2022	Head of Emergency Planning
No. 29 – Decision logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	**Partially compliant** - Do not have 24 hour access to trained loggist Key response staff aware of need to create and maintain own personal records and decision logs - reiterated in command training and in on call information.	Ongoing recruitment of loggists to increase pool of staff. However no on call arrangements for loggists in relation to 24/7 availability - Trust to consider necessity.	December 2022	Head of Emergency Planning
No. 30 – Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and	**Fully compliant** - Covid-19 sitrep process well established, included bed state, ICU data, NCTR data, workforce information. CRIP report also utilised. Patient data sheets available for use by Information	Sitrep information and template for major incidents to be reviewed	December 2022 **Completed Oct 2022**	Head of Emergency Planning

Core Standard Description	Requirement	Compliance	Action	Timescale	Lead Manager
	briefings during the response to incidents including bespoke or incident dependent formats.	Team. Generic sitrep template under development			
No. 33 – Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	**Fully compliant** - Comms team have specific action card/role in respect of Major incidents and briefing of staff, public and media. Contact available 24/7. Also are part of wider ICS communications network to ensure consistency of message. Media log sheet to be utilised for recording of all requests/actions/responses.	Testing of comms team response and media centre - desk top exercise to be undertaken	March 2023	Head of Emergency Planning/ Director of Comms and Engagement
No. 34 – Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	**Partially compliant** - Communications requirements incorporated into MIP and associated action cards. Communication between ICB and NHS Regional teams - protocols in place as per Covid-19 experience re what can and cannot be communicated by the organisation dependent upon Opel level and declaration of a major or critical incident. Protocol for media announcements in place (Comms team)	Incident Communications Plan to be developed Plan to be tested both in and out of hours.	March 2023	Director of Comms and Engagement
No. 35 – Communication with Partners and Stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	**Fully compliant** - Comms to staff - established via management cascade and via global email and Trust intranet site (Pattie) Contact protocol in place for escalation/warning to partner organisations, local stakeholders and ICB. Established process via LRF for sitrep notification. Public comms via social and local media, also via Trust website. Displaying of public info at entrance points to hospital buildings as appropriate, also ward and department entrances. Utilisation of telephone, text messaging and email to contact patients regarding appointments/treatment. EPRR self assurance report to public board annually showing compliance and state of readiness Example of East Cowick/Snaith floods - comms participation and response.	Contact lists to be combined and held centrally with access for appropriate on call managers/Exec Directors	December 2022	Head of Emergency Planning

Core Standard Description	Requirement	Compliance	Action	Timescale	Lead Manager
No. 36 – Media Strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	**Fully Compliant** - Trust VIP Visitor Access & VIP Patient Poilcy approved in February 2020 Exec Directors trained to represent the organisation to the media Trust has a Communications Policy which incorporates social media guidelines. Monitoring of social media information is via the Comms team.	All elements of media contact (including social media) during an incident to be brought together in a guidance document for managers to refer to	March 2023	Director of Comms and Engagement
No. 39 – Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	**Fully Compliant** - Mutual aid agreements in place over last two years in relation to Covid-19 response and elective recovery. Mutual aid agreement under development with Fire Brigade re CBRN response Established mutual aid relationships with NLaG and York. Liaison with ICB and community partners where mutual aid extends beyond secondary care provision	Review of mutual aid documentation to ensure up to date	March 2023	Head of Emergency Planning
No. 49 – Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	**Partially compliant** - DPST compliance rating of 'Approaching Standards'. Improvement Plan in place	Regular downtime exercise programme to be developed	March 2023	Chief Clinical Information Officer
No. 51 – Business Continuity Audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has	**Fully compliant** - Internal Audit undertaken in 2018/19. Report available and outcome of internal audits are reported to the Trust Board via the Trust Audit Committee.	To arrange for audit of BCPs 2023/24	August 2023	Head of Emergency Planning

Core Standard Description	Requirement	Compliance	Action	Timescale	Lead Manager
	conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.				
Deep Dive No. 12 – Equality and Health Inequalities	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.	**Not compliant** - No equality or health inequalities impact assessment of evacuation and shelter plans	Impact assessments to be drafted	March 2023	Head of Emergency Planning

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item	8.1	**Meeting**	Trust Board	**Meeting Date**	8 November 2022
Title	Quality Report				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Donna Pickering – Head of Patient Safety and Improvement, Leah Coneyworth – Head of Quality Compliance and Improvement and Andy Lockwood – Head of Patient Experience and Engagement				
Report previously considered by (date)	This report has previously been considered at Quality Committee in October 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:

The Trust Board is recommended to review the executive summary of the key indicators and decide if assurance has been received with the actions been taken to address the concern areas and confirm if any further action is required.

Quality Report

September 2022 Performance Data

Produced for the November 2022 Trust Board

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1. EXECUTIVE SUMMARY

1.1 ESCALATION OF KEY INDICATORS

The following table provides an executive summary of the key indicators that require escalation from the performance in September 2022.

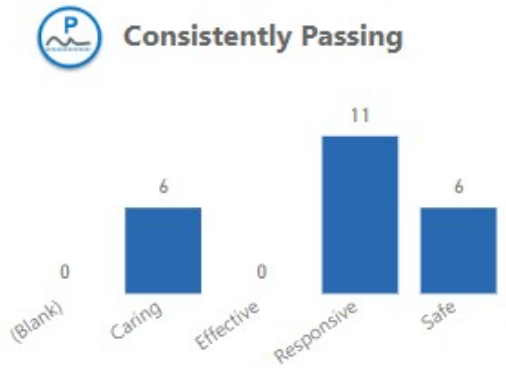
	Indicator	Successes	Risks / Challenges	Actions / Future Plans
Safe Domain	Patient Safety Incident Reporting	The Trust has a positive patient safety reporting culture (high volume, low harm)	There has been a reduction in the incidents that are being reported. Incidents causing moderate harm or above have 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 linked to the Quality Strategy are informed by incident data.
	Serious Incidents	The trajectory to be in a sustainable position of ~35 SI open at any time has been met.	There are still a number of SIs that have been open for more than 100 days. The Trust will continue to declare SIs in line with the Serious Incident Framework (2015) until April 2023	Renewed focus on the oldest open SI investigations. All incidents meeting SI criteria are discussed at the WPSS. Where there is no new learning, differing approaches other that SI investigations are considered e.g. AAR, Safety Huddles, and Thematic Reviews to identify if there are improvement opportunities. Transition to PSIRF planned from April 2023.
Effectiveness Domain	HSMR	HSMR reduced in May 2022 following the spike in April 2022 indicating this was not a continued increase in deaths	The Trust continues demonstrate 'higher than expected deaths' and is an outlier against its HSMR	Undertake an investigation into the spike highlighted in April 2022 if these deaths were avoidable, are they appropriately coded, should the patients have been in hospital and was there preferred place of death achieved, ReSPECT and EOL discussions, the quality of end of life care and could anything have been done differently for these patients
	SHMI	Establishment of a Sepsis Steering	The Trust continues to demonstrate	Continue to undertake the improvement

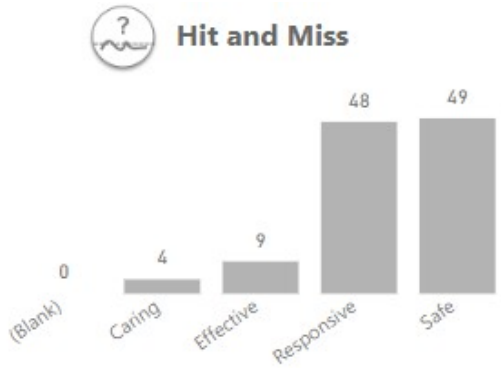
		Group and a Pneumonia Steering Group to really focus and drive the improvements with the relevant clinical teams	'higher than expected deaths' against its SHMI and is highlighted as one of the top 12 Trusts with an outlier status by NHS Digital The top 3 common clinical conditions remain Sepsis, Pneumonia and Stroke An increase in deaths attributed to Urinary Tract Infections (UTI) has been identified by the Mortality Task and Finish Group	work relating to the areas identified to make the required improvements to the whole pathways, reduce any avoidable deaths and reduce the unexpected deaths. Have a positive impact on clinical outcomes and mortality rates.
	CQUIN	Joined up improvement work with UTI and Pneumonia indicators and the whole pathways 91% of major elective blood loss surgery patients were treated in line with NICE guideline NG24 in Q1	The CQUINS which were not achieved require substantial resources to complete a case note audit of 100 cases per quarter and rely heavily on the correct and consistent documentation in the patients records. The financial payments attached to the CQUINs were not fully achieved in Q1	Work has been ongoing to improve the Q2 submission with additional support from the nursing and medical teams raising the importance of the documentation of key elements and support from Junior Doctors to complete the audits. Exploration of electronic solutions where possible.
	Procedural Documents	62% (465) of procedural documents are in date, in line with best practice and implemented by staff	As of 27 September 2022 there are currently 282 (38%) procedural documents overdue for review, updating, ratification and publication for implementation with an additional 80 due for review by the end of March 2023	The Compliance Team continue to provide a significant amount of support to the clinical teams regarding the template changes and ratification processes to ensure the position improves.
Responsive Domain	Complaints	CSHG & EMHG complaints within acceptable limits. BSL deaf centre for the deaf manager attended nurse exec with patient storey	Capacity of Patient Experience Team to log new complaints in timely manner. >40 day backlog Implementation of the PHSO complaints framework	Quality Governance Team assessing ways to support Patient Experience. Trajectory given to each HG to clear backlog of open complaints. Quality Governance assessing ways to help HGs to clear backlog.
	Continuous Quality Improvement	First QSIR Practitioner delivered as accredited faculty.	Challenge in the delivery of GIRFT portfolio due to absence within the team. This has now been identified and	Actions / Future Plans; Upcoming Celebration Event.

		CQI Team led a Humber system wide innovation event around the process for neurotherapy referrals. Growing Faculty of accredited QSIR associates.	development of GIRFT is moving forward.	CQI public facing website to celebrate all things QI. This will also incorporate the Human Factors Hub. Start of HUTHs first QSIR Virtual cohort in November which is a full course of 15 delegates.

1.2 EXECUTIVE SUMMARY SCORECARD

The following provides a high level executive summary of the number of Quality Indicators which are achieving, those which are displaying variance between achieving and failing and those that are consistently failing as detailed on the Integrated Performance Report for September 2022.





–											
Domain	Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)	Unreliable	Not capable	Capable	N/A

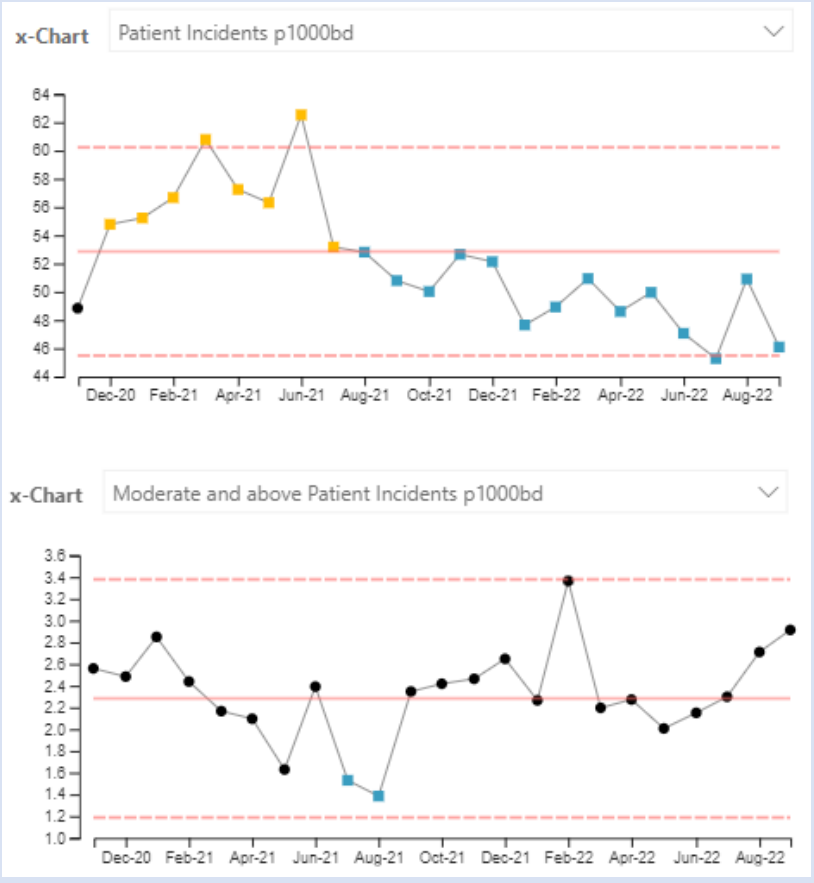
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Statistical Process Control (SPC) is an established analytical technique that plots data over a period of time to help us understand variation and assurance and as a result directing us to the correct area of improvement for the appropriate action to be taken to make a difference. The charts also allow us to monitor the relevant KPIs and determine if they are improving.
A minimum of 15 data points are required for an SPC to be meaningful and inform decision making, improvements and change. This is completed in line with NHS Improvement 'Making Data Count'

2. SAFE DOMAIN

2.1 PATIENT SAFETY INCIDENT REPORT AND INCIDENTS CAUSING HARM

Patient Safety Incidents reported per 1000 bed days
Patient Safety Incidents causing harm per 1000 bed days



Aim: To promote a safe learning culture by reporting patient safety incidents

Target: To see a reduction in the number of incidents resulting in harm

What is the chart telling us:

- There were 46 patient safety incidents per 1000 bed days recorded in September 2022 (n=1471); 2.91 (per 1000 bed days) incidents resulted in moderate, severe or catastrophic harm to the patient.
- The number of incidents of all severities is with control limits but there has been reduction over recent months.
- The number of incidents causing harm to patients is showing an upward trend over the last 5 months

Successes:

- The Trust has a positive patient safety reporting culture (high volume, low harm)
- The Trust continues to sustain incident-reporting levels above the national average of 45 per 1000 bed days.

Key Risks and Challenges:

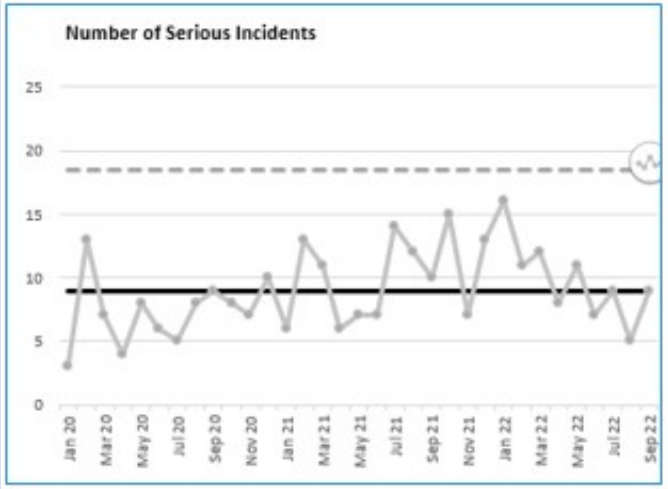
- Ongoing clinical pressures within the ED and patient flow within the Trust continues to be challenging with a number of harms occurring on the no criteria to reside wards.
- There has been an increase in hospital acquired pressure ulcers occurring in the ED
- The highest reported harms are hospital acquired pressure ulcers and inpatient falls

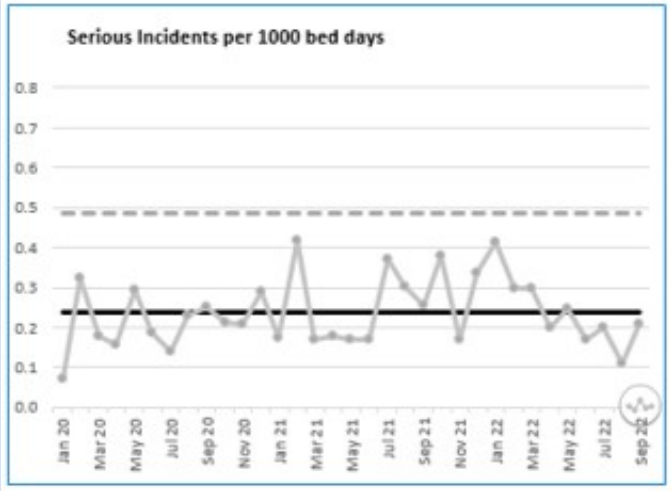
Actions / Future Plans for Improvement:

- Quality Improvement Project is planned to increase the number of patient safety events being reported and will incorporate work to integrate the transition from the NRLS to Learn from Patient Safety Events service (LFPSE) from April 2023.
- QI work streams aligned to Quality Strategy strategic ambitions for harm free care

2.2 SERIOUS INCIDENTS

Number of Serious Incidents reported
Serious Incidents per 1000 bed days





Aim: To reduce the number of serious incidents being declared

Target:

What is the chart telling us:

- The Trust declared 9 serious incidents in September 2022 equating to 0.21 serious incidents per 1000 bed days
- The graphs above show common cause variation with no cause for concern with a downward trend since January 2022.

Successes:

- The Weekly Patient Safety Summit (WPSS) reviews patient harms and allows for discussion on emerging themes and immediate learning, improvement opportunities and differing approaches to investigation methods e.g. AAR, Safety Huddles, and Thematic Reviews required.
- The WPSS allows for timely identification of serious incidents however fewer serious incidents are being declared

Key Risks and Challenges:

- The Trust will continue to declare SIs in line with the Serious Incident Framework (2015) until April 2023
- Family & Women's Health Group saw the highest number of SIs reported (4); 3 SIs were within the Obstetric service with 1 meeting HSIB criteria
- The Surgery Health Group had 3 SIs declared; there were no commonalities
- There was 1 Never event declared in Clinical Support Health Group relating to wrong site administration of local anaesthetic

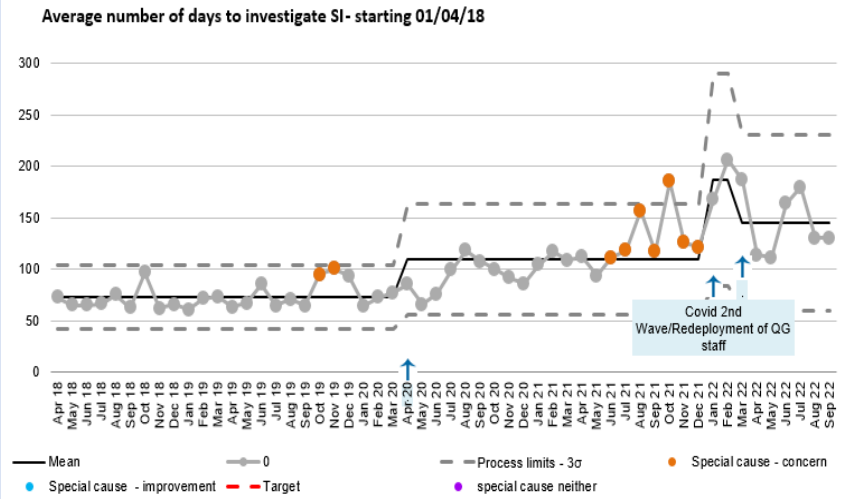
Actions / Future Plans for Improvement:

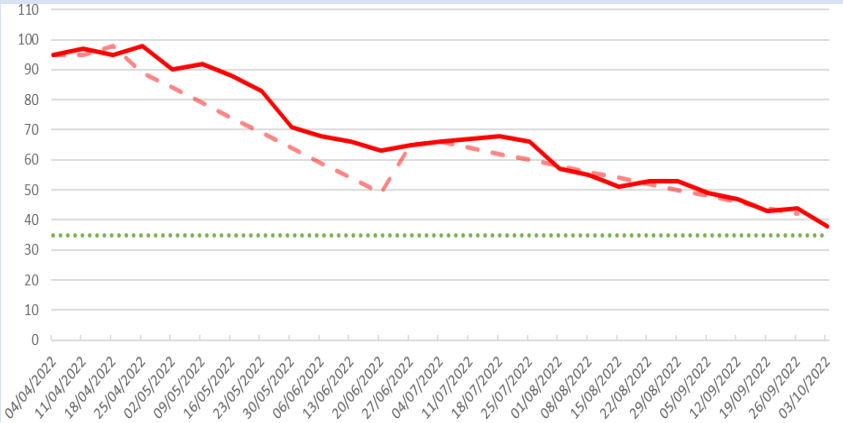
- Transition to PSIRF from April 2023 will transform the approach to patient safety incident investigations (PSII) with a move away from the traditional root cause analysis training that most are familiar with to a proportionate systems based approach. This is grounded in human factors, engaging families and staff affected by the incident and a focus on continuous improvement

2.3 SERIOUS INCIDENTS COMPLETED WITHIN TIMESCALES

Average number of days to investigate serious incidents

Trajectory for reducing investigation backlog





Aim: To reduce the number of serious incident investigations open more than 100 days

Target: For serious incidents to be investigated within 60 working days

What is the chart telling us:

- The number of days taken to close serious incident investigations is reducing
- The number of open investigations is reducing with the trajectory being met

Successes:

- In April 2022 a trajectory was set with an aim be in a stable position, within agreed tolerance limits, by October 2022 with a sustainable case load of ~35 open SIs at any time and for no serious incident investigation to take more than 100 days
- This trajectory has been met in terms of number of investigations open at any one time.
- 103 investigation were closed over the last 6 months
- 4 investigations were closed with national 60-day timescales in September

Key Risks and Challenges:

- Clinical pressures continue to impact on timely conclusion of serious incident investigations
- The average number of days to close an investigation is 130 days
- 14 investigations remain open over 100 days

Actions / Future Plans for Improvement:

- The reduction in the number of serious incident investigations being open has resulted in a smaller more manageable caseload that will allow for timelier completion of investigations
- Sharing the learning from serious incidents in line with a Trust Lessons Learned framework will ensure learning from serious incidents is communicated to all areas within the Trust and actions are embedded
- Patient Safety Incident Investigation (PSII) Training is planned in November to drive a systems approach to investigations and improvement

2.4 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

The first Patient Safety Incident Response Framework training took place on the 1st November with the Executive team having an oversight session.

Aim: The Trust aims to launch the new framework by the 1st April 2023.

Successes:

- The Trust has secured an external provider for the training and we have secured dates for multi-disciplinary staff attending the first cohorts.
- Patient Safety Incident Investigation Training commences on the 2nd December.
- Human Factors & Patient Safety for Senior Leaders sessions are being held on 22nd and 25th November
- Human Factors Train the Trainer sessions start 11th November.
- Patient Safety Toolkit is being populated

Key Risks and Challenges:

- Clinical pressures may impact on the ability to attend training.
- The cultural shift away from the serious incident framework with fewer comprehensive investigations towards a systems based approached (AAR and Thematic Reviews)
- Ensuring stakeholders are aware of the changes and maintain assurance around learning from incidents.

Actions / Future Plans for Improvement:

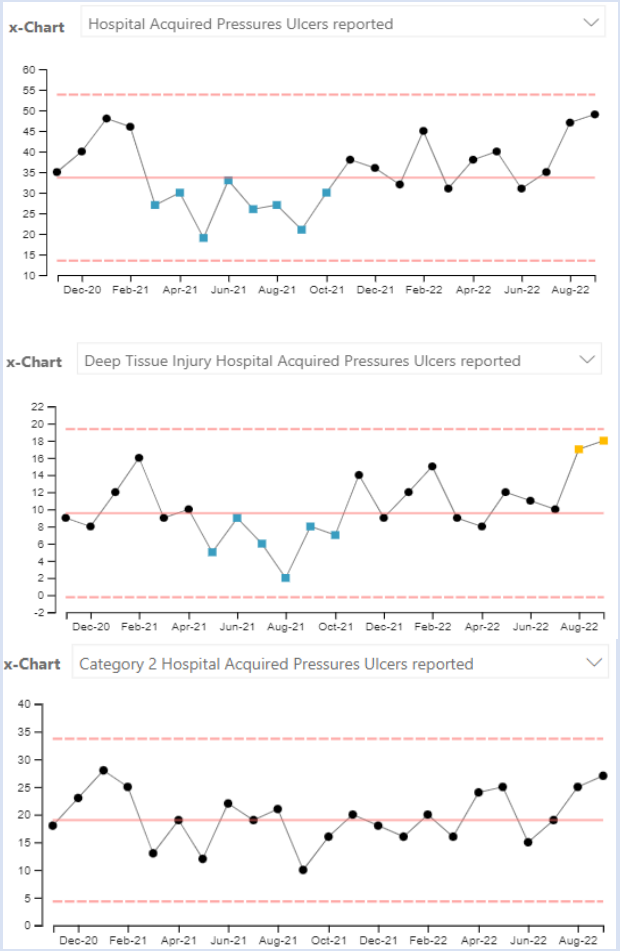
- The Trust plans to establish their own Human Factors Hub which will link with the Continuous Quality Improvement.
- This will support the shift to immediate improvement and learning rather than 60 day reports.
- The PSIRP will be presented as part of the Board Development session in December.

2.5 HOSPITAL ACQUIRED PRESSURE ULCERS CAUSING HARM

Hospital acquired pressure ulcers
Deep Tissue Injury pressure ulcers
Category 2 pressure ulcers

Aim: To have a zero tolerance approach to hospital acquired pressure ulcers

Target: To reduce the number of hospital acquired pressure ulcers to below the mean



What is the chart telling us:

- There were 1.19 pressure ulcers per 1000 bed days in September (n=51)
- The number of pressure ulcers reported remains above the mean
- There has been an increase in deep tissue injuries occurring

Successes:

- The first TV task and finish group has taken place, with fortnightly meetings planned.

Key Risks and Challenges:

- There were 26 Category 2 pressure ulcers reported; 1 Category 3, 21 Deep Tissue Injuries (DTI) (2 device related) and 2 unstageable pressure injuries (11 device related)
- Total pressure ulcers for September = 51 with 15 still to be investigated, so the numbers may be lower.
- Incidents continue to have the incorrect level of harm reported; the Tissue Viability Team inform the incident investigators for this to be addressed.

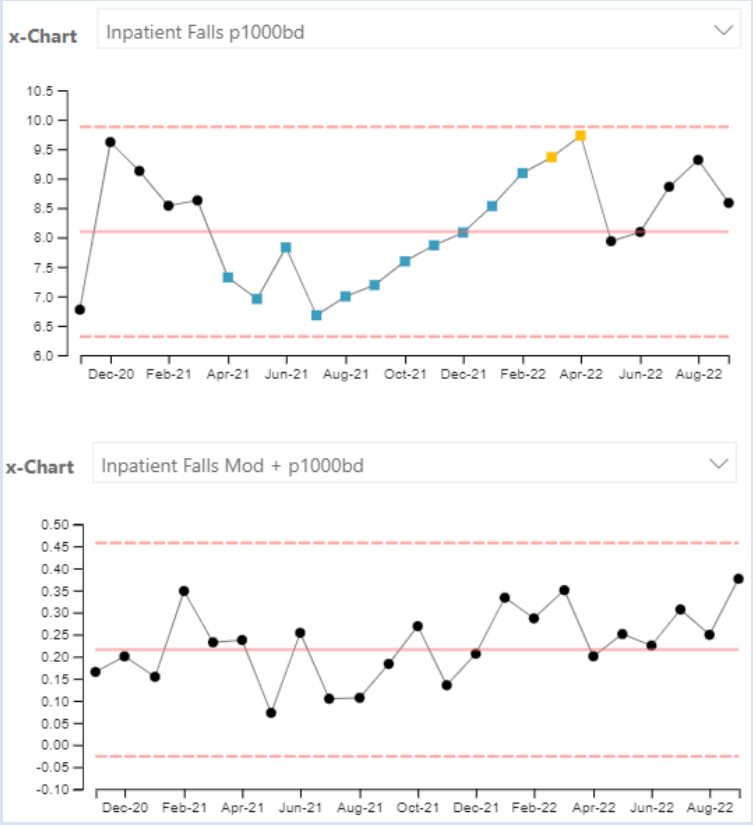
Actions / Future Plans for Improvement:

- We are planning a video to share best practice across the organisation and hope to mandate this best practise. This will be agreed at the task and finish group.
- TV training is being reviewed and updated.
- Datix and RCA to be reviewed now all areas are digitalised.
- Improvement trajectories to be determined for all areas.
- All staff are to have specific performance objectives in relation to TV as part of the appraisal process.
- To review TV link nurse roles and responsibilities.

2.6 INPATIENT FALLS CAUSING HARM

Inpatient falls per 1000 bed days

Inpatient falls resulting in harm per 1000 bed days



Aim: To reduce the number of inpatient falls resulting in harm

Target: To reduce the number of inpatient falls to below the mean

What is the chart telling us:

- There were 8.6 inpatient falls per 1000 bed days recorded in September 2022 (n=274).
- 0.38 (per 1000 bed days) inpatient falls resulted in moderate, severe or catastrophic harm to the patient.
- The number of falls being reported is within control limits

Successes:

- Participated in National Falls Awareness week, raised the profile of Falls Prevention within the trust.
- Information stands held at HRI/ CHH providing information, education to staff, and members of the public.
- Visited wards, gave updates, information with positive staff engagement
- Task and Finish group created in April outstanding actions to continue through the falls Committee
    - MDT actions developed from own incidents, NICE guidance and CQC KLOEs. Successes were Falls Prevention training should be made a required learning for majority of staff.

Falls Training

- On-line training for registered practitioners and medical staff, from the Royal College of Physicians now available on HEY 247.
- Face to face training for non-registered clinical staff fully booked until March 2023, feedback forms demonstrating positive feedback.
- Bespoke training resources targeting specific staff groups/ clinical areas complying with the trusts digital strategy and have inclusivity and diversity at the forefront
- Working clinically on wards to support staff with bedside education.
- Provided face to face training for 356 staff members since February 2022, and an additional 97 on the flojac equipment.

Falls Training 2022

Topic	Apr	Jun	Aug	Sep	Oct	Grand Total

Preventing Falls in Hospital: Carefall		1	9	8	8	26
Preventing Falls in Hospital: Fallsafe	2		324	440	241	1007
Grand Total	**2**	**1**	**333**	**448**	**249**	**1033**

- Continue to support the university in the nursing education in relation to falls prevention.

Key Risks and Challenges:

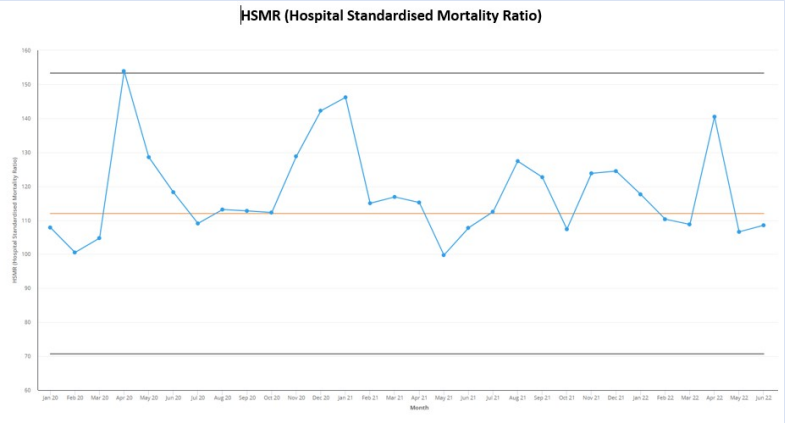
- The Trust is reporting a high number of inpatient falls however the number of falls resulting in harm remains low within control limits.
- The Chest Medicine wards reported the highest number of inpatient falls resulting in harm
- The majority of falls reported are un-witnessed

Actions / Future Plans for Improvement:

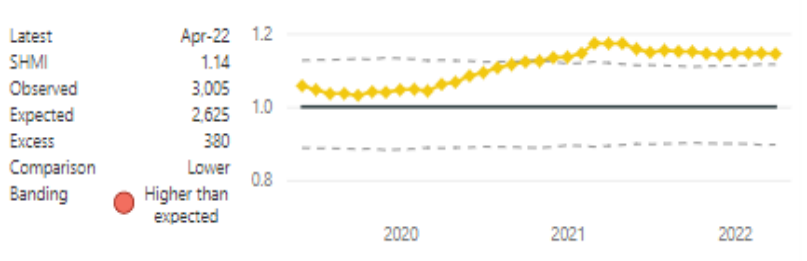
- To work with the digital team to develop an electronic falls bundle on NerveCentre
- Development of Falls Champions network to share lessons learned, best practice and quality improvement initiatives
- The Trust Multi-Disciplinary Falls Committee continues to meet bi-monthly
- Implementation of improvement programme to see a reduction in patients coming to harm from falls against strategic ambition 'harm free care' in the Quality Strategy 2022/2025.
- Worked with the digital team to improve clinical assessments and the provision of individualised patient centre care
- Planning to visit any ward areas not yet engaged with during National Falls Awareness week
- Promote the initiative of 'TAG support' to keep our patients safe. (TAG is where nominated staff support patients 1 to 1 who are assessed as at high risk of falling)
- Introduce a trial of 'yellow falls risk' bracelets in high risk areas
- Work in collaboration with the Dementia and CNE's teams to improve approach to holistic care
- Improve audit processes to include the development of 'Myassure' and a specific fundamental standard for falls prevention
- Complete a business case to obtain sufficient flat lifting equipment

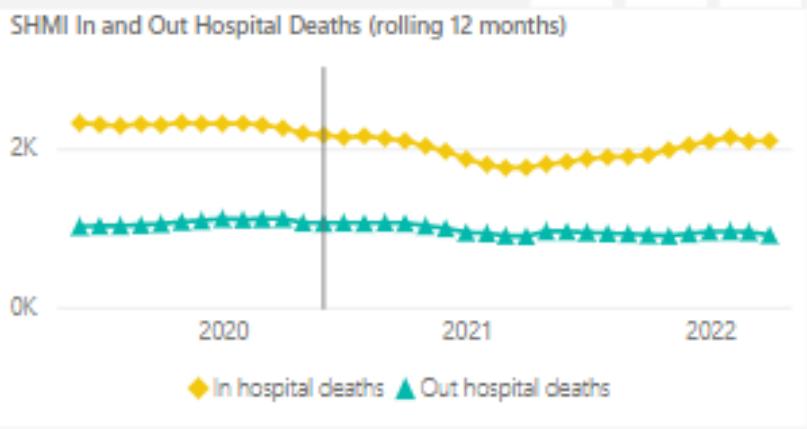
3. EFFECTIVENESS DOMAIN

3.1 MORTALITY

Hospital Standardised Mortality Ratio (HSMR)	**Aim:** To reduce the HSMR to below the national average of 100 and improve patient outcomes **Target:** Below 100
	**What is the chart telling us:** • HSMR reporting period January 2020 to July 2022 • HSMR continues to demonstrate 'higher than expected deaths' and is above the national average and target of 100 • Spike in the HSMR noted for April 2022 which is under investigation
	Successes: • HSMR reduced in May 2022 following the spike in April 2022 indicating this was not a continued increase in deaths
	Key Risks and Challenges: • The Trust continues demonstrate 'higher than expected deaths' and is an outlier against its HSMR
	Actions / Future Plans for Improvement: • A review of the mortality data for April 2022 highlighted an increase in COVID-19 in-hospital deaths and deaths from secondary malignancies. An investigation is underway to determine if these deaths were avoidable, are the appropriately coded, should the patients have been in hospital and was there preferred place of death achieved, ReSPECT and EOL discussions, the quality of end of life care and could anything have been done differently for these patients. The outcome of the review will be presented to the November 2022 Mortality and Morbidity Committee. • The Mortality and Morbidity Task and Finish Group continue to meet monthly to closely monitor the HSMR data and to work on improving the areas that are highlighting as a potential risk

Summary Hospital-level Mortality Indicator (SHMI)	**Aim:** To reduce the SHMI to below the national average of 1.0 and improve patient outcomes **Target:** Below 1.0





What is the chart telling us:

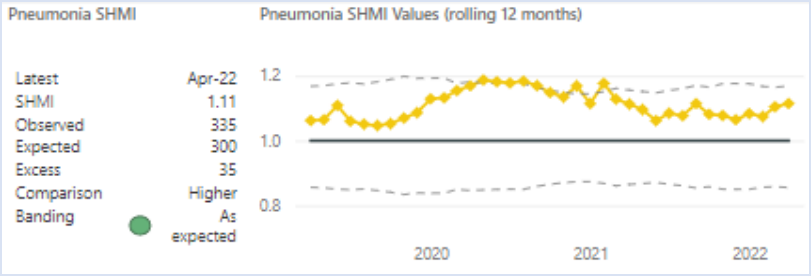
- Charts are displaying performance for a rolling 12 month period. Latest data is for April 2022
- Trust SHMI continues to demonstrate 'higher than expected deaths' and is above the national average and target of 1.0. Excess deaths were 380. The out of hospital deaths remain consistent, it is the in-hospital deaths that is causing the increase
- Pneumonia SHMI continues to demonstrate a 'higher than expected deaths' with an excess of 35 and is above the national average and target of 1.0
- Sepsis SHMI continues to demonstrate 'higher than expected deaths' with an excess of 50 and is above the national average and target of 1.
- Stroke SHMI continues to demonstrate 'higher than expected deaths' with an excess of 20 and is above the national average and target of 1.0

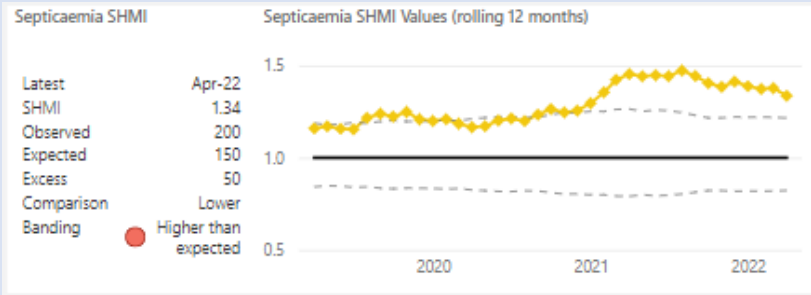
Successes:

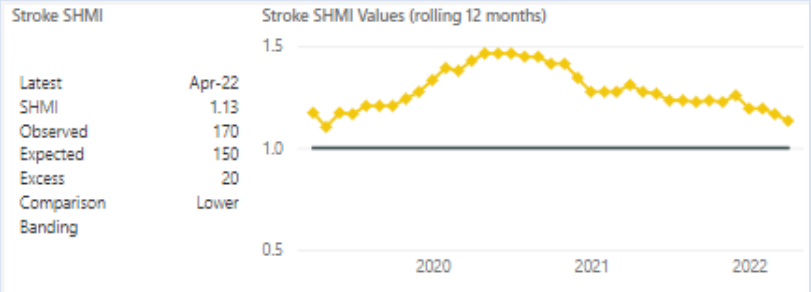
- Establishment of a Sepsis Steering Group and a Pneumonia Steering Group to really focus and drive the improvements with the relevant clinical teams

Key Risks and Challenges:

- The Trust continues to demonstrate 'higher than expected deaths' against its SHMI and is highlighted as one of the top 12 Trusts with an outlier status by NHS Digital
- The top 3 common clinical conditions remain Sepsis, Pneumonia and Stroke
- An increase in deaths attributed to Urinary Tract Infections (UTI) has been identified by the Mortality Task and Finish Group







Actions / Future Plans for Improvement:

- The Mortality and Morbidity Task and Finish Group continue to meet monthly to closely monitor the mortality data and to work on improving the areas that are highlighting as a potential risk
- The Mortality and Morbidity Task and Finish Group will run alongside the Sepsis and Pneumonia Steering Groups. The M&M Task and Finish Group will continue to closely monitor the mortality data, undertake benchmarking and comparison work and highlight areas for further investigation and seek assurance from the other established steering groups
- A presentation on the UTI and Community Acquired Pneumonia CQUIN Q1 data was provided to the September 2022 Mortality and Morbidity Committee. To really understand why patients are dying in-hospital from these conditions it is essential the group also looks at the patients who were discharged, those who had died and their journey to inform further improvements in those pathways and how we can reduce any avoidable deaths that may be occurring. This work will be incorporated into the Steering Groups for further analysis and improvements.
- The Trust continues to learn from others. Actions identified following the visit to Liverpool continue to be addressed and the Mortality and Morbidity Task and Finish Group are currently reviewing Sepsis SHMI comparison data against NLAG.
- The coding team continue to support all areas of investigation and are undertaking a small exercise to review the coding of Pneumonia deaths to establish if they were appropriately coded based on the primary diagnosis

3.2 CQUIN

CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	**Aim:** Improve antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment **Target:** 40% - 60%
Chart to be added from Q2 onwards	**What is the chart telling us:** • Q1 was submitted in line with the NHSEI timescales, performance was 35%
	Successes: • Presented the findings to Mortality and Morbidity Committee to inform improvements against the full pathway for the care and treatment of patients diagnosed with a UTI. Improvement work and clinical/primary care leads agreed to take this work forward
	Key Risks and Challenges: • CQUIN was not achieved for Q1 • The main reason for non-compliance was because a urine dip stick test was not always used to diagnose the UTI or sent to Microbiology in line with NICE Guidelines • The Mortality and Morbidity Task and Finish Group has identified an increased in deaths coded as UTI in the SHMI data
	Actions / Future Plans for Improvement: • Q2 submission is due to be submitted by 30 October 2022 • Junior doctor supporting the completion of the audit • Quality Improvement Plan to be developed with the agreed Medical Quality Improvement Leads, Clinical Leads within ED and Primary Care. This will focus on the patients who are discharged and in-hospital deaths coded as a UTI.

CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	**Aim:** Improved recording of having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) for unplanned critical care unit admissions from non-critical care wards of patients aged 18+ **Target:** 20% - 60%
Chart to be added from Q2 onwards	**What is the chart telling us:** • No submission for Q1, performance was 0%
	Successes: • None to report
	Key Risks and Challenges: • CQUIN was not achieved for Q1 • The main reason for non-compliance was because of the recording of the escalation and response times. The NEWS2 score is electronically recorded; however, the timings for escalation and response isn't
	Actions / Future Plans for Improvement: • Q2 submission is due to be submitted by 27 November 2022 • Junior doctor supporting the completion of the audit • The Trust already has a deteriorating patient improvement project underway; therefore, the current project will be reviewed to include CQUIN • Exploration of electronic solutions for the recording of timings
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle	**Aim:** Patients with confirmed community acquired pneumonia are managed in concordance with relevant steps of BTS CAP Care Bundle **Target:** 45% - 70%
	What is the chart telling us: • Q1 was submitted in line with the NHSEI timescales, performance was 16%
	Successes: • Presented the findings to Mortality and Morbidity Committee to inform improvements against the full pathway for the care and treatment of patients

Chart to be added from Q2 onwards	diagnosed of community acquired pneumonia (CAP). Pneumonia Steering Group established to focus on the patients who are discharged and in-hospital deaths coded as a pneumonia and community acquired pneumonia.
	Key Risks and Challenges: • CQUIN was not achieved for Q1 • The main reasons for non-compliance are chest x-ray performed within 4 hours of arrival, recording of a CURB score and antibiotics received within 4 hours of arrival. • Pneumonia continues to be one of the top 3 clinical conditions contributing to the Trust increased HSMR and SHMI
	Actions / Future Plans for Improvement: • Q2 submission is due to be submitted by 27 November 2022 • Junior doctor supporting the completion of the audit • Quality Improvement Plan to be developed with the agreed Medical Quality Improvement Leads, Clinical Leads within ED and Surgery. This will focus on the patients who are discharged and in-hospital deaths coded as a Pneumonia.
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery	**Aim:** To ensure major elective blood loss surgery patients are treated in line with NICE guideline NG24 **Target:** 45% - 60%
Chart to be added from Q2 onwards	**What is the chart telling us:** • Q1 was submitted in line with the NHSEI timescales, performance was 91%

	Successes:
	• 91% of patients were treated in line with NICE guideline NG24 and in particular for this CQUIN meant that the following actions were completed prior to surgery for these patients:
	  ○ Haemoglobin (Hb) measured at pre-op assessment, or reviewed and recorded if test results were already available
	  ○ If anaemia present, have serum ferritin level tested
	  ○ If diagnosed with iron-deficiency anaemia offered appropriate iron treatment (oral and/or IV iron); or refer to back to primary care for treatment where an existing local pathway is in place

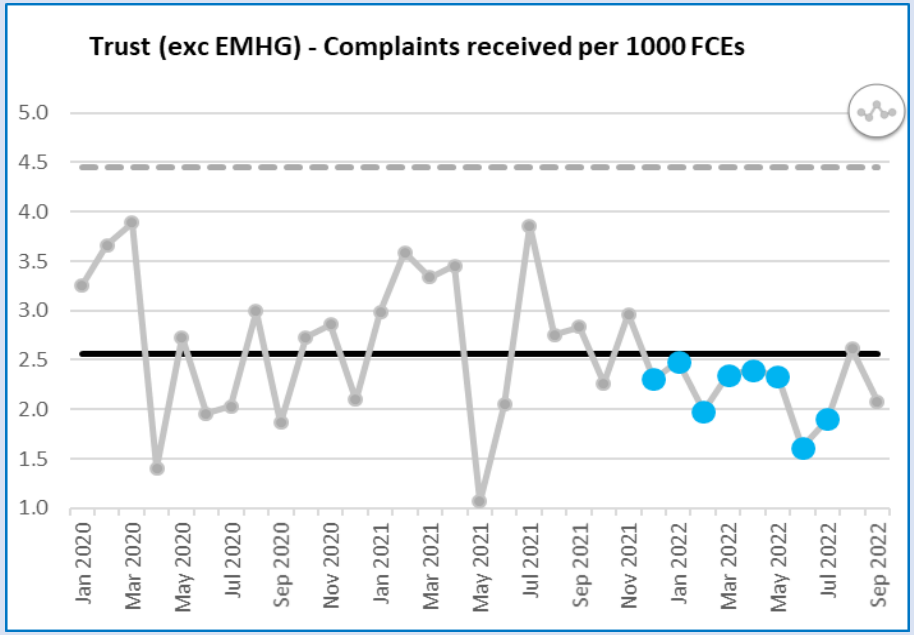
	Key Risks and Challenges: • None to report
	Actions / Future Plans for Improvement: • Q2 submission is due to be submitted by 27 November 2022 • The service continue to monitor closely to maintain improved clinical outcomes for patients and compliance with NICE and the CQUIN
CCG8: Supporting patients to drink, eat and mobilise after surgery	**Aim:** To ensure surgical patients are supported to eat, drink and mobilise within 24 hours of surgery ending **Target:** 60% - 70%
Chart to be added from Q2 onwards	**What is the chart telling us:** • No submission for Q1, performance was 0%
	Successes: • None to report
	Key Risks and Challenges: • CQUIN was not achieved for Q1. Missed payment of £270,470 for Q1 • Improvement project is required with the input of HDigital for an electronic solution in particular regarding the documentation of mobilisation after surgery.
	Actions / Future Plans for Improvement: • Q2 submission is due to be submitted by 27 November 2022 • Junior doctor supporting the completion of the audit • Exploration of electronic solutions for the recording of mobilisation

CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients	**Aim:** Ensure all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis **Target:** 20% - 35%
Chart to be added from Q2 onwards	**What is the chart telling us:** • Q1 was submitted in line with the NHSEI timescales, performance was 22.1%
	Successes: • Q1 was partially achieved and received part payment of £37,781 against the £270,470 for Q1.
	Key Risks and Challenges: • The service achieved minimum compliance and is working on improving this quarter on quarter. Changes to some of the current processes and recording are required to further improve this
	Actions / Future Plans for Improvement: • Q2 submission is due to be submitted by 27 November 2022 • The service are making some changes to their processes and how some of the information is recorded, which is aimed to improve compliance with this CQUIN from Q2 onwards

4. RESPONSIVE DOMAIN

4.1 COMPLAINTS RECEIVED

Title of chart: Trust (exc EMHG) - Complaints received per 1000 FCEs



Aim: Minimise formal complaints & increase PALs/Early resolution

Target: 2.5

What is the chart telling us:

- HUTH has a sustained level of formal complaints per month
- 9 data points from last 10 below target
- Remains within upper control limit

Successes:

- Early resolution and PALS have a sustained increase helping to keep formal complaints within target

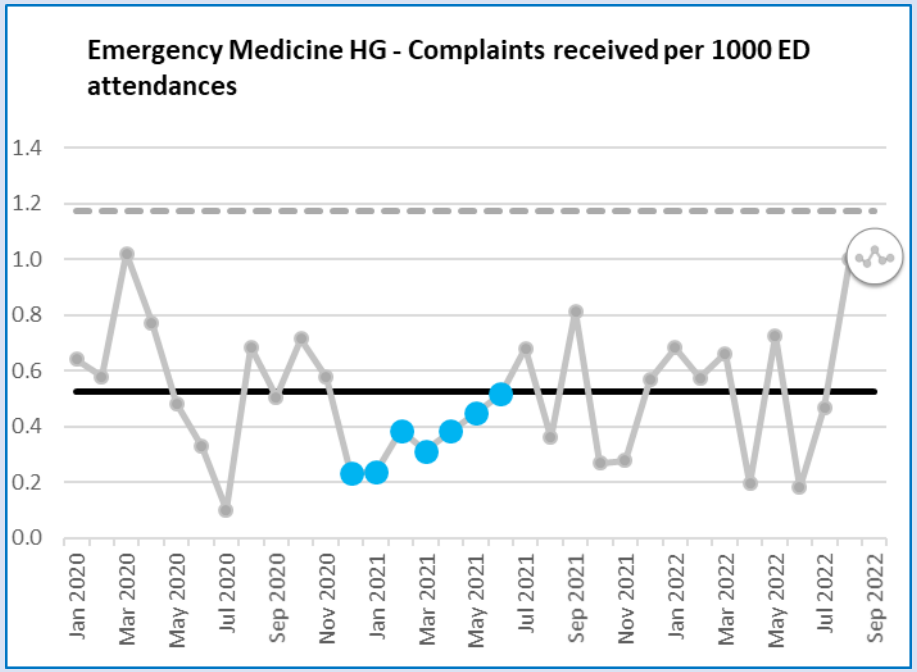
Key Risks and Challenges:

- Patient experience team capacity to log and process complaints
- HG operational pressures slow complaint response process
- Updated “complaints handling framework” to implement

Actions / Future Plans for Improvement:

- Quality Governance Directorate supporting Patient Experience
- Proposed central help to support HG’s to tackle backlog
- Learning from complaints/experience/actions to be monitored via PESC

Title of chart: Emergency Medicine HG - Complaints received per 1000 ED attendances



Aim: Minimise formal complaints & increase PALs/Early resolution

Target: 0.5

What is the chart telling us:

- Common cause variation
- Remains within upper control limit

Successes:

- HG very efficient at responding lead time

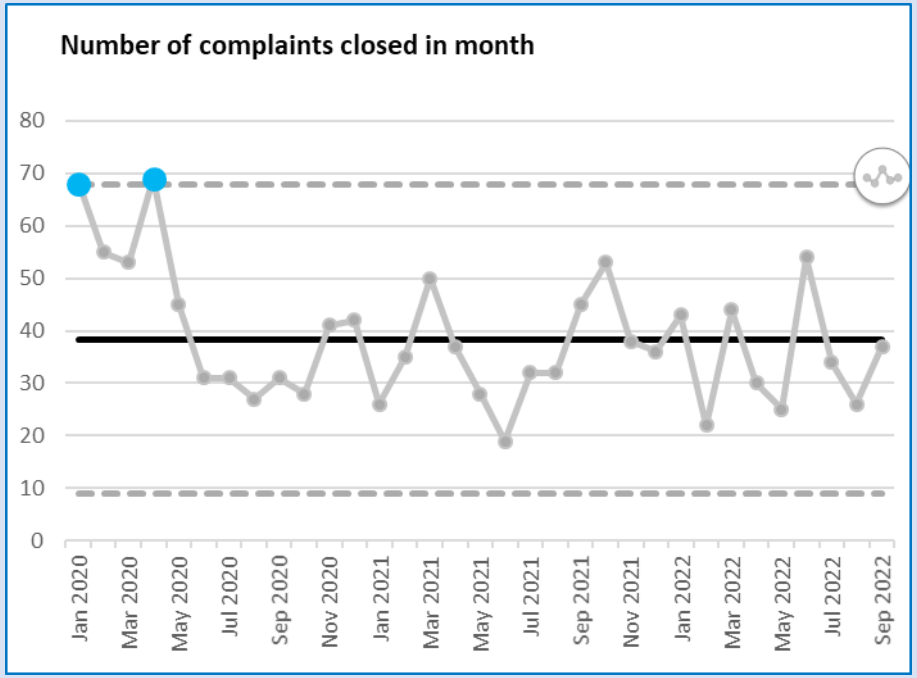
Key Risks and Challenges:

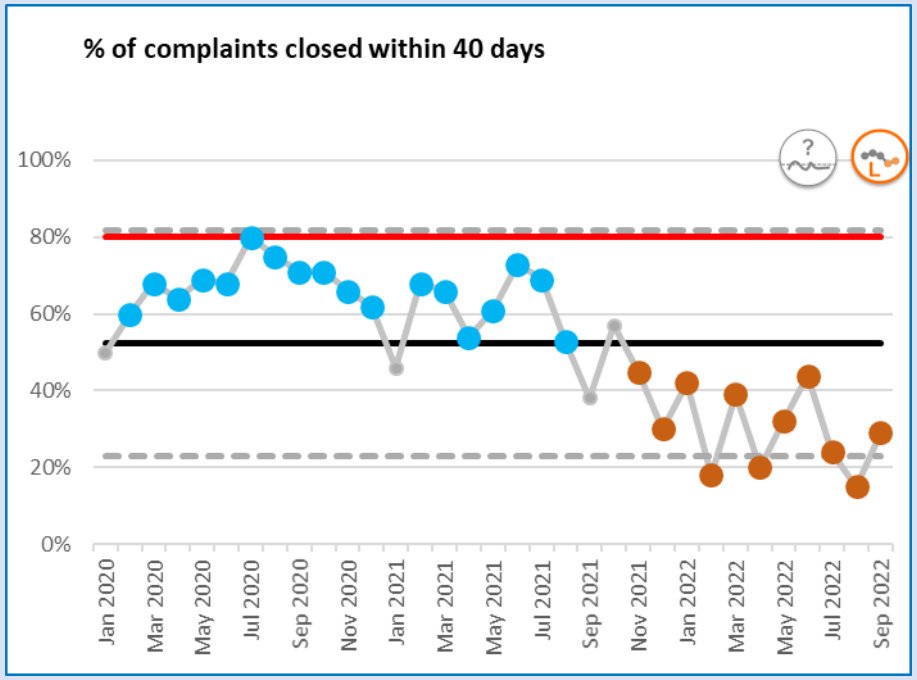
- Patient experience team capacity to log and process complaints
- HG operational pressures may impact during winter months
- Updated “complaints handling framework” to implement

Actions / Future Plans for Improvement:

- Quality Governance Directorate supporting Patient Experience
- Learning from complaints/experience/actions to be monitored via PESC

4.2 COMPLAINTS CLOSED

Title of chart: Number of complaints closed in month	Aim: To close more each month than opened Target: 40 (minimum) closed per month
	**What is the chart telling us:** • The HUTH complaints closure rate is not sufficient to decrease the backlog or maintain the target of closing complaints within the 40 day target **Successes:** • CSHG & EMHG both maintain their closure rate **Key Risks and Challenges:** • Patient Experience Team capacity to quality check, and close complaints on DATIX in acceptable timeframe. • HG operational pressures through winter months • Updated “complaints handling framework” to implement **Actions / Future Plans for Improvement:** • Patient Experience working with colleagues to provide additional support to reduce the backlog

Title of chart: % of complaints closed within 40 days	Aim: Increase % of complaints closed within 40 day target Target: 80%
	**What is the chart telling us:** • Complaints response lead time deteriorated in 2022 • Reduced response time increases >40 day backlog **Successes:** • CSHG & EMHG >40 day response are at acceptable levels **Key Risks and Challenges:** • Patient Experience Team capacity to quality check, and close complaints on DATIX in acceptable timeframe. • HG operational pressures through winter months • Updated “complaints handling framework” to implement **Actions / Future Plans for Improvement:** • Trajectory figures reported on weekly directors report • Patient Experience working with colleagues to provide additional support to reduce the backlog

4.3 NATIONAL INPATIENT SURVEY

2021 INPATIENT SURVEY RESULTS	
Where patient experience is best ✓ Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital ✓ Cleanliness: patients feeling that the hospital room or ward they were in was clean ✓ Food outside set meal times: patients being able to get hospital food outside of set meal times, if needed ✓ Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital ✓ Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital **Where patient experience could improve** o Expectations after the operation or procedure: patients being given an explanation from staff, before their operation or procedure, of how they might feel afterwards o Information on discharge: patients being given information about what they should or should not do after leaving hospital o Information about medicines to take at home: patients being given information about medicines they were to take at home o Noise from staff: patients not being bothered by noise at night from staff o After the operation or procedure: patients being given an explanation from staff of how their operation or procedure went Link to view Full Survey Results	This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2021. Between January 2022 and May 2022, a questionnaire was sent to 1248 inpatients at Hull University Teaching Hospitals NHS Trust who had attended in late 2021. Responses were received from 517 patients, which is a 44% response rate. **Successes:** • In comparison with other Trusts we performed about the same in the majority of the questions. **Key Risks and Challenges:** • There is no significant improvement from the 2020 results, with 5 areas having significantly lower results than 2020. **Actions / Future Plans for Improvement:** • Action plans to be developed with the health groups to be monitored via the Patient Experience Sub-Committee • Focus groups to be held with patients

5. WELL-LED DOMAIN

5.1 CONTINUOUS QUALITY IMPROVEMENT

57

20

37

49

21

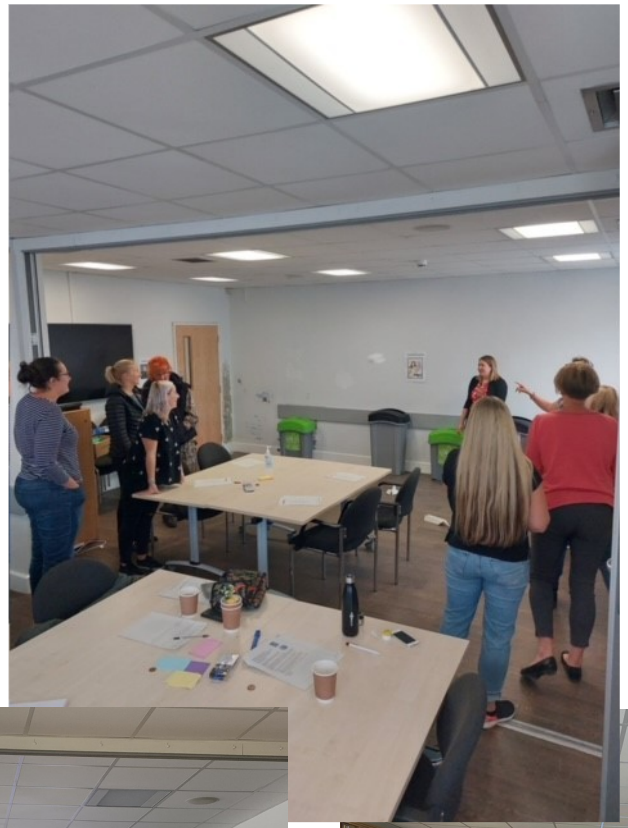
28

163

1

- To date HUTH has trained 57 members of staff on the QSIR 5 day Practitioner programme over two cohorts. This includes 20 clinical (Nursing & Medical) and 37 non-clinical staff. A third cohort is currently running with a further 12 delegates. This includes 21 clinical (Nursing & Medical) and 28 non-clinical staff.
- To date HUTH has trained 49 members of staff on the QSIR 1 day Fundamentals programme over two cohorts.
- The trust launched ThinkTank a staff improvement and suggestions platform in September 2022 during Improvement Month. To date the ThinkTank platform has seen 163 staff suggestions submitted to the platform. All 163 suggestions have been reviewed and are being progressed with the staff submitting ideas.
- We welcomed another member to the Trusts QSIR Faculty meaning the faculty is now supported by 13 accredited QSIR associates

5.2 QSIR & QUALITY IMPROVEMENT



In September 2022 the QSIR Faculty launched cohort 3 QSIR Practitioner; a five-day intensive Quality Improvement training programme. This is the first cohort delivered as an accredited QSIR Faculty and supported by NHS England and Improvement Regional System Improvement Team.

The Faculty have delivered a further two QSIR Fundamentals our one-day introduction to Quality Improvement programme cohorts over the reporting period with these cohorts being supported by faculty members from the Operational Improvement Team, Pharmacy and Emergency Medicine Health Group.

> “I have really enjoyed the QSIR Fundamentals course it has given me an insight into Quality Improvement and I’m excited to move onto my QSIR practitioner programme”

> “The QSIR Practitioner programme gave me the tools and techniques I needed to bring Quality Improvement to life in my area and support others to make meaningful improvements”

5.3 GREATIX

11 in total

3 Sept-Oct

58 Certificates Sept-Oct

Dr Ilyas Mansoori and Louise Walters (pictured left) received an award for their help in creating one of the most useful services nationally for oncology (Queens Cancer Assessment Unit). Dr Mansoori's work changed the way we treat acute oncologic emergencies, whilst Louise Walters' leadership and dedication supported the application of this working day and night to care for patients. This area has become a hub of teaching for junior doctors, registrars and nurses, as well as being the centre of oncology QIPs including the Sepsis pathway.

Humberside Breast Screening Service were awarded for the sheer amount of hard-work they put into responding to 40,000 delayed and cancelled assessments due to Covid-19's first wave. The team worked extended days and weekends to ensure women could return to undergoing 3-yearly screenings as required. In June 2022, they achieved their 'round length' for the first time in a year. This nomination is particularly close to my heart, because the team were ecstatic about receiving their certificates and badges, so it was very special to meet them. This included 42 staff and a picture of some of the team

5.4 CARE QUALITY COMMISSION

The Trust received an unannounced inspection between 01 and 03 November 2022. The CQC focussed on the Emergency Care, Medicine and Surgery core services across both Hull Royal Infirmary and Castle Hill Hospital. The CQC provided some very high level feedback to the Executive Team as they concluded the onsite visit on 03 November 2022, which primarily focussed on the overcrowding in ED. The Trust is already working on its immediate response to the feedback.

The well-led element of the inspection is scheduled to take place between 06 and 08 December 2022. Interviews will take place with the Executive Team and other Senior Leaders across as required.

The Trust is expected to receive the draft report in January 2023, which will commence the factual accuracy checking process in line with usual inspection processes. The Trust will have 10 working days to respond. The final report will then be received shortly after this checking period.

Agenda Item		**Meeting**	Quality Committee and Trust Board	**Meeting Date**	18/10/22
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	Jayne Gregory Clinical Governance Midwife Helen Yates Neonatal Consultant Lorraine Cooper Director of Midwifery				
Report previously considered by (date)	Quality Committee November 2022				

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

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

Hull University Teaching Hospital NHS Trust
FAMILY AND WOMENS HEALTH GROUP
WOMEN SERVICES DIVISION

Avoiding Term Admissions into Neonatal Units (ATAIN): Learning from Term Admissions Quarter Two 2022

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 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 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 the ATAIN program at hull University Teaching hospital 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 2 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 NUU 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 4 01/01/22-01/03/22
Table 3 highlights the number of admissions in Quarter 1 of 2022

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 2021/2022

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 2022	1223	34.7%	2.6%

Table 3 2022/2023

Duration	In born admissions	% of total NNU	% of term admissions
Quarter 1 2022	1182	26.6	2.6
Quarter 2 2022	1212	40.5%	3.4%

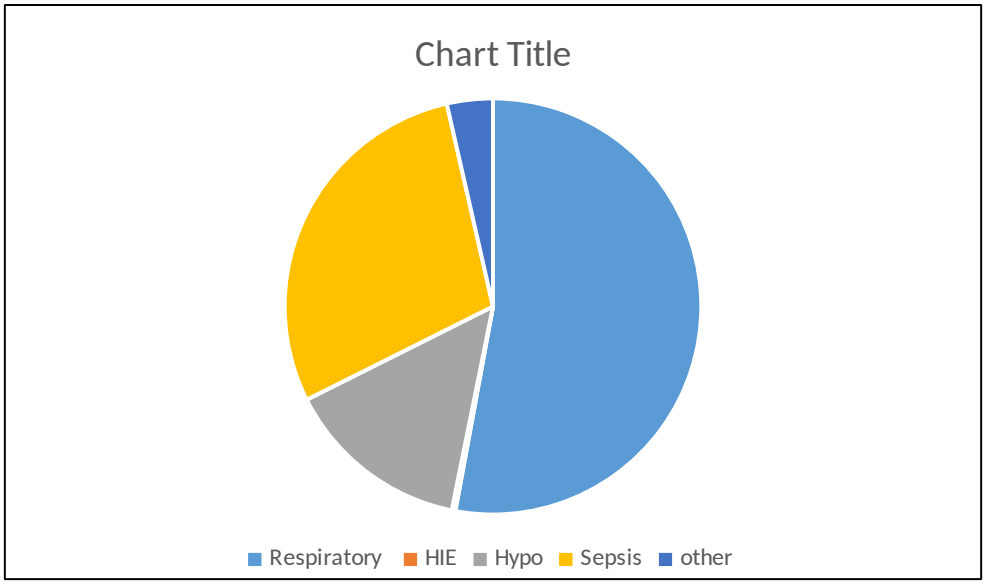
All unexpected term admissions to NICU are reported through the DATIX system and investigated through the weekly Maternity Case Review multi-disciplinary meeting .The CNST approved template ATAIN proforma is completed for data collection purposes. The themes, trends and learning points are shared amongst 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.

This report considers all term admissions to the NICU in previous reports the length of stay has currently only been considered if over 4 hours. 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 39- 39+7weeks 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 looked focused on area of admission.

Gestation

In quarter one, 42 cases of Unexpected Term Admissions to NICU have been reviewed through Maternity case review and the themes identified are presented below. The average gestation at admission to NICU was 39 -39+ 6 weeks

The primary reason for admission at gestation 39 weeks 39+6 to NICU was for respiratory support, which from this Cohort of baby's 16 where treated for hypoglycaemia. This results in 38% of babies between the gestations of 39 weeks – 39.6 weeks admitted to NICU for low blood sugars.



Admission Location
Babies were most commonly admitted to NICU from the labour ward and theatre. The auditors have identified through this review that that this cohort of babies did not receive skin to skin. In addition the babies identified in this report where commenced on the hypoglycaemia pathway however did not receive a feed within the first hour.

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 Elective Caesarean Sections in labour. 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 in this mode of delivery within a theatre situation therefore this has been added as a quality improvement within the action plan. This work is ongoing and training video is in the process of being completed and will be added to the maternity and obstetrics workspace. In addition the infant feeding co- ordinatiors are delivery additional training on the mandatory training days around skin to skin at birth and the additional benefits to this.

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

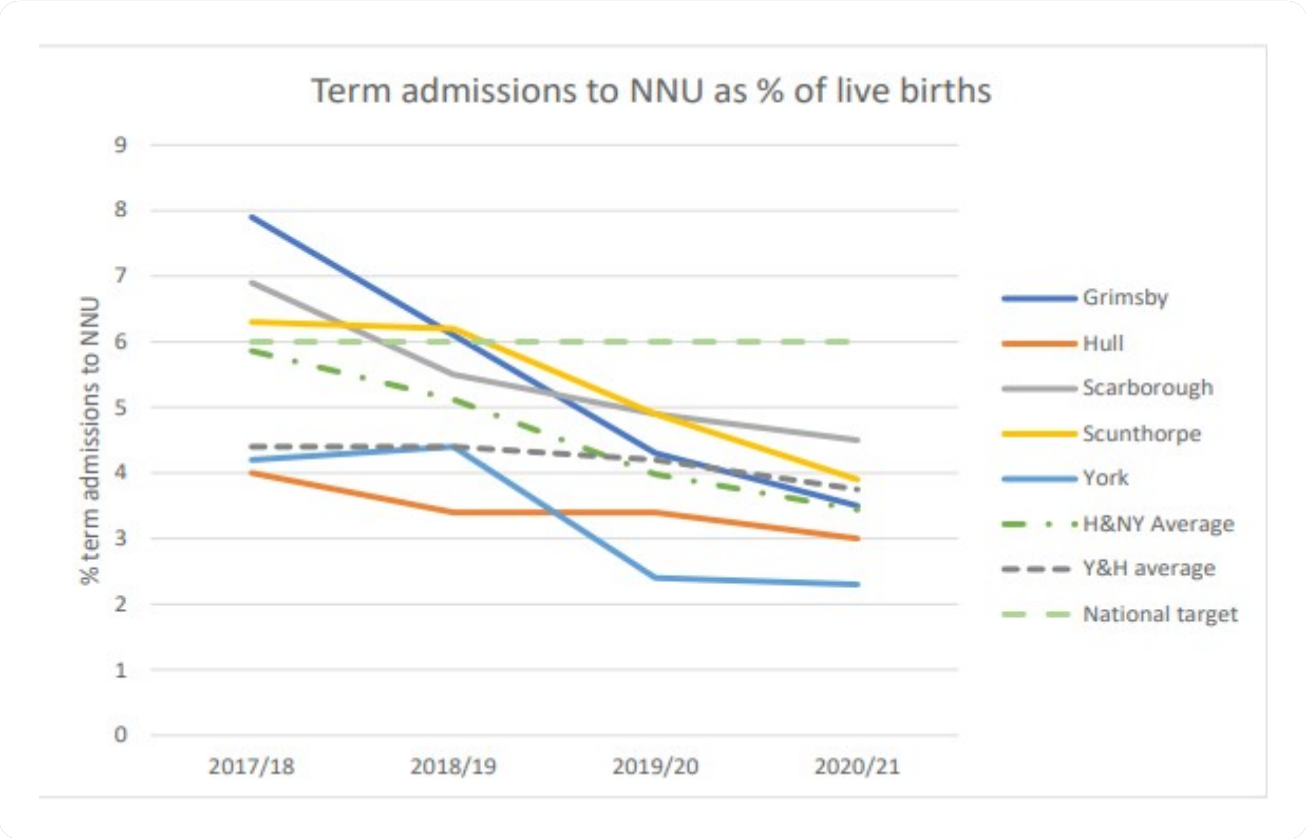
Length of NICU stay
- The length of stay on NICU was most commonly between 1 -3 days.

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 TC admission criteria but were admitted to the NNU is and the number of babies that were admitted to, remained on NNU because of their need for nasogastric tube feeding is 0. It has been identified the capacity on the transitional care is the reason in all 11 cases.

Yorkshire and the Humber Local Maternity System review of all Maternity Units

Unit		Unit Level			Term admissions to NNU as % of live births		
2017/18		2018	2019	2019/20	2020/21		
Grimsby	LNU	7.99	6.1 ↓	4.3	↓	3.5	↓
Hull	NICU	4	3.4 ↓	3.4	↔	3	↓
Scarborough	SCU	6	5.5 ↓	4.9	↓	4.5	↓
Scunthorpe	LNU	6.3	6.2 ↓	4.9	↓	3.9	↓
York	LNU	4.2	4.4 ↓	2.4	↓	2.3	↓
H&NY	5.9	5.1	↓	4.0 ↓	3.4	3.5	↓
Average							
Y&H Average	4.4	4.4	↔	4.2 ↓	3.8	↓	



Since collation of ATAIN data commenced in 2017 Humber &North Yorkshire Local Maternity System have consistently been under the national achievement rate of <6% across all sites, and since 2018/19 have been under the Y&H target of <5%. Since 2019 they have seen a sustained reduction in admission rates in all units and have seen a significant overall reduction from 5.9% in 2017/18 to 3.4% in 2020/21.

The themes as identified locally were reviewed and the following action plan agreed through multidisciplinary discussion

Action	**Lead**	**Status**
Working group to be developed on labour ward how to improve the skin to skin compliance at birth irrespective of the mode of delivery	Labour ward Matron	February 2023

Hypoglycaemia and NEWWTT chart video to be relaunched NEWTT sticker to be placed in the front of the red baby notes	Pippa Toogood and Anna Lee Hughes	Completed
To embed practice of skin to skin at EMCS/ELCS Training video to be completed by the infant feeding co ordinatiors	Pippa Toogood and Anna Lee Hughes	August 2022

Compliance with the above 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)
October 2022

Sources:
Term Admissions - Yorkshire and Humber Neonatal ODN - Futures Collaboration Platform
reducing-harm-leading-to-avoidable-admission-of-full-term-babies-into-neonatal-units.pdf (england.nhs.uk)

Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee

Agenda Item		**Meeting**	Trust Board Meeting	**Meeting Date**	
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
October 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

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.

Revised maternity incentive scheme guidance

Following communication in May 2022, the members of the maternity incentive scheme's Collaborative Advisory Group have further revised the scheme's standards in order to support trusts to continue to work towards improving quality and safety.

The submission deadline has been extended to provide Trusts with extra time to achieve the standards. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by 12 noon on Thursday 2 February 2023. The Board declaration form, will be published on the NHS Resolution website.

In response to concerns highlighted by trusts regarding their ability to achieve the scheme requirements, we have now published the revised maternity incentive scheme guidance. The technical guidance has been strengthened, which includes amendments to:
Safety action two:

- Regarding what alternative options are available if the integrated care board are unable to sign off your digital strategy.
- What to do if midwifery continuity of carer pathway has been suspended at your trust.

Safety action four:

- Please note the email address for Royal College of Nursing has changed to cypadmin@rcn.org.uk

Safety action five

- Strengthened technical guidance on the role of the labour ward co-ordinator and supernumerary status

Safety action six (element one and two):

- Strengthened technical guidance around element one, two and five which includes clarity and timeframes for audits

Safety action eight:

- Strengthened guidance regarding online training and training timeframes

Safety action nine:

- Revised guidance on Maternity Continuity of Carer (MCoC) in light of the continued workforce challenges that maternity services are facing.

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** **Compliant**	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** **Partial Compliance**	**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 Partial Compliance**	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. 3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. 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 four standard and partial compliance with the remaining six 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:

- Decide if any further information and/or assurance is required.

Lorraine Cooper
Head of Midwifery
October 2022

Joanne ledger
Executive Chief Nurse

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

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

Key Recommendations to be considered:

The Committee is requested to:

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

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY SERVICES
FAMILY AND WOMEN'S HEALTH GROUP

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

1. Purpose of the Report

The purpose of this report is to provide assurance to the Trust Board that a multidisciplinary team is completing the national Perinatal Mortality Review Tool (PMRT) to the standard required by the Clinical Negligence Scheme for Trusts (CNST) Year 4.

2. Introduction

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

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme, to support the delivery of safer maternity care. Trusts involved in the maternity incentive scheme will contribute an additional 10% of the CNST maternity premium creating the CNST maternity incentive fund. The scheme incentivises 10 safety actions, Trusts demonstrating they have achieved all ten of the safety actions will recover their contribution and will receive a share of any unallocated funds. The scheme was relaunched in May 2022 and will included eligible cases between the 6th May and 5th December 2022. In order to be eligible for payment under the scheme, Trusts must demonstrate that they have been compliant with action one and submit their completed declaration form to NHS Resolution by 12 noon on Thursday 5th January 2023. Trust submissions will be subject to a range of external verification points including cross checking with MBRRACE-UK data (safety action 1 point a,b,c).

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

A)

i. Perinatal deaths eligible to be notified to MBRRACE-UK from 6th June 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month. When surveillance is required to be assigned to another Trust cases are exempt from being completed in a month.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6th 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

B) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6th May will have been reviewed using the

PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

C) For at least 95% of all deaths of babies who died in your Trust from 6th 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. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors, which may have a bearing on a future pregnancy. In the absence of a bereavement lead, ensure that someone takes responsibility for maintaining contact and for taking actions as required.

D) Quarterly reports will have been submitted to the Trust Board from 6th 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.

4. Perinatal Mortality Review Tool (PMRT)

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

The PMRT has been designed with the following principles:

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

5. Summary

The below summaries Q2 July to September 2022 which is within the reporting period of the CNST year 4 incentive scheme.

a) I.The Trust was **100%** compliant with the standard in Q2. All eligible perinatal deaths were notified to MBRRACE-UK within 7 working days and the surveillance was completed within one month.

ii.In Q2 there have been new cases totalling 4 stillbirths and 1 neonatal death suitable for a PMRT review in the Trust. In **100%** of all deaths of babies, a PMRT review has been started within two months, during the reporting period.

b) In Q2, PMRT reviews have been completed within 4 months for 8 cases from Q1 in the Trust and 5 reports have been written and published. 1 case remains outstanding which is a joint case with other Trusts demonstrating **88%** compliance. The 5 reports published are **100%** compliant with the 6 months' timeframe.

c) In **100%** of all deaths of babies who were born and died in the Trust Q2 reporting period, the parents have been told that a review of their baby's death will take place, and the parents' perspectives and any concerns they have about their care and that of their baby has been sought. The bereavement midwife maintains contact with the parents through the PMRT review.

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

6. Recommendations

The Trust Board is requested to:

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

Sue Cooper
Bereavement Midwife

Lorraine Cooper
Head of Midwifery October 2022

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY PMRT ACTION TRACKER FOR Q2 2022

MBRRACE ID	ACTIONS	Lead	Due date	RAG
80937	Highlight in PMRT newsletter recording observations consummate with maternal risk, completing the partogram and obtaining a HVS for infection screening	SC	30/09/22	
	To review care provision for women those first language is not English in relation to late booking, failure to attend appointments, information leaflets and AN care	JC	30/12/22	
81125	To highlight in community midwives newsletter the need to check Lorenzo prior to sending letters re missed appointments	AH	31/10/22	
81126	Highlight in PMRT newsletter ensuring women receive written information on reduced fetal movements and documenting risk correctly in the hand held records	SC	31/08/22	
81213	Meeting with the postnatal manager and lead midwife to discuss patients concerns with the IOL process	NE JC	30/11/22	
	Review the organisational pressures on the maternity service in relation to induction of labour	JC	30/11/22	
81534	Highlight in PMRT newsletter documentation of risk, undertaking maternal observations consummate with risk and appropriate fetal monitoring in extreme pre-term labour	SC	31/10/22	
81543	Highlight in the PMRT newsletter the need to record CO readings at booking and obtaining a HVS in an unexpected loss	SC	30/09/22	
81761	Highlight in the PMRT newsletter the need to record CO readings at booking	SC	30/09/22	
	Review process to ensure women who are identified as GDM at booking are prescribed Aspirin	AW	30/11/22	
82125	Highlight in PMRT newsletter that maternal observations are undertaken consummate with risk and that progress in labour is recorded on a partogram	SC	30/11/22	

Leads

SC – Sue Cooper
JC- Julia Chambers
AH – Anna Harrison
NE- Nicola Easby
AW – Amanda Waterton

RAG rating

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

Report to the Board in Public
Quality Committee
October 2022

Item: Neonatal Standards Deep Dive	Level of assurance gained: Reasonable

The committee received a presentation and supporting papers on Neonatal standards which provided an overview on the Neonatal Critical Care Review (NCCR) and the Getting It Right First Time (GIRFT) National Report.
The update shared activity and capacity actions and highlighted that the unit was not meeting targets and ran at near full capacity. The unit had submitted a successful bid for expansion.
The committee were informed about the workforce recommendations, gap analysis had been undertaken against the requirements and shortfalls identified in nursing, AHP and medical staffing and training requirements. Processes and Outcomes were also discussed.
Areas highlighted for further support were;

- Medical and AHP workforce issues
- Specialist nursing roles development
- Early EPR implementation
- Reference costs to be checked
- Detailed Neonatal Dashboard to monitor progress against all standards

Item: Quality Indicator Report	Level of assurance gained: Reasonable

The chief nurse shared that the Trust had adopted the Bristol model to support the pressures in ED and maintain flow and were boarding patients routinely, which is having a positive effect and reducing patient safety concerns.

The Serious Incident backlog has reduced and the number being declared has also reduced, the weekly Patient Safety Summit and Serious Incident Overview Group were working well.

The trust remain an outlier for SHMI and HSMR although there are initial signs that are the figures are improving. Analysis have been undertaken and there are not issues identified and care was good.

Complaints work is ongoing to reduce the backlog with Surgery and Medicine having the highest.

The report highlighted the Greatix received by the Breast team and the work they had done to remove the backlog.

Item: Infection Prevention and Control Update	Level of assurance gained: Reasonable

The Director of Infection Prevention and Control report provided an overview to the Quality Committee on the progress made to date on the management of HCAIs, hospital outbreaks and progress on IPC priorities.

Peaks in Klebsiella bacteraemia notably coincide with heat waves which affected Yorkshire & Humber through June to August 2022.

The Trust was an outlier for Pseudomonas Aeruginosa bacteraemia in quarter 1 and returned to normal baselines for quarter 2.

MRSA cases had seen a marked increase, post infection reviews had been undertaken and appear unavoidable, and there was one case that was deemed avoidable. Concern was raised at the increase in MRSA cases but assurance was provided and the Trust have not stopped screening despite changes to the guidance.

Item: Maternity Clinical Negligence Scheme For Trusts (CNST)	Level of assurance gained: Reasonable

The head of midwifery provided an update on the CNST, Avoiding Term Admissions into Neonatal Units (ATAIN) and Perinatal Mortality Review Tool

The Trust is performing well against the ATAIN targets and for CNST we are partially meeting 6 standards and 4 fully. We are meeting all set standards for the mortality review.

Item: Maternity and neonatal services in East Kent Report	Level of assurance gained: Reasonable

The committee received a presentation on the recent East Kent report which summarised the findings and reflected on the work already underway at the trust. The report shared the themes identified and failures within the report and set out the next steps for all health groups and services within the trust and made recommendations for escalation for the Board.

Health Groups to task services to complete gap analysis and take to HG Quality/Governance Committees. Updates to be provided to Operational Risk and Compliance Subcommittee (February 2023)

The Maternity thematic analysis to be presented to November Quality Committee.

Item: CQC Update	Level of assurance gained: Reasonable

The committee received an overview of the paper that was received and that the Well-Led assessment was undertaken in August 2022 as part of their Board Development and suggested the rating of 'Good'

The schedule of internal assurance visits were paused due to organisational pressure but had been progressing well and well received. It was also noted the recent whistleblowing and the responses.

Item: Research and Innovation Strategy Update	Level of assurance gained: Reasonable

The committee received an update on the strategy update and shared their headline positions at the end of quarter 2 along with their progress on key priorities;

- Recruited 3,773 participants to NIHR Portfolio research, we have achieved 87% of our year-end recruitment target after 28 weeks.
- Recruited 116 participants to commercial trials since 1st April 2022 and recruited at least one new patient to 25 new commercial studies since 1st April 2021.
- Received feedback from 146 research participants as part of the annual NIHR Participant Research Experience.
- Continuing to deliver an ongoing COVID-19 and Urgent Public Heath legacy workload.
- Delivering a diverse portfolio of research activity across 22 clinical areas.
- HUTH is currently supporting the set-up of the 'Born and Bred in' (BABi) study which originates from the work of Bradford Teaching Hospitals Trust.
- A concerted effort by our local partners (HYMS, UoH and Daisy Appeal) to bring together all key stakeholders to embed a pipeline of PET-CT research is gathering momentum.
- The Trust continues to work towards securing additional research capability and capacity. An additional £165k of Clinical Research Network funding has been awarded to the Trust in Q2 to be utilised by the end of March 2023.
- As the largest provider Trust and most active research partner, the Trust is taking a proactive approach in shaping the establishment of a HNY ICB 'Research Collaborative'

The committee received the following papers for assurance and there were no escalations raised and the committee accepted the ratings suggested;

- Board Assurance Framework – Q2
- Patient Safety and Clinical Effectiveness Sub-Committee Escalation Report
- Operational Risk and Compliance Sub-Committee Escalation Report
- Non Clinical Quality Sub-Committee Escalation Report

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	8.11.22
Title	Our People				
Lead Director	Simon Nearney - Director of Workforce and Organisational Development				
Author	Simon Nearney - Director of Workforce and Organisational Development				
Report previously considered by (date)	This report has not been received at any other meeting.				

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

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

Hull University Teaching Hospitals NHS Trust

Trust Board

8th November, 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 September, 2022 the Trust had 36 Covid-19 inpatients. As at 1st November, 2022 the Trust have 35 Covid-19 inpatients. The pandemic still poses a real threat to the Trust and staff absence remains higher than normal. Covid-19 staff absences did increase during the summer but have continued to reduce. The Trusts key challenge remains the number of 'No Criteria to Reside' patients in a hospital bed which is currently 173 patients which affects the number of surgical patients that can be seen and treated. The Trust's Emergency Department also remains under extreme pressure and the flow of patients through our acute assessment areas and wards.

3. Key Issues

The total staff sickness absence for the financial year 2020-21 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 31 staff absent due to Covid-19 which is 0.34% of the workforce. Total sickness and Covid-19 absence is currently 3.68%. This is a reduction from 5.04% as at the last Board meeting in September.

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.

5. Employee Service Centre (ESC)

Temporary Increase in Mileage Rates

In view of the increased fuel costs, and following discussions with staff side colleagues, the Trust increased all its mileage rates by 9p per mile. The increase, which is a temporary measure, commenced 1st August 2022. Following a three month review the 9p per mile temporary increase has been extended to 31 December 2022.

Potential Industrial Action

A number of NHS trade unions are in the process of balloting/are due to ballot their members on industrial action. The ballots are linked to demands being made at a national level for a meaningful pay rise and a package of additional retention measures related to settlement of the 2022/2023 pay round.

The proposed action union members are being balloted on varies between unions but covers strike action and industrial action short of a strike. The timescales for potential action again varies

between unions but could impact from mid November 2022 to May 2023. The Trust would also be impacted by potential industrial action within the Ambulance Service. The Employee Resourcing Team continue to work closely with the Emergency Planning Team to monitor the position and ensure the Director of Workforce and OD is able to keep Executive colleagues updated as necessary.

Pay Awards and On-Call Availability Rates
The Trust's Payroll team have successfully implemented a number of retrospective pay award for both Agenda for Change and Medical and Dental Staff. In addition the on-call availability payment rates for both Agenda for Change staff and Trust Casual Workers have been increased by 5%, backdated 1 April 2022.

Electronic Rostering – Students and Nursing Trainees
The team continue to proudly support the rostering of all students and nursing trainees. During the last 5 years, the numbers of students and nursing trainees has significantly increased from 956 to 1746. The numbers of students are set to increase again with a consensus that this trend will continue in the years to come as we seek to recruit more people to the health and care sector.

6. Staff Vacancies
The Trusts overall vacancy position as at 30th September 2022 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1442.4	1383.3	57.2	1.9	0.1%
Add Prof Scientific and Technical	359.8	327.1	3.5	29.2	8.1%
Administrative and Clerical Staff	1639.2	1640.6	9.2	0.0	0.0%
Allied Health Professionals	515.9	483.2	3.1	29.6	5.7%
Estates and Ancillary	622.8	525.9	3.6	93.3	15.0%
Healthcare Scientists	189.7	152.6	1.4	35.7	18.8%
Medical & Dental - Consultant	510.9	466.9	14.9	29.1	5.7%
Medical & Dental - SAS	72.5	57.6	0.2	14.7	20.3%
Medical & Dental – Trainee Grades	704.1	676.6	20.4	7.1	1.0%
Nursing and Midwifery Registered	2491.2	2303.9	36.5	150.8	6.1%
Trust Total	8548.5	8017.7	150.0	380.8	4.5%

Overall the Trust vacancy position is 4.5%. The Consultant vacancy rate has reduced to 5.7%. The vacancy rate for Registered Nursing and Midwifery is currently 6.1% across the organisation.

The Trust has recruited 146 adult nurses and 20 paediatric nurses predominantly from the University of Hull. In addition the Trust has employed 340 international nurses and are recruiting a

further 60 this year. From this month onwards whilst the our newly qualified staff will be completing their preceptorship the Trust will have no registered nurse vacancies and will actually be over-established to assist the Trust with the additional wards open because of the NCTR patients and winter pressures.

As detailed in previous reports the Trust offers a range of apprenticeship programmes across clinical and non-clinical services including our Registered Nurse Associate (RNA) programme, our Registered Nurse Degree (RND) programme and our Health Care Support Worker (HCSW) programme.

7. 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.

The staff 2022/3 Covid-19 Autumn Booster and flu vaccination programme is underway. Vaccination hubs offering booked and walk-in appointments have been set up in the Lecture Theatre at CHH and Ward H20 at HRI and roving teams of vaccinators and peer vaccinators in some area will be available to vaccinate staff. The Occupational Health nurses will offer opportunistic flu vaccines to staff attending the department for other reasons.

8. Communications and engagement

The Golden Hearts Awards were held on 30th September 2022 for the first time since 2019. This ceremony recognised the 2020 winners and runners up who missed out on the opportunity to celebrate due to the pandemic. The 2023 Golden Hearts Awards is due to be launched shortly.

A full package supporting the cost of living for staff will be launched this month. It contains details of a hardship fund we are running in partnership with Citizen's Advice, a school uniform exchange scheme, free sanitary products for staff, staff discounts and a scheme to provide warm spaces for staff over winter.

The National Staff Survey is now live. It closes on the 17th November. Staff receive their survey via email and managers are encouraged to help staff find the time and provide access to a PC to complete their surveys.

Work is underway to return to providing a face-to-face staff induction. We will go live with this in January. This will be the first time in almost three years that induction has not been held virtually. The induction aims to set out our vision, values and expected behaviours for all staff, as well as provide information about our equality and diversity agenda.

9. Staff Support

Occupational Health Services remain the main route for staff to access support and help for a wide range of mental and physical challenges at work. The staff support service continues to work alongside our Occupational Health Service and offers an email and telephone hotline service. The Trust is promoting and advertising the Humber, Coast and Vale Resilience Hub widely for staff to access support. The Trust continues to support staff via Focus Counselling, Occupational Health Team and the Pastoral and Spiritual Care Team for general mental wellbeing support. Coaching services are now being accessed via the coaching referral form available on Pattie.

The 24/7 staff support hotline continues to be available and is run by the Pastoral and Spiritual Care team. The OD team continue to monitor and signpost staff through the hyp-tr.staff.support@nhs.net email address.

Trauma Risk Incident Management (TRiM) Service Launch

TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event for psychological debriefing. TRiM is an evidence-based, post-incident management process, which promotes an organisational approach to colleague management following potentially traumatic incidents. It is a peer review system whereby TRiM Practitioners within the organisation are trained to support colleagues following incidents and identify risk factors that might otherwise go unnoticed which indicate their colleague is finding things difficult. Individuals exhibiting such risk factors can then be referred for appropriate treatment in a timely manner.

Piloting in the emergency department and Intensive care, on succession of this it will become trust wide. Departments or individuals can ask for TRIM support and have TRiM Manager Allocated to support and initiate a TRiM Incident Briefing (TIB), via TRIM page on Pattie, scanning a QR code on posters, text TRIM 07884757010 or via TRIM inbox hyp-tr.trim@nhs.net. The TIB allows all those involved to have their reactions to the event recognised and normalised, alongside offering voluntary TRiM interviews to staff as needed. A TRiM interview takes place from 72 hours after the initial incident and allows the TRiM practitioner to complete a risk assessment. If the person needs immediate mental wellbeing support this is arranged. They are re-interviewed 4-6 weeks later and a new risk assessment completed. Most people's trauma responses return to normal after this time. If challenges remain, the evidence based shows that early intervention can stop post-traumatic stress disorder and other trauma related issues taking hold.

We hope that the TRiM Service will start to embed understanding that it's ok not to be ok and that sometimes we are affected by things unexpectedly. It normalises talking about mental and emotional wellbeing in the workplace and that it's vital not only to our staff experience but patient quality and safety too.

New Staff Health and Wellbeing Committee
Two new formal meetings are being established to ensure the Trust culture is underpinned by strong and proactive health and wellbeing. This builds on the developments that were put in place throughout the pandemic and make them business as usual.

- Health and Wellbeing Committee – Commences December 2022 and Chaired by the Deputy Chief Nurse.
    - Reports to Workforce Transformation Committee and the terms of reference focus on the self-assessment of trust progress against the NHS People Promise; Developing a clear Health and Wellbeing Strategy for the Trust; Setting clear objectives for the delivery of this Strategy; Agreeing the scope of Health and Wellbeing activities and Managing the implementation of the Health and Wellbeing Strategy
- Mental and Emotional Wellbeing Multidisciplinary Team Meeting – Commenced October 2022 and Chair by our Organisational Development Manager.
    - Reports to Health and Wellbeing Committee and is focused on providing expert guidance to both the strategic and operational delivery of mental and emotional wellbeing services.

Period Dignity
The Period Dignity project launched at the end of October to enable staff who are having difficulty obtaining period products due to financial or emergency situations free of charge. Supplies of products are available from various locations including Occupational Health Departments and Alderson House during working hours or lockers accessible out of hours by contacting switchboard.

10. Learning and Organisational Development

Career Engagement/Health Ambassadors

We now have 70 HUTH colleagues signed up as Career Ambassadors, with an average of three new ambassadors joining weekly. A diary of school and college career events is now in place with 14 events booked in for the next four weeks. In addition we also have a lot of services beginning to offer work experience opportunities following the pandemic.

Apprenticeships

It has been a busy couple of months in September/October for apprenticeship starts with Registered Nurse Degree Apprentices (RNDAs), Trainee Nursing Associates (TNAs), Apprentice Healthcare Support Workers (AHCSWs), Advanced Clinical Practitioners (ACPs), Mammography Associates, Degree Healthcare Scientists (audiology, cardiology, ophthalmology), Pharmacy Assistants, Accounting Assistants, and Diagnostic Radiographers all commencing programmes. Recruitment has also commenced for apprentices to support clinical administration services (all Hubs).

Future apprenticeships in the pipeline include additional therapeutic radiographers, 2-year RNDA top ups, audiology support workers, physiotherapists, and a further cohort of Allied Health Clinical Support Workers in the New Year.

11. Equality, Diversity & Inclusion (EDI) Initiative

Dr Yoghini Nagandran, Consultant Physician in Elderly Care replaces Mr Dumbor Ngaage, Consultant in Cardiothoracic Surgery as Chair of the BAME Leadership Staff Network. Mr Ngaage was instrumental in the development and launch of the Trust's Zero Tolerance to Racism Framework. The Framework is supported by a QR code to facilitate reporting of incidents and the Equality, Diversity and Inclusion Team are actively working to develop a culture of psychological safety to encourage staff to report incidents of racism.

October was Black History Month, with a theme of "Time for Change, Action not Words". Mr Ngaage and Mano Jamieson, Equality Diversity and Inclusion Manager, worked with colleagues across the Humber and North Yorkshire ICB to facilitate a number of events including a panel discussion during which Mr Ngaage showcased the Trust's Zero Tolerance to Racism Framework.

In October, the Disabled Staff Network once again held a hugely successful annual conference. Guest speakers championed the development of an organisational culture where physical and mental health disability are recognised and supported within the workplace.

A glossary of terms related to LGBTQ+ inclusivity has been developed in consultation with the LGBTQ+ Staff Network to raise awareness. The aim of the glossary is to continue to support the organisations progress in considering LGBTQ+ inclusion from a staff, patient and service user perspective. In October the LGBTQ+ Network also promoted Asexual Awareness Week and International Pronouns day via a number of articles and blogs on Pattie.

All three of the Trust's Staff Network Chairs (LGBTQ+, BAME and Disability) have been supported to sign up to their respective staff network development programmes organised through the North East & Humber regional EDI team, these events will focus on strengthening the voice of our people; a key part of the People Promise.

The Trust has been accepted on the Health & Care Partnership Programme being run though the NHS Confederation. The programme, which features four in person events and a number of virtual events, aims to share best practice amongst participating organisations and develop a platform for Equality, Diversity and Inclusion leads to support one another to improve the experiences of staff with protected characteristics. Each of the staff chairs will rotate attendance at an in person event.

12. Recommendations

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

Officer to contact:
Simon Nearney
Director of Workforce and OD

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	08/11/22
Title	Responsible Officer Report 2021/22				
Lead Director	Peter Sedman, Responsible Officer & Deputy Chief Medical Officer				
Author	Oliver Miskin, Senior e-Medical Workforce Officer on behalf of Mr Peter Sedman, Responsible Officer & Deputy Chief Medical Officer				
Report previously considered by (date)	11th October 2021 Workforce Education and Culture 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	Y	Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	Y
Assurance	Y	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 Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is compliant with the regulations.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

RESPONSIBLE OFFICER REPORT 2021/22

1. Purpose of the Paper

The Responsible Officer has a duty, defined in the 'Framework for Quality Assurance of Responsible Officers and revalidation' (NHS England and NHS Improvement, first published in April 2014 and updated in February 2019), to present an annual report to the Trust Board. This duty is endorsed by the General Medical Council, the Care Quality Commission and NHS England and NHS Improvement. The Framework for Quality Assurance, in defining the purpose of the annual report, states that: "The Trust Board should understand its responsibilities under the Responsible Officer Regulations. It should also understand the appraisal and revalidation process within the organisation, and be aware of progress in establishing and maintaining a successful revalidation programme for medical staff. NHS England and NHS Improvement requires that the Trust Board demonstrates fulfilment of these requirements by formally acknowledging receipt of this paper, and returning a statement of compliance signed by the Chairman."

2. Background

Following public and professional concern about the regulation of the medical profession a new system of assurance was introduced from the end of 2012. A Statutory Instrument passed in 2010 mandates the appointment of a 'Responsible Officer' for each organisation employing Doctors. The Responsible Officer has a duty to confirm that the Doctors for whom they are responsible are fit to practise, and comply with General Medical Council guidance on Good Medical Practice. This Statutory Instrument is the legislation underpinning the General Medical Council process of revalidation, which applies to all Doctors in the United Kingdom who require a licence to practise. A licence is required by all Doctors working at Hull University Teaching Hospitals NHS Trust. Revalidation is the process by which Doctors have to demonstrate to the General Medical Council that they are fit to practise. The purpose of revalidation is to assure patients and the public, employers, and other healthcare professionals that licensed Doctors are up to date and working appropriately. Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations, and it is expected that the Trust Board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking that there are effective systems in place for monitoring the conduct and performance of their Doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their Doctors; and
- ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Previous reports outlining GMC revalidation and appraisal at Hull University Teaching Hospitals NHS Trust have been submitted to the Trust Board since 2013/14 and to the Quality Committee / Workforce, Education and Culture Committee.

The Trust has chosen to separate performance management from appraisal, thus allowing a formative and developmental appraisal process to operate alongside the assurance framework. The appraisal system is described in more detail in section 5. Performance management and assurance remains the responsibility of clinical managers, and is described in section 6.

3. Governance Arrangements

Recommendation to the General Medical Council for revalidation of individual Doctors is the responsibility of the Responsible Officer. The Responsible Officer is supported in discharging this duty by a Revalidation Panel consisting of representation from senior clinical management, the Senior Appraiser Team, a representative from the Local Negotiating Committee, the HUTH Revalidation Team and the Head of HR Services. The Panel meets on a monthly basis. Appraisal and revalidation processes are overseen by the Revalidation and Appraisal Committee, chaired by the Responsible Officer. This committee reviews progress against appraisal and revalidation targets, and determines actions to address failures to meet these targets. The Revalidation and Appraisal Committee meets monthly and reports by exception to the Quality Committee.

The Trust is required to maintain an accurate record of Doctors with a prescribed connection to the organisation (as a Designated Body). This is done using the online GMC Connect system, and is kept up-to-date by the HUTH Revalidation Team. Doctors transferring between Designated Bodies are required to provide their new RO with details of their previous Designated Body, so that information can be exchanged between the two ROs. The Trust has developed a standard form to respond to requests for information from other Designated Bodies.

Mr Peter Sedman is the Trust's appropriately trained and appointed Responsible Officer for the Hull University Teaching Hospitals NHS Trust Designated Body and for Dove House Hospice Designated Body via a Service Level Agreement (SLA). Mr Sedman took over from Dr Makani Purva, Chief Medical Officer as the Responsible Officer on 1st February 2022.

Prior to the Covid-19 pandemic, the Trust was required to complete an annual report (with quarterly updates) to NHS England and NHS Improvement describing the extent of compliance with its obligations as a Designated Body. The report was called the Annual Organisational Audit (AOA). Due to the Covid-19 global pandemic, the National Responsible Officer for NHS England and NHS Improvement, Professor Stephen Powis wrote to all Responsible Officers in England in March 2020 to advise that NHS England and NHS Improvement had made the decision to cancel the 2019/20 Annual Organisation Audit with Trusts not expected to submit a return. In April 2021, a further update to Responsible Officers and Medical Directors in England was provided to inform them that although the 2020/21 AOA exercise had been stood down, organisations would still be able to report on their appraisal data in their annual Board report and Statement of Compliance. This remains the same in 2021/22 with a redesigned AOA template anticipated in 2022/23.

Policy and Guidance

Revalidation and appraisal is conducted in accordance with the Revalidation and Appraisal for Medical Staff policy, which underwent a full review and update in February 2020. A Medical Appraisal Escalation Policy, which sets out the process to be followed when a Medical member of staff (with a prescribed connection to Hull University Teaching Hospitals NHS Trust) does not undertake an appraisal within the 12 month period required is also in place and underwent a full review with an updated version published in October 2019. The next policy review is expected in autumn 2022

In order to comply with Maintaining High Professional Standards in the NHS (HSC 2003/12), the Trust has in place the Maintaining High Professional Standards Policy for Medical and Dental Staff and supporting procedures. The policy and supporting procedures are also based on the NHS Resolution (formerly National Clinical Assessment Service, NCAS) document 'Back on Track' and is in line with the Department of Health document 'Tackling Concerns Locally'. The policy underwent a full review with an updated version published in March 2022.

4. Restrictions, Remediation, and Investigations

Hull University Teaching Hospitals NHS Trust was the Designated Body for 664 Doctors in 2021/22; this included 491 Consultants, 48 Specialty and Associate Specialist (SAS) Doctors and 125 other non-training Doctors (mainly short term Trust Grade Doctors).

In 2021/22, there was 1 Doctor for whom the Trust is the Designated Body who were either under active investigation by the General Medical Council, or who had current notices on their licence to practise as a result of previous GMC investigations. This is summarised in the table below:

Type of sanction	Consultant	Non-Consultant
Licence warning	0	0
Undertakings	0	0
Conditions	0	0
Under investigation	1	0

It is important to note that Doctors in training working at the Trust who may either be under investigation by the GMC or who have warnings on their licence fall under the responsibility of Health Education England (Yorkshire and the Humber), with the aforementioned acting as their Designated Body. Doctors in training are therefore not included in these statistics.

During 2021/22, there were 10 doctors with a prescribed connection to Hull University Teaching Hospitals NHS Trust involved in employee relations processes; 1 capability, 5 disciplinary, 2 grievances, and 2 complaints of Bullying and Harassment.

The outcomes are summarised in the table below:

Grade	Employee Relations Process	Outcome
Consultant	Bullying & Harassment	Closed – No further action
Consultant	Bullying & Harassment	Closed – No further action
Consultant	Capability	Ongoing
Consultant	Disciplinary	Closed - 1st written warning
Consultant	Disciplinary	Ongoing
Locum Consultant	Disciplinary	Closed - withdrawn
Consultant	Disciplinary	Closed - Informal Accepted Responsibility
Trust Doctor	Disciplinary	Closed - final written warning
Consultant	Grievance	Closed - Employee Grievance Upheld
SAS Doctor	Grievance	Closed - withdrawn

5. Medical Appraisal

Appraisal rates

In response to the Covid-19 global pandemic, the national Responsible Officer (RO) for NHS England and NHS Improvement, Professor Stephen Powis wrote to all Designated Bodies and ROs in the UK to advise that with immediate effect (in March 2020), it was strongly recommended that medical appraisals were suspended until further notice, unless there were exceptional circumstances agreed by both the Doctor and their Appraiser. This was to help to immediately increase capacity in the Medical workforce by allowing Doctors to focus on clinical practice and deal with the expected clinical pressures that Trusts/Organisations would face.

As a result of the NHS England and NHS Improvement advice received, the RO for Hull University Teaching Hospitals NHS Trust made the decision to cancel medical appraisals across the Trust with effect from March 2020. The appraisal process remained cancelled until March 2021, with no requirement for Doctors to catch up on an appraisal that was missed/cancelled in 2020/21 due to the pandemic.

The GMC re-commenced putting Doctors under notice of their revalidation submission dates from April 2021 and advised that appraisal should continue to be managed and delivered locally. It was agreed at the Revalidation & Appraisal Committee in April 2021 that all Doctors are expected to participate in the appraisal process in the appraisal year 2021/22.

The appraisal system now includes a personal and professional wellbeing section to allow doctors to consider:

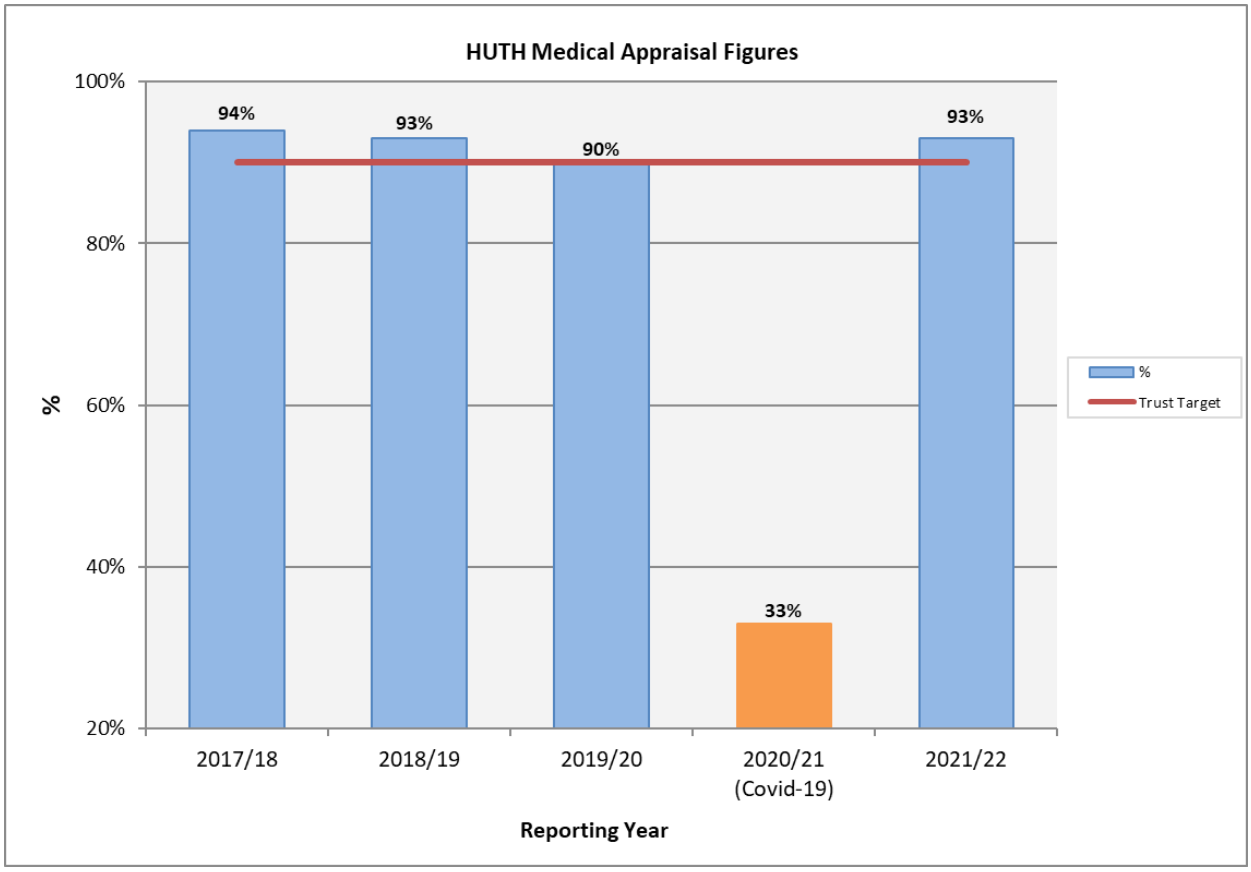
- How has the COVID-19 pandemic has impacted them?
- How they maintain their health and wellbeing and what they may need to do differently, if anything?
- Have they needed any support, and was the help they needed available?

The Trust's medical appraisal figures are discussed monthly at every Health Group performance meeting, as well as at the monthly Revalidation and Appraisal Committee chaired by the Responsible Officer. It is to be noted that the Medical Appraisal Escalation policy (referred to in section 3) was suspended during 2020/21 as a result of the Covid-19 pandemic and subsequently the cancellation of medical appraisals. This was re-introduced in 2021/22.

The table below provides further information on medical appraisals in 2021/22 and shows that 618 (93%) of appraisals were undertaken in 2021/22:

Total number of Doctors with a prescribed connection as at 31 March 2022	**664**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	618
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	46
Total number of agreed exceptions	17

Prior to the cancellation of medical appraisals in 2020/21, Hull University Teaching Hospitals NHS Trust had a medical appraisal completion rate that was consistently above, or in-line with the Trust target of 90%, with the exception of 2020/21. This is shown in the 5-year graph below:



As a process of facilitated self-review, medical appraisal offers an opportunity to help Doctors reflect on their health and wellbeing to the extent that this is relevant to their ability to provide high-quality, safe care. While there is evidence that this has already been a valuable component of many appraisals, it continues to be of particular importance during the current pandemic and future appraisals due to take place.

Appraisers

The Trust currently has 67 'active' trained Appraisers, including 2 'Senior Appraisers'. The Senior Appraisers are responsible for ensuring that the training of the Appraiser team is up-to-date, delivering training to new Appraisers and the Quality Assurance of appraisals. Each Appraiser is responsible for carrying out up to 10 appraisals per year. There is an annual Appraiser Network meeting which provides the opportunity for the Trust's medical Appraisers to share best practice and receive updates on local and national processes surrounding revalidation and appraisal. The last meeting occurred in April 2022.

Quality Assurance

Every Doctor being appraised completes an anonymous feedback form on the appraisal process and their Appraiser. To complete the appraisal process, every Doctor must complete this feedback questionnaire otherwise their appraisal will remain incomplete. This means that 93% of Doctors completed anonymous feedback in the 2021/22 appraisal year This feedback is then collated and an anonymous report is provided to Appraisers for inclusion in their own appraisal as supporting information for appropriate discussion and reflection.

There is a bi-annual revalidation bulletin which is circulated to all Doctors with a prescribed connection to Hull University Teaching Hospitals NHS Trust. This bulletin provides updates from the Responsible Officer, Senior Appraiser Team and HUTH Revalidation Team and provides Doctors with the opportunity to raise any queries they may have in relation to the revalidation and appraisal process. Throughout the pandemic, updates have been provided to Doctors on

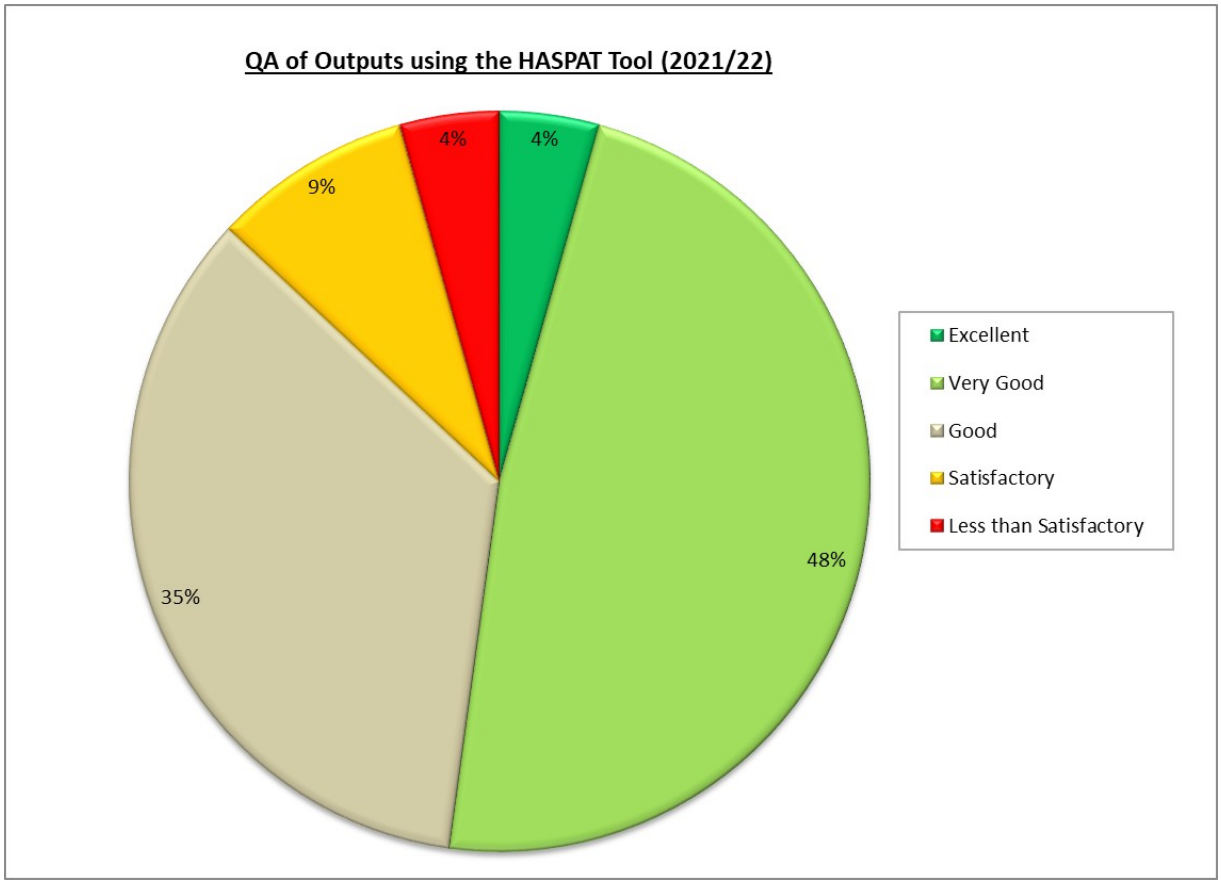
behalf of the Responsible Officer and HUTH Revalidation Team to keep them informed on the revalidation and appraisal process, requirements and any such changes.

The Responsible Officer, Senior Appraiser Team and HUTH Revalidation Team attend quarterly NHS England and NHS Improvement regional RO Network and Medical Appraisal Lead (MAL) Networks, which provide updates from NHS England and NHS Improvement and the GMC on matters surrounding revalidation and appraisal.

All appraisal inputs and outputs of those Doctors due for revalidation are reviewed by the Senior Appraiser Team and HUTH Revalidation Team prior to the monthly Revalidation Panel in the form of a revalidation checklist. Any concerns are raised by the Senior Appraiser Team/HUTH Revalidation Team at the monthly Revalidation Panel chaired by the Responsible Officer for appropriate discussion and action. Reflections on good or bad practice in completing these outputs are then used in the ongoing Appraiser training programme.

The Senior Appraiser Team undertook a Quality Assurance exercise on a 10% sample of PReP appraisal output forms (the Trust's electronic appraisal system for Medical staff) in 2021/22 for whom the Trust is the Designated Body. The QA was completed using a locally designed QA template called HUTH Appraisal Summary & PDP Audit Tool (HASPAT), which is based on the ASPAT tool developed by NHS England and NHS Improvement. The HASPAT tool was designed by the Senior Appraiser Team and Senior e-Medical Workforce Officer.

The results of HASPAT QA exercise are as follows:



The data above shows that 96% of output forms that were quality assured were scored as satisfactory to excellent. This data is shared with the Appraiser workforce and forms part of ongoing constructive appraiser feedback and development.

Clinical Governance
The Trust continues to provide suitable governance and performance information for individual Doctors to support appraisal. Trust information about complaints, claims, serious incidents, is managed using the DATIX system. Doctors are sent information specific to them in relation to claims, complaints and Serious Incidents (SI's) by the HUTH Revalidation Team in the months leading up-to their annual appraisal. Doctors are also able to request a report (at any time) to support appraisal.

With the progression of the Humber Acute Services Programme (HASR) and new ways of working to deliver care across the Humber, Coast and Vale, it is increasingly likely that Doctors whose Designated Body is Hull University Teaching Hospitals NHS Trust will be undertaking sessions at Northern Lincolnshire and Goole Hospitals NHS Foundation Trust whose governance structure is separate. It will be necessary for those Doctors to also include evidence in their appraisal documentation that no Governance concerns have arisen there, or provide information and reflection on any complaints, claims and/or serious incidents as appropriate.

Doctors who provide work outside of the NHS e.g. via the private and/or independent sector are required to provide evidence of no complaints/serious incidents in their annual appraisal, as well as declaring these roles in their scope of work. Similarly, if there are any complaints/serious incidents, these must be declared and discussed as appropriate.

6. Monitoring Performance

All Doctors being considered for revalidation must demonstrate participation in regular appraisal. However appraisal in itself is neither an objective assessment of a Doctor's performance, nor of their compliance with Trust policies and procedures. The Revalidation Panel therefore also requires confirmation from each Doctor's clinical manager that there are no concerns about performance or conduct. At present, this takes the form of a signed statement from the relevant Health Group Medical Director, based on personal knowledge and information from line managers. In any case the revalidation process (occurring as it does once every 5 years) should not be the point at which concerns first come to light.

7. Revalidation Recommendations

In response to the Covid-19 global pandemic, the national Responsible Officer (RO) for NHS England and NHS Improvement, Professor Stephen Powis wrote to all Designated Bodies and ROs in the UK to advise that with immediate effect (in March 2020), it was strongly recommended that medical appraisals were suspended until further notice, unless there were exceptional circumstances agreed by both the Doctor and their Appraiser. This was to help to immediately increase capacity in the Medical workforce by allowing Doctors to focus on clinical practice and deal with the expected clinical pressures that Trusts/Organisations would face.

As a result of the NHS England and NHS Improvement advice received, the RO for Hull University Teaching Hospitals NHS Trust made the decision to cancel medical appraisals across the Trust with effect from March 2020. The appraisal process remained cancelled until March 2021, with no requirement for Doctors to catch up on an appraisal that was missed/cancelled in 2020/21 due to the pandemic.

The GMC re-commenced putting Doctors under notice of their revalidation submission dates from April 2021 and advised that appraisal should continue to be managed and delivered locally. It was agreed at the Revalidation & Appraisal Committee in April 2021 that all Doctors are expected to participate in the appraisal process in the appraisal year 2021/22.

The Trust made 169 revalidation recommendations to the GMC between 1st April 2021 and 31st March 2022; 164 positive and 5 deferrals. The Responsible Officer has three options in making

a recommendation: recommendation for revalidation (positive recommendation), deferral, or failure to engage. It is not possible to recommend 'non-revalidation'. The Trust has not made any notifications of failure to engage/non-engagement. The breakdown of recommendations is shown below:

Recommendation	Deferral Reason(s)	No. Recommendations submitted
Recommendation to revalidate		164
Defer	Interruption to practice	3
	Appraisal activity & MSF 360	2
Non-engagement		0
Total Recommendations		**169**

In summary, 97% of recommendations submitted by the RO in 2021/22 were for a positive recommendation.

8. Recruitment and engagement background checks

The Trust's Human Resources department has in place a system for checking identity, current and previous GMC conditions or undertakings, appropriate recent references, details of last (or current) Responsible Officer, qualification check, and police clearance. The Responsible Officer continues to use an 'RO Transfer Form', to be completed by the RO from the prospective employee's previous organisation: this includes revalidation date, date of last appraisal and any concerns arising from appraisal, details of ongoing or previous GMC/NHS Resolution investigations (formerly NCAS), local conditions or undertakings, and any unresolved performance concerns.

9. Responding to Concerns and Remediation

Revalidation should not be the expected route for identifying concerns about an individual Doctor's conduct or capability, occurring as revalidation is only every 5 years. Appraisal may sometimes identify areas for improvement, but again it is unlikely that serious concerns will come to light purely through appraisal, which is principally a formative and developmental process. More commonly problems will be identified either through investigation of a specific incident, or following expression of concern by staff or patients. Please refer to section 4 of this report for information relating to this restrictions, remediation and investigations.

Where there is concern about a Doctor's conduct or capability this is managed under the Trust's Maintaining High Professional Standards Policy. In all cases involving capability, and where appropriate in cases of possible misconduct, the investigation process would be conducted in consultation with NHS Resolution (formerly the National Clinical Assessment Service, NCAS). If misconduct is substantiated a range of disciplinary sanctions, ranging from reflective learning to dismissal are available. If concerns regarding capability are substantiated, an appropriate course of action developed in conjunction with NHS Resolution may be put in place. In the majority of capability cases the first option is to consider remediation and support.

In addition to local Trust investigations Doctors may also be subject to investigation by the GMC. Where appropriate. this is as a result of the Trust reporting the result of a local investigation to the GMC, but more commonly the Doctor has been referred to the GMC by someone else (patient, relative, previous employer, etc.). The Trust cooperates fully with any GMC investigation into employees.

10. Conclusions

- The Trust has an appointed Responsible Officer, who is trained and supported to perform the role

- The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on revalidation

- The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice

- There is a robust appraisal system in place, which is developmental and formative in nature.

- The Trust has a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required 12 month period are given the appropriate steps to follow. This policy has been ratified by the Local Negotiating Committee (LNC) - It is to be noted that this policy was suspended during 2020/21 as a result of the Covid-19 pandemic and resumed in 2021/22

- Uptake of appraisal in the Trust has continued to increase since the restart of appraisals in April 2021 (following the cancellation due to Covid-19 in 2020/21) and now surpasses the NHS England and NHS Improvement target of 90%

- Maintaining a high level of appraisal rate is reliant on the continued implementation of an electronic platform, continuing essential administrative support and the Trust having sufficient numbers of trained medical Appraisers

11. Recommendations

The Board is asked to accept this report, and to approve the formal statement of compliance (Appendix 1), confirming that the organisation, as a Designated Body, is in compliance with the regulations. This must be signed and returned to NHS England and NHS Improvement.

Appendix 1

Designated Body Statement of Compliance

The Board of Hull University Teaching Hospitals NHS Trust has reviewed the content of this report and can confirm the Organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013):

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Yes – Mr Peter Sedman is the Trust's appropriately trained and appointed Responsible Officer for Hull University Teaching Hospitals NHS Trust and Dove House Hospice for 2021/22

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Yes

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   Yes

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

   A peer review did not take place in 2021/22 due to the reintroduction of the appraisal process following the Covid-19 pandemic and the focus on meeting the 90% compliance Trust target. It is anticipated that a peer review will take place in 2022/23.

6. A process is in place to ensure locum or short-term placement Doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

   Yes

7. All Doctors in this organisation have an annual appraisal that covers a Doctor's whole practice, which takes account of all relevant information relating to the Doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any

other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the Doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change.

Yes

8. Where in Question 7 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Yes

9. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

10. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Yes

12. The appraisal system in place for the Doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes

13. Timely recommendations are made to the GMC about the fitness to practise of all Doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Yes

14. Revalidation recommendations made to the GMC are confirmed promptly to the Doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the Doctor before the recommendation is submitted.

Yes

15. This organisation creates an environment which delivers effective clinical governance for Doctors.

Yes

16. Effective systems are in place for monitoring the conduct and performance of all Doctors working in our organisation and all relevant information is provided for Doctors to include at their appraisal.

Yes

17. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

18. The system for responding to concerns about a Doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the Doctors.[2]

Yes

19. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about Doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

persons with appropriate governance responsibility) about a) Doctors connected to your organisation and who also work in other places, and b) Doctors connected elsewhere but who also work in our organisation.[3]

Yes

20. Safeguards are in place to ensure clinical governance arrangements for Doctors including processes for responding to concerns about a Doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes

21. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all Doctors, including locum and short-term Doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Hull University Teaching Hospitals NHS Trust**

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Hull University Teaching Hospitals NHS Trust

Workforce, Education and Culture Committee

Monday 10th October 2022

Agenda Item	9.3	**Meeting**		**Meeting Date**	10/09/22
Title					
Lead Director	Dr Makani Purva				
Author	Professor Mahmoud Loubani				
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:

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st April – 30th June 2022

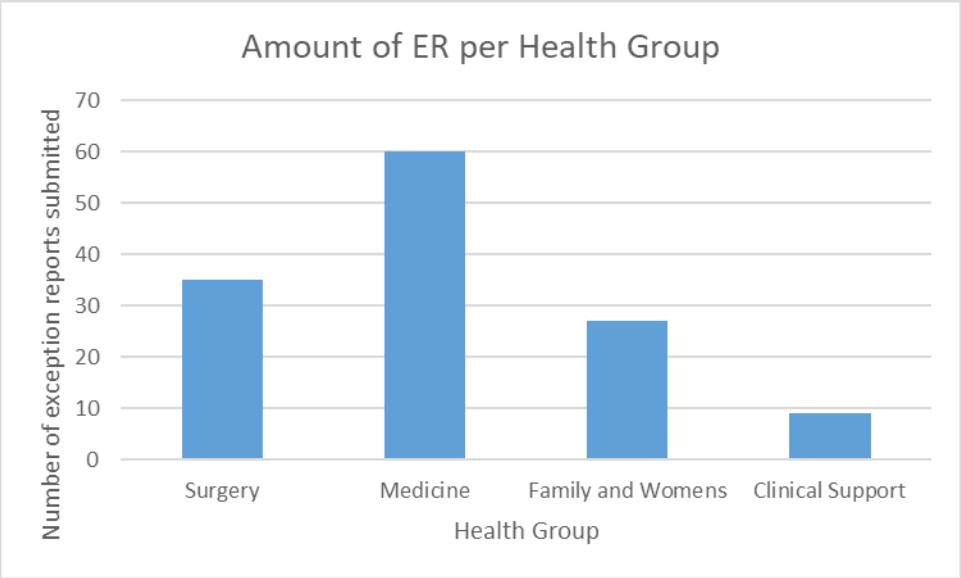
Executive Summary

The Guardian Report for this Workforce, Education and Culture Committee meeting covers the quarter from 1st April – 30th June 2022.

Exception Reporting patterns and responses

There were a total of 114 exception reports (114 episodes) reported by trainees. The most common reason for submitting an exception report remains in relation to the volume of work which leads to trainees staying beyond their contracted hours. Other reasons include missed educational and training opportunities. This includes missed self-development time and teaching. As well as a change in pattern from their work schedule or the type of service support available.

In this quarter the following number of episodes of exceptions reported per Health Group



Exception Report trends:

The Medicine health group have received the highest number of exception reports submitted for this quarter. The most common reason for submission is to report and receive compensation for additional hours worked. A reoccurring theme of lack of phlebotomists was highlighted and consequently a business has been made. Discussions with paediatric surgery department have uncover a lack of junior grades requiring registrar to step in, work is continuing to improve this and guardian of safe working fines have been issued.

Issues:

1. In order to ensure the Trust is complying with the Junior Doctors terms and conditions, it is important that all departments are using the eroster system fully. This allows the Guardian of Safe Working to monitor the working hours. When an exception report has been submitted for the difference in hours of work; eroster is updated to reflect the actual hours worked. Eroster then automatically flags up any rules that have been broken. Projects are currently being undertaken to improve the amount of rotas on e-roster. The Medical Staffing Team are commencing the work of implementation of the usage of eRostering and improving visibility of live rotas. Surgery and Clinical Support Health groups are the main areas of focus for the first

year of the project and this work can now begin as the new members of staff have recently joined the Medical Staffing team.

2. The lack of support from Phlebotomy services continues to be highlighted as an issue via exception reporting and from trainee feedback raised at the Junior Doctors Forum. This may result in overtime payments for doctors working late to cover the extra workload. The time spent taking bloods also takes the junior doctors away from educational / training opportunities. The business case submitted has now been approved.

3. There is a process in place to chase supervisors for the completion of exception reports. There is a system-automated email that is issued so the supervisor are informed when a report has been submitted which is followed by up to manually emailing 3 chaser emails. Each email is escalated to an increasing number of senior people. There are also monthly reports submitted to each HG with details of the exceptions that have occurred and the status of the reports. However, there are still many reports that remain outstanding.

Questions for consideration
The Workforce, Education and Culture and committee meeting 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
- Support the 3 recommendations stated above

Professor Mahmoud Loubani
Consultant Cardiothoracic Surgeon
Guardian of Safe Working Hours
Encl:
Appendix 1: Board Report GSW 1st April – 30th June 2022

Appendix 1

Hull University Teaching Hospitals NHS Trust

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st April – 30th June 2022

1. Purpose of this Report

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from April to June 2022.

- Exception reports and monitoring
- Locum usage, both bank and agency
- Vacancy levels amongst trainees
- Work schedule reviews and fines

2. High Level Data

Number of doctors / dentists in training (total):	590.3
(establishment)	638
Number of doctors / dentists in training on 2016 TCS (total FTE's):	590.3
Amount of time available in job plan for guardian to do the role:	1 PA / 4 hours per
Admin support provided to the guardian (if any):	1 WTE
Amount of job-planned time for educational supervisors:	1 WTE 0.25 Pas per trainee (max; varies between health groups)

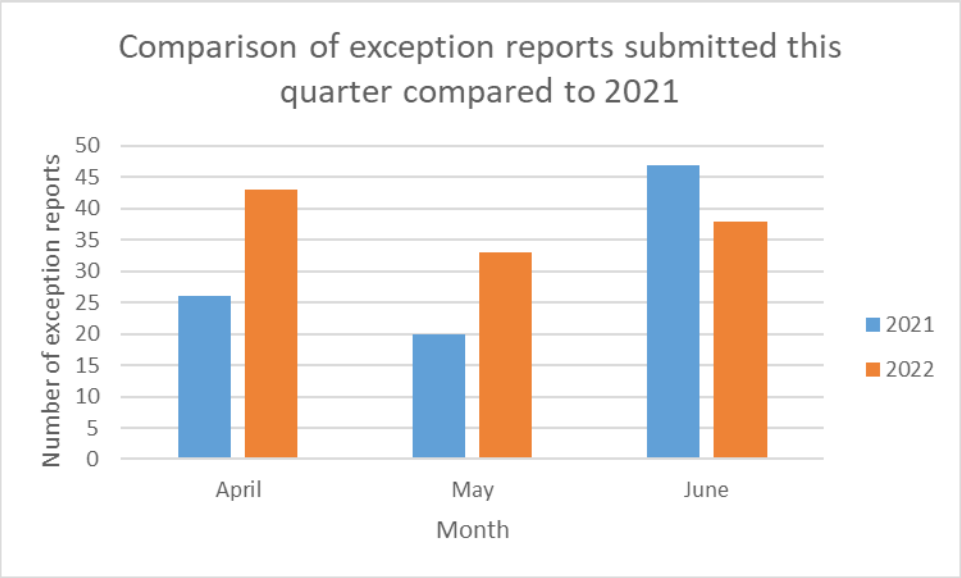
Information on exception reporting is detailed within the junior doctor's contract (pages 37-39)

3. Junior Doctor Working Hours

The data in this section are presented according to a standard template which was produced by NHS Employers. At the request of HEE Yorkshire & the Humber, data will continue to be presented in this way to allow comparison to be made between Trusts across the region. In all cases the data below is presented in relation to exception report episodes, since a single exception report may contain a number of episodes of concern.

There were 114 exception report episodes submitted between 1st April and 30th June 2022 with 338 carried forward from the previous quarter.

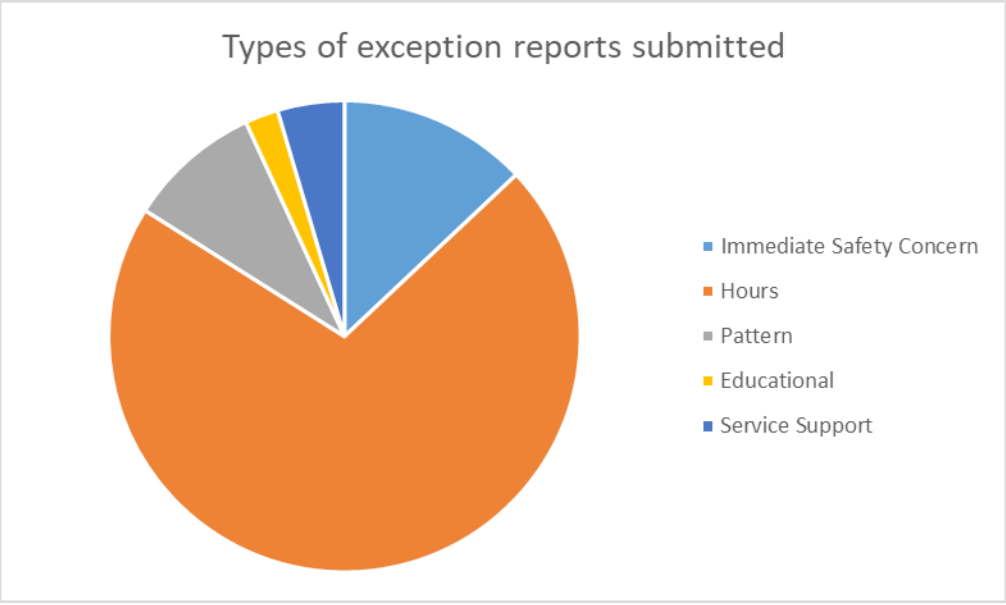
Exception reports from 2021 in comparison to 2022.



The graph above shows the number of exception reports from April to June in comparison to that received in 2021. The majority of the reports relate to staff shortages in conjunction with service pressures and therefore additional hours worked. On average there were 31 exception reports submitted per month in 2021 compared to an average on 38 a month in 2022.

This data can also be compared against the previous year.

Types of exception reports received 1st April – 30th June 2022

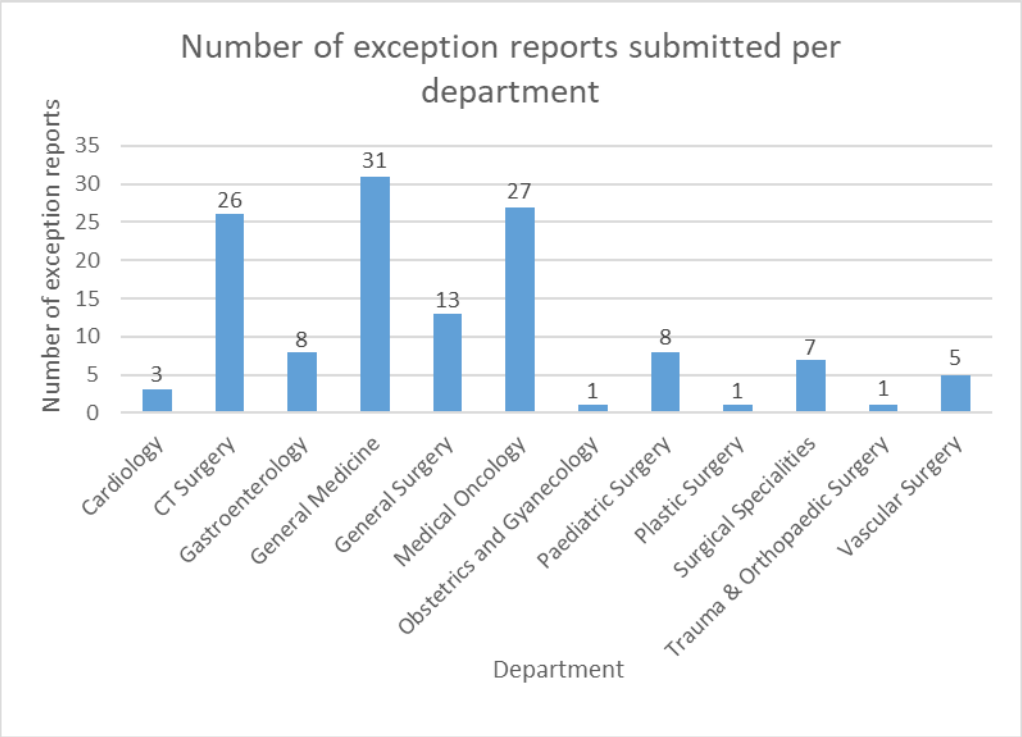


Due to increases in service demand, staffing shortages and prioritising patient care the most frequent type of exception report is submitted is in relation to a difference in hours worked. To compensate the trainee TOIL and payment are offered in addition to this a GoSW fine may be applicable if the additional hours broke any rota rules. The option to highlight the

exception report has been incorrectly used by trainees many times this quarter. In light of this a help guide was created for both trainees and supervisors detailed when the immediate safety concern option should be used. After this was communicated we found it was mostly being used only in the correct scenarios. For a difference in pattern it was found that some rotas had a deficiency in some grades so other grades were working a different pattern to cover the vacancy. Within educational exception reports it has been found that due to a high workload and staffing shortages trainees are not able to attend all opportunities offered to them. By reporting this we are able to confirm with supervisors so this data can be used to confirm details in their ARCP. The exception reports relating to service support echos similar finding from the other option as a lack of staff with limited bed spaces meaning trainees feel unsupported in their role.

Exception reports (episodes) by specialty 1st April – 30th June 2022

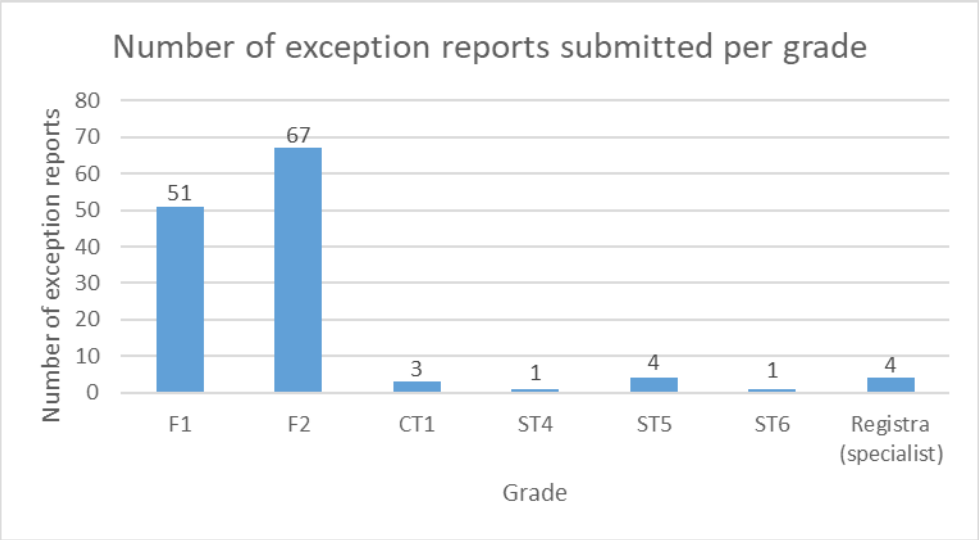
The following graph shows the top 12 departments with the highest number of reports.



General Medicine received the highest number of reports within this quarter from April to June 2022.

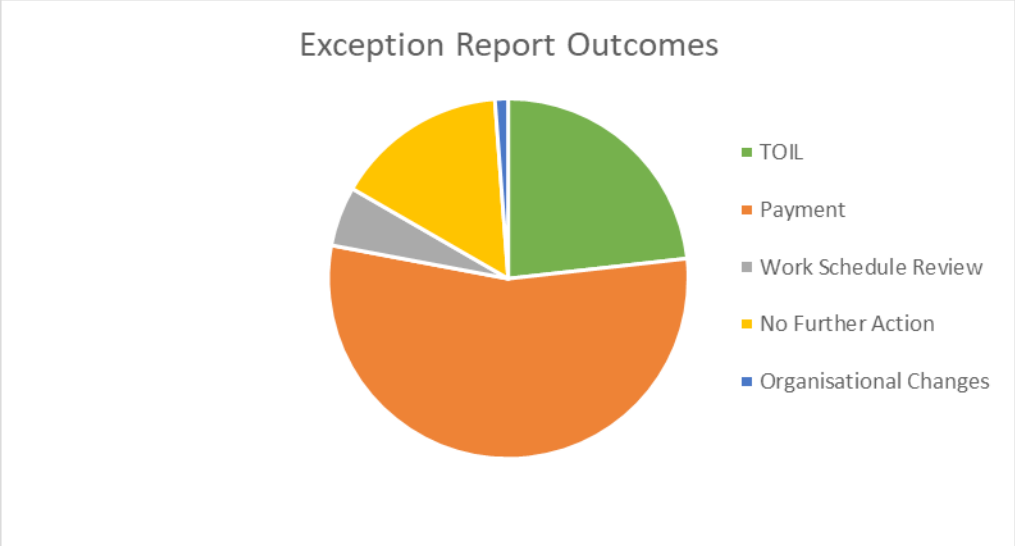
Most commonly in exception reports additional hours worked is seen due an increased workload, staffing shortages and lack of support to work around these. Exceptions reports were also submitted for missed educational opportunities, including not being able to take self-development time due to patient safety taking priority or not being able to witness educational opportunities such as in theatre.

Exception reports (episodes) by grade 1st April – 30th June 2022



FY2 trainees were the grade with highest submission rates closely followed by FY1. There has been an overall increase in submission rates but specifically in higher grades, this continues to be encouraged.

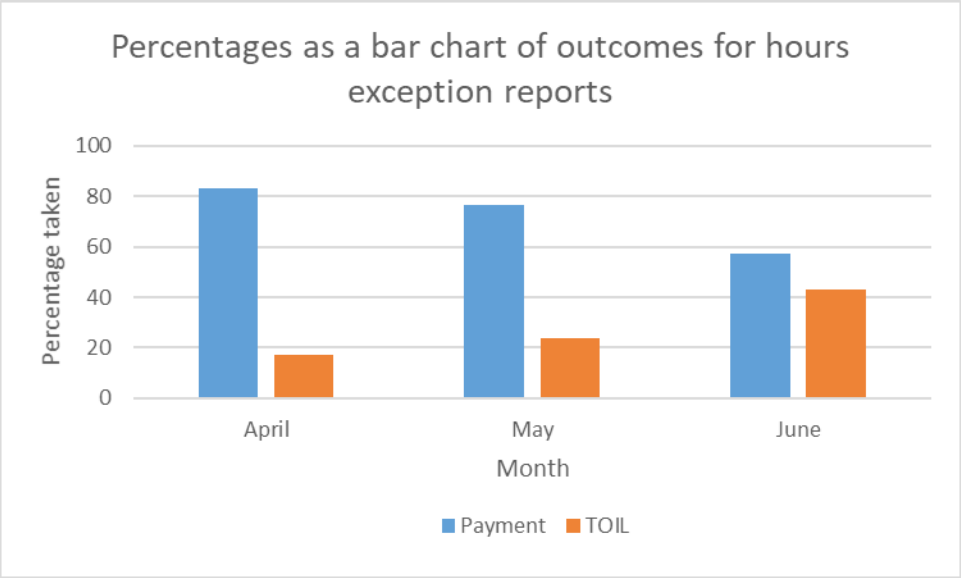
Outcomes of completed exception reports 1 January – March 2022



The above pie chart shows the outcomes of completed exception reports within this quarter. The most common outcome was payment which is in line with the reoccuring theme of a different in hours being the highest submission option. TOIL follows payment with roughly half of the amount chosen in comparison to payment. Once decided between trainee and supervisor the outcomes are facilitated by the Guardian of Safe Working. If the trainee is unable to take TOIL the outcome will be changed to payment although the trainees are encouraged to take the time rather than payment. Work schedules reviews make up 5% as most exception reports are isolated incedents. If the supervisor feels that there is nothing further able to do no further action will be taken however the exception report is recorded

and noted. This allows it to be refered back to and recognise any reoccuring trends appearing. Few organisational changes are made as there has to be a pattern of exception reports in order to make a significant change, the Guardian of Safe Working continues to monitor exception reports while recognising appearing trends.

Payment and TOIL trends by month 1 January – March 2022



When an exception report is submitted for a difference in hours worked the two main outcomes are payment for the hours or to receive them as TOIL to use at a later date. As previously seen payment is frequently chosen over TOIL, a contributing factor to this is staffing shortages making taking TOIL difficult in the current climate.

Fines

A process was set up in December 2019 to investigate any exceptions that lead to fines. The JD contract states fines should be issued for the following breaches:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule);
- A breach of the maximum 13-hour shift
- A breach of the maximum of 72 hours worked across any consecutive 168-hour period.
- Where 11 hours' rest within a 24-hour period has not been achieved (excluding on-call shifts);
- Where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved;
- Where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved

When an exception report has been submitted for the difference in hours of work, eroster is updated to reflect the actual hours worked. Eroster then automatically highlights any breaches.

Fines will be issued at four times the basic / enhanced rate of pay applicable at the time of the breach. The doctors will be paid 1.5 times the rate and the remaining amount will be paid to the Guardian of Safe Working who uses the fines to support Junior Doctor Initiatives through the Junior Doctors Forum.

Where a concern is raised that breaks have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct, the Guardian of Safe Working hours will levy a fine at the rate of twice the relevant hourly rate for the time in which the break was not taken.

Summary of fines this quarter.

The following 17 fines have been issued within this quarter:

Grade	Dept where occurred	Rules Broken	Reason for working over
F2	Cardio-thoracic surgery	Maximum 13 hour shift and minimum 11 hour rest	Doctor worked over by 1 hour due to late ward round which resulted in late handover.
F1	General Surgery	Maximum 13 hour shift length	Doctor worked over by 1.5 hours due to acutely ill patient requiring interventions, having to speak to the family and organise palliative care.
F2	Cardio-thoracic surgery	Maximum 13 hour shift and minimum 11 hour rest	Doctor worked over by 1 hour due to late ward round which resulted in late handover due to only doctor covering 4 wards so increased workload.
F2	Cardio-thoracic surgery	Maximum 13 hour shift and minimum 11 hour rest	Doctor worked over by 1.5 hours as they were the only FY2 on-call to complete ward jobs, discharges, clerking and prepping notes.
F2	Cardio-thoracic surgery	Maximum 13 hour shift and minimum 11 hour rest	Doctor worked over by 1.5 hours as they were the only FY2 on-call to complete ward jobs, discharges, clerking and prepping notes.
F2	Cardio-thoracic surgery	Maximum 13 hour shift	Doctor worked over by 1 hour due to taking on additional work load and discussing high risk patient with another department.
FY2	Cardio-thoracic surgery	Maximum 13 hour shift	Doctor worked over by 1.5 hours due to high quantity of admissions.
ST3	Medical Oncology	Maximum 13 hour shift	Doctor worked 24 resident on call shift
ST4	General Surgery	5 hours continuous rest (on-call)	Doctor was called several times through the night not allowing them to receive 5 hours continuous rest between 22:00 – 07:00
ST4	General Surgery	5 hours continuous rest (on-call)	Doctor was called several times through the night not allowing them to receive 5 hours continuous rest between 22:00 – 07:00
F2	Medical Oncology	Maximum 72 hours work in a week breeched.	Doctor worked 2.5 hours overtime to maintain patient safety and ensure ward round was complete.

Multiple fines are issued for multiple breaches.

Further information can be found on the following:

Appendix A: Exception reports per specialty
Appendix B: Exception reports by grade
Appendix C: Exception reports by rota
Appendix D: Response time of exception reports

Work schedule reviews
There are currently no ongoing work schedule reviews relating to exception reports.

a) Locum bookings 1st April – 30th June

i) Bank 1st April – 30th June

The Trust currently had an informal medical bank in place which strives to fill as many shifts internally as it can. This data does not include additional shift worked by rotational doctors. From 21st October 2019, the Trust has launched its 'Remarkable Bank' in a view to expanding its use of internal Locums. We currently have 122 Medical Staff signed up to the 'Remarkable Bank' and we have also published an advert on the Trust's Website, NHS Jobs and the BMJ to attract external candidates onto the Bank. With the 'Remarkable Bank' going live, we are hoping to see an increase in Bank Locum Bookings and a decrease in the reliance of Locum Agency Staff.

The information in this table only covers shifts that have been booked by the Medical Staffing Team. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

The below figures are calculated correctly as there are circumstances in which it would not be appropriate to advertise to an agency for locum cover so it is sourced within the Trusts bank which is why the totals differ. There were a total of 587 in which this was the case.

Locum Bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
CT/ GPSTR/ ST1-2	1932	486	17158	583
F1	0	57	0	59
F2	1367	117	13646.75	131
ST3+	370	425	3838	480
Total	**3669**	**1085**	**69285.50**	**1262**

Locum Bookings (bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine	53 5	38 4	4659.25	3967.78
Anaesthesia	554	1	5537.50	9
Cardiology	72	23	574.50	258
Chest Medicine	-	15	-	228
Clinical Oncology	-	72	-	44.5
Colorectal	-	95	-	1215
CT Surgery	-	20	-	197
Elderly Medicine	237	34	1942.75	278.50
ENT	111	59	1364.50	12.5
Gastroenterology	5	1	83.50	20
General Medicine	23	6	201.25	51.50
Haematology	1 12	2	1503.50	40
Infectious Diseases	2 1	29	168	93.75
Neonatal Medicine	20	2	234	26

Neurology	71	8	568	107
Neurosurgery	68	32	809.50	384.75
Obstetrics & Gynaecology	40	4	451.75	31.5
Oral and Maxillofacial Surgery	13	21	247	148
Paediatric Surgery	-	14	-	143
Paediatrics	323	4	2805.50	73
Plastic Surgery	3	2	27	43
Radiology	65	8	520	33
Renal Medicine	-	2	-	16.75
Rheumatology	78	13	628.25	151
Stroke Medicine	2	103	16	858.25
Trauma & Orthopaedics	25	58	289.50	578
Upper GI	-	12	-	158
Urology	-	34	199	355
Vascular Surgery	-	27	-	219.50
Total	**2378**	**1077**	**22830.25**	**9741.28**

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual leave	-	13	-	101.50
Compassionate Leave	3	4	36.75	12.5
Extra Cover	4	55	32	598.25
Maternity/Paternity Leave	6	3	65	36
Sickness	33	103	380.75	969.05
Study Leave	-	3	-	37.5
Vacancy	3442	904	32345.25	7629.98
Total	**3488**	**1085**	**32859.75**	**9384.78**

ii) Agency 1 April – 30 June 2022

Locum Bookings (Agency) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
CT/GPSTR/ST1-2	1932	928	17158	7875.63
F1	0.00	0.00	0.00	0.00
F2	1367	571	13646.75	645
ST3+	370	100	3838	114
Total	**3669**	**3198**	**69285.50**	**30047.26**

Locum Bookings (Agency) by department

Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Acute Medicine	53 5	22 1	4659.25	1991.75
Anaesthesia	554	310	5537.50	3244.13
Cardiology	72	39	574.50	312.5
Dermatology	9 1	27	728	249.50
Elderly Medicine	237	96	1942.75	877.75
Emergency Medicine	768	204	7728	1911.83
ENT	111	53	1364.50	583
Gastroenterology	5	0	83.50	0
General Internal Medicine	23	3	201.25	36
General Surgery	128	77	1503.50	700.25
Haematology	1 12	43	1503.50	700.25
Infectious Diseases	2 1	0	168	0
Neonatal Medicine	20	9	234	103
Neurology	7 1	53	568	402.17
Neurosurgery	68	63	809.50	695

Obstetrics & Gynaecology	40	17	451.75	191
Oncology	123	59	1098.75	486.25
Ophthalmology	127	43	1016	334
Oral and Maxillofacial Surgery	13	0	247	0
Paediatric Surgery	0	0	0	0
Paediatrics	323	202	2805.50	1639
Pathology	27	22	216	176.50
Plastic Surgery	3	0	27	0
Radiology	65	19	520	114.50
Rehabilitation	0	0	0	0
Renal Medicine	0	0	0	0
Respiratory Medicine	11	9	129.75	101.50
Rheumatology	78	11	628.25	83
Stroke Medicine	2	0	16	0
Trauma & Orthopaedics	25	19	289.50	209
Trauma and Orthopaedic Surgery	0	0	0	0
Urology			199	0

	16	0		
Total	**3669**	**1599**	**34642.75**	**15023.63**

Locum Bookings (Agency) by Reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Additional demand / resource	63	53	504	402.17
Compassionate Leave	3	0	36.75	0
Coronavirus (Covid-19)	0	0	0	0
Covid – Escalation rota	7	0	55	0
Covid-19 (pressures)	22	0	180.50	0
Covid-19 (self-isolation)	0	0	0	0
Covid-19 (sickness cover)	0	0	0	0
Extra Activity / Escalation	4	0	32	0
Long term Vacancy	10	0	91	26.25
Maternity / Paternity Leave	6	3	65	26.25
Operational Pressures	5	0	42	0
Other	1	0	8	0
Short Term Vacancy	72	36	893.50	371
Sickness	1	0	13	0
Sickness - Long Term	0	0	0	0
Sickness - Short term	32	7	367.75	78.50
Vacancy	3442	1500	32345.25	14145.71

WLI	1	0	9	0
Total	**3669**	**1599**	**34642.75**	**15023.63**

Please be aware that the above figures for Agency use show a high number of shifts booked due to a number of departments booking long term Agency staff to ensure that rota gaps are covered consistently. The Trust's difficulty in recruiting to certain departments within the Trust has required that they have to rely heavily on the use of long term bookings to ensure that rota gaps are covered.

As the Trust's systems for data capture improve, both the available bank and agency information raise more questions, such as: What is the effect on departments if identified gaps are not able to be filled by bank or agency locums? It is also clear that more detailed information is required to identify the reasons behind the need for locum cover if it doesn't fall into one of the above categories.

iii) Emergency Department

The Emergency Department books its own doctors directly, due to short time scale the Emergency Department have not been able to provide these for the report.

Locum work carried out by trainees 1 April – 30 June 2022
This data is collected to help assess whether individual trainees are in breach of the WTR and the 2016 TCS, or at significant risk of breaching. HEE are particularly interested in the results in this section, but, as yet, the information is not fully available using the current systems. Further information is required about the trainee's rostered hours and the actual hours worked.

At present the data is collected in an aggregated form by department, rather than on a trainee by trainee basis. The table below represents the top 10 doctors that have worked the most extra hours and whether they have opted out of the WTD.

Base Specialty	Grade	Number of hours worked	Number of hours rostered per week	Opted out of WTD
Neurology	Trust Doctor	395		No
General Acute	ST3	268.50		No
General Practice	GP	221		Yes
Colorectal	Trust Doctor	219.50		No
Neurology	Specialty Doctor	193.75		No
General Practice	GP	158.50		Yes
General Practice	GP	144.8		Yes
Neurology	Specialty Doctor	135.50		No
Upper GI	ST3	126		Yes
General Practice	GP	116.3		No

Please be aware that the above extra hours may not necessarily have been worked in the base speciality mentioned. Doctors are able to pick up shifts at their level across Health Groups due to the rotational nature of their posts with the Trust.

The rostered hours on all rotas are known to be within safe limits, but live, real-time information is required on, for example, late working, swapped shifts, and extra shifts worked for locum pay. E-roster is capable of recording this information, but this requires working patterns to be updated live and rotas to be locked down for analysis.

Trainee opt-out from the Working Time Regulations is collected systematically from new starters is recorded on ESR so that this information can be used live when trainees book shifts.

Historically, trainees at risk of breaching the Working Time Regulations by doing lots of extra shifts, even with an individual opt-out, have not been easy to police. The Medical Staffing team utilise e-Roster for the rotas covered by their team. The system has WTD and 2016 T&Cs rota rules built in and it is clear to the team when a doctor offering extra hours will be at risk of breaking any of these rules. A doctor will not be allowed to book themselves in for extra hours if this risks breaking any of the rota rules however Medical Staffing are not responsible for

overseeing booking extra hours for all rotas. In order for all departments to ensure that they are not booking doctors for extra hours against these rota rules, the full utilisation of e-Rostering for junior doctors' rotas is required

Hull University Teaching Hospitals NHS Trust - Junior Doctor Rota Establishment Effective April 2022

	Trainee Establishment						Rota Establishment						In Post							
Department	F1	F2	CT/ST 1&	GPSTR	ST3+	Total	F1	F2	CT/ST1-2	GPSTR	ST3+	Total	F1	F2	CT/ST1-2	GPSTR	ST	Total	% Posts Filled April 2022	% Posts Filled September 2021
Academic, GP, Psych & Community	5	29	0	91	0	125	5	29	0	91	0	125	5	29.7	0	81.1	0	115.8	92.64%	96.22%
Acute Medicine	3	6	9	0	5	23	3	6	13	0	5	27	3	6	13	0	9	31	114.81%	137.08%
Anaesthetics	4	4	20	0	29	57	4	4	17	0	23	48	4	4	17	0	29.3	54.3	113.13%	98.77%
Breast Surgery	2	0	1	0	2	5	2	0	1	0	4	7	2	0	1	0	3	6	85.71%	42.86%
Cardiology	2	1	3	1	9	16	2	1	3	2	12	20	2	1	2	2	16	23	115.00%	108.42%
Cardiothroacic Surgery	0	3	0	0	3	6	0	3	0	0	9	12	0	3	0	0	9	12	100.00%	58.33%
Chemical Pathology	0	0	0	0	1	1	0	0	0	0	1	1	0	0	0	0	1	1	100.00%	50.00%
Colorectal Surgery	7	0	1	0	3	11	7	0	2	0	7	16	6.8	0	2	0	7	15.8	98.75%	50.00%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	1	0	0	1	0	2	100.00%	100.00%
Elderly Medicine	5	3	5	8	6	27	5	3	5	8	5	26	5	3	5	7.6	3.8	24.4	93.85%	84.21%
Emergency Medicine	0	12	14	6	15	47	0	12	12	6	15	45	0	12	11.7	5.5	14.6	43.8	97.33%	147.22%
Endocrinology	3	0	2	0	6	11	3	0	2	0	6	11	3	0	2	0	6	11	100.00%	95.56%
ENT	1	1	2	3	4	11	1	1	2	3	6	13	1	1	2	3	3.6	10.6	81.54%	89.77%
Gastroenterology	3	1	3	0	5	12	3	1	3	0	5	12	4.4	1	3	0	5	13.4	111.67%	100.00%
General Surgery	0	1	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	1	100.00%	74.36%
Haematology	2	2	2	0	4	10	2	2	2	0	6	12	2	2	2	0	6.6	12.6	105.00%	46.80%
Histopathology	0	0	3	0	1	4	0	0	0	0	4	4	0	0	2	0	1	3	75.00%	50.00%
Immunology	0	0	0	0	2	2	0	0	0	0	2	2	0	0	0	0	1	1	50.00%	78.57%
Infectious Diseases	2	0	1	1	5	9	3	0	4	3	5	15	2	0	3	2.8	5	12.8	85.33%	90.00%
Neurology	2	2	3	0	5	12	3	2	3	0	6	14	2	3	2	0	4.6	11.6	82.86%	97.89%
Neurosurgery	1	1	2	0	4	8	1	1	6	0	12	20	1	1	5.8	0	11	18.8	94.00%	101.92%
Obstetrics & Gynaecology	0	3	6	4	13	26	0	3	6	4	9	22	0	3	5.8	4	9.8	22.6	102.73%	96.15%
Oncology	2	0	2	4	4	12	2	0	5	4	12	23	2	1	5	4	10.4	22.4	97.39%	94.44%
Ophthalmology	1	1	2	0	4	8	1	1	2	0	7	11	1	1	2	0	7	11	100.00%	65.00%
Oral & Maxillofacial Surgery	0	0	10	0	2	12	0	0	10	0	6	16	0	0	7	0	6	13	81.25%	117.00%
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	9	0	9	18	0	0	7	0	7.4	14.4	80.00%	100.00%
Paediatric Surgery	0	0	2	0	0	2	0	2	0	0	4	6	0	0	1	0	3	4	66.67%	127.00%
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	0	0	0	2	0	2	100.00%	90.97%
Plastic Surgery	0	1	3	0	6	10	0	1	3	0	8	12	0	0	3	0	5.6	8.6	71.67%	48.40%
Paediatrics	3	5	4	3	9	24	4	5	4	3	9	25	4	5	3.1	2.5	8.5	23.1	92.40%	106.40%
Radiology	0	1	13	0	28	42	0	1	12	0	12	25	0	1	12	0	12.5	25.5	102.00%	100.00%
Renal Medicine	2	1	2	0	5	10	2	1	3	0	5	11	2	1	3	0	5	11	100.00%	100.00%
Respiratory Medicine	6	2	2	2	8	20	6	2	2	2	8	20	6	2	2	2	8	20	100.00%	7.33%
Rheumatology	0	0	1	2	3	6	0	0	6	2	3	11	0	0	6	2	5	13	118.18%	0.00%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	1	1	0	0	0	0	1	1	100.00%	106.67%
Trauma & Orthopaedics	0	4	3	1	9	17	0	11	5	1	14	31	0	11	4	0	14	29	93.55%	100.00%
Upper GI	7	0	3	0	4	14	7	0	4	0	9	20	6	0	3	0	8.8	17.8	89.00%	94.00%
Urology	1	3	2	0	3	9	1	3	3	0	5	12	1	3	2	0	5	11	91.67%	91.67%
Vascular Surgery	5	0	1	0	3	9	5	0	1	0	6	12	4	0	1	0	3	8	66.67%	96.08%
TOTAL	70	87	134	129	218	638	73	96	150	132	260	711	70.2	95.7	140.4	119.5	256.5	682.3	95.96%	94.37%

Increased vacancies since last report
Decreased vacancies since last report
No change in vacancies since last report

Hull University Teaching Hospitals NHS Trust - Junior Doctor Trainee Establishment effective April 2022

	Trainee Establishment						Trainee In Post						
Department	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	F1	F2	CT/ST1-2	GPSTR	ST	**Total**	**% Filled**
Academic, GP, Psych & Community	5	29	0	91	0	125	5	28.8	0	85.7	0	119.5	**95.6%**
Acute Medicine	3	6	9	0	5	23	3	6	8	0	4	21	**91.3%**
Anaesthetics	4	4	20	0	29	57	4	4	19.8	0	29.3	57.1	**100.2%**
Breast Surgery	2	0	1	0	2	5	2	0	1	0	1	4	**80.0%**
Cardiology	2	1	3	1	9	16	2	1	3	1	8	15	**93.8%**
Cardiothroacic Surgery	0	3	0	0	3	6	0	3	0	0	3	6	**100.0%**
Chemical Pathology	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**
Colorectal Surgery	7	0	1	0	3	11	6.8	0	1	0	3	10.8	**98.2%**
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	**100.0%**
Elderly Medicine	5	3	5	8	6	27	5	3	4	7.4	4.8	24.2	**89.6%**
Emergency Medicine	0	12	14	6	15	47	0	12	10.2	4.8	14.6	41.6	**88.5%**
Endocrinology	3	0	2	0	6	11	3	0	2	0	6	11	**100.0%**
ENT	1	1	2	3	4	11	1	1	1.8	2.5	3	9.3	**84.5%**
Gastroenterology	3	1	3	0	5	12	4.4	1	3	0	5	13.4	**111.7%**
General Surgery	0	1	0	0	0	1	0	1	0	0	0	1	**100.0%**
Haematology	2	2	2	0	4	10	2	2	2	0	3.8	9.8	**98.0%**
Histopathology	0	0	3	0	1	4	0	0	2	0	1	3	**75.0%**
Immunology	0	0	0	0	2	2	0	0	0	0	2	2	**100.0%**
Infectious Diseases	2	0	1	1	5	9	2	0	0	1	5	8	**88.9%**
Neurology	2	2	3	0	5	12	2	2	3	0	3.6	10.6	**88.3%**
Neurosurgery	1	1	2	0	4	8	1	1	1	0	3	6	**75.0%**
Obstetrics & Gynaecology	0	3	6	4	13	26	0	2	5	4	12.8	23.8	**91.5%**
Oncology	2	0	2	4	4	12	2	0	2	3.6	3.8	11.4	**95.0%**
Ophthalmology	1	1	2	0	4	8	1	1	2	0	3	7	**87.5%**
Oral & Maxillofacial Surgery	0	0	10	0	2	12	0	0	4	0	1	5	**41.7%**
Paediatric Neonatal Medicine	0	0	7	0	7	14	0	0	7	0	7.4	14.4	**102.9%**
Paediatric Surgery	0	0	2	0	0	2	0	0	1	0	0	1	**50.0%**
Palliative Care	0	0	0	2	0	2	0	0	0	2	0	2	**100.0%**
Plastic Surgery	0	1	3	0	6	10	0	1	3	0	5.6	9.6	**96.0%**
Paediatrics	3	5	4	3	9	24	4	5.6	3	2	8.7	23.3	**97.1%**
Radiology	0	1	13	0	28	42	0	1	12.6	0	25.3	38.9	**92.6%**
Renal Medicine	2	1	2	0	5	10	2	1	2	0	4	9	**90.0%**
Respiratory Medicine	6	2	2	2	8	20	6	2	1	2	7	18	**90.0%**
Rheumatology	0	0	1	2	3	6	0	0	1	2	2.8	5.8	**96.7%**
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	1	1	**100.0%**
Trauma & Orthopaedics	0	4	3	1	9	17	0	4	3	1	9	17	**100.0%**
Upper GI	7	0	3	0	4	14	6	0	2	0	4	12	**85.7%**
Urology	1	3	2	0	3	9	1	3	1	0	3	8	**88.9%**
Vascular Surgery	5	0	1	0	3	9	4	0	1	0	1.8	6.8	**75.6%**
TOTAL	**70**	**87**	**134**	**129**	**218**	**638**	**70.2**	**86.4**	**112.4**	**120**	**201.3**	**590.3**	**92.5%**

Appendix A: Exception reports episodes per specialty 1st April – 30th June 2022

Specialty (Where exception occurred)	No. exceptions carried over from last report	No. exceptions raised (episodes)	No. exceptions closed (episodes)	No.exceptions outstanding (episodes)
Accident and emergency	14	0	3	11
Acute Medicine	6	0	3	3
Anaesthetics	2	0	2	0
Cardiology	1	0	1	0
Cardio-thoracic surgery	22	26	32	16
Communicable diseases (infectious diseases)	0	2	0	2
Diabetes & endocrinology	2	0	2	0
Gastroenterology	7	8	0	15
General medicine	110	31	64	77
General surgery	54	13	30	37
Geriatric medicine	2	0	2	0
Medical oncology	12	27	17	22
Neonatology	2	0	1	1
Neurosurgery	2	0	0	2
Obstetrics and gynaecology	14	1	1	14
Otolaryngology (ENT)	5	0	3	2
Paediatrics	6	0	0	6
Paediatric Surgery	0	8	3	5
Plastic surgery	2	2	0	4
Surgical specialties	32	7	0	39
Trauma & Orthopaedic Surgery	14	1	4	11
Vascular Surgery	13	5	3	15

Appendix B: Exception reports (episodes) by grade 1st April – 30th June 2022

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	178	51	86	143
F2	71	67	66	72
CT1	4	3	2	5
CT2	15	0	4	11
Specialty registrar in core training 1/2	18	0	3	15
ST1	10	0	0	10
ST2	19	0	2	17
ST3	6	0	6	0
ST4	3	1	3	1
ST5	3	4	2	5
ST6	7	1	1	7
ST7	2	0	2	0
Registrar	2	3	0	5

Appendix C: Exception reports (episodes) by rota 1st April – 30th June 2022

Rota	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Rota 18 - Medicine F1 Oncology	5	5	0
Rota 134 – Orthopaedic/Orthogeriatric F2	1	1	0
Rota 40 – Plastic Surgery	1	1	0
Rota 51 – O&G ST1-2	1	1	0
Rota 29 - Vascular Surgery	2	2	0
Rota 23 - Surgery F1	2	1	1
Rota 124a - General Surgery, Acute & Elective	7	4	3
Rota 25 - Acute/Elective F1	10	6	4
Rota 9 - Chest/Renal (Blp 575)	1	1	0
Rota 14 - DME (Blp 431)	8	5	3
Rota 22 - Cardiothoracic Surgery Sp	19	18	1
Rota 15 - Gastro/Endo/Renal/ID (Blp 450)	6	0	6
Rota 8 - Oncology & Haematology	17	8	9
Rota 121 - CT Surgery & Cardiology	10	7	3

Rota 4 - Medicine F1, DME/Gastro	18	15	3
Rota 66 – Paediatric Surgery	5	5	0
Rota 12 - Medical Oncology SpR	1	1	0

Appendix D: Exception reports (episodes) - response time 1st April – 30th June 2022

The 2016 TCS require that the trainer meets with the trainees to discuss an exception report within seven days. This is a very difficult timescale to achieve, because of trainers and trainees often working on different shift patterns, but the timescale is there to ensure that safety concerns, including excessive working time, are addressed quickly.

Looking at response time by grade is not a particularly useful measure, but it is one that is requested by NHS employers. Of more use is response time by department, as this shows the areas either where trainers are not engaging in the exception reporting process, or where trainers and trainees are too busy to sit down and discuss or record the incidents.

This is shown in the table below:

Grade	Addressed within 48hrs	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	1	0	37	10
F2	14	9	16	33
CT1	0	0	0	3
Registrar	0	0	0	2
Specialist Registrar	0	1	0	0
ST4	0	0	22	0
ST6	0	2	0	0
Specialist Registrar 6	0	1	0	0

Agenda Item		Meeting	Trust Board	Meeting Date	8th November 2022
Title	Freedom to Speak Up Guardian report – Quarter 2 2022/2023 report				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Frances Moverley, Head of Freedom to Speak Up				
Report previously considered by (date)	N/A				

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

Key Recommendations to be considered:

- The Trust Board are asked to receive and accept this Quarter 2 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 Q2 2022/2023

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 an update on the concerns raised by staff, students, trainees or volunteers through HUTH's FTSUG during Q2, 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 FTSUG in place. There are a number of processes at HUTH 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.

3. FTSUG Activities during Q2 2022/2023

A summary of the activities of the FTSUG are detailed below:

- The recruitment to 'Speak Up Champions' was launched to establish a network of colleagues across the Trust who raise awareness and signpost others to speaking up services. The principles and the role description of the Speak Up Champions has been closely developed in line with the National Guardian Office guidance and advice from the Information Governance Team.
- The FTSUG was invited to participate in a focus group with Lord Jonathan Evans, the Chair of the Independent Committee on Standards in Public Life, who advises the Prime Minister on arrangements for upholding ethical standards of conduct across public life in England. The discussions held in the focus group forms part of a national review examining the role of leadership in embedding the Principals of Public Life.
- Following the launch of the Zero Tolerance to Racism Framework, the FTSUG has become a member of the 'circle group', assisting with the discussions of the incidents of racism reported using the online tool. This involvement has been within the national guidance of the FTSUG role e.g. impartiality.
- Q2 has included a number of induction presentations to ensure new starters to the Trust are aware of the FTSUG role, remit and key contact details. Presentations and training have been provided as part of the newly qualified midwives study day, FY1 training programme and three Doctors in Training induction days.
- The FTSUG was also invited to present at the Executive Nursing and Midwifery Committee, Occupational Health Nurses team time out and to the CHH surgical Ward Managers, to explain and further reinforce the Guardian role and speaking up across the Trust.

- The joint HR Business Partner, HR Manager and HR Advisor meeting was attended to present key learning and promote partnership working.
- Further partnership working was also discussed and agreed with the Lead Chaplain for Staff Support.
- Following a query at the previous Public Trust Board, the FTSUG has commenced a comparison of the number of individual concerns raised at similar sized Acute Trusts.

4. Future activities planned for Q3:

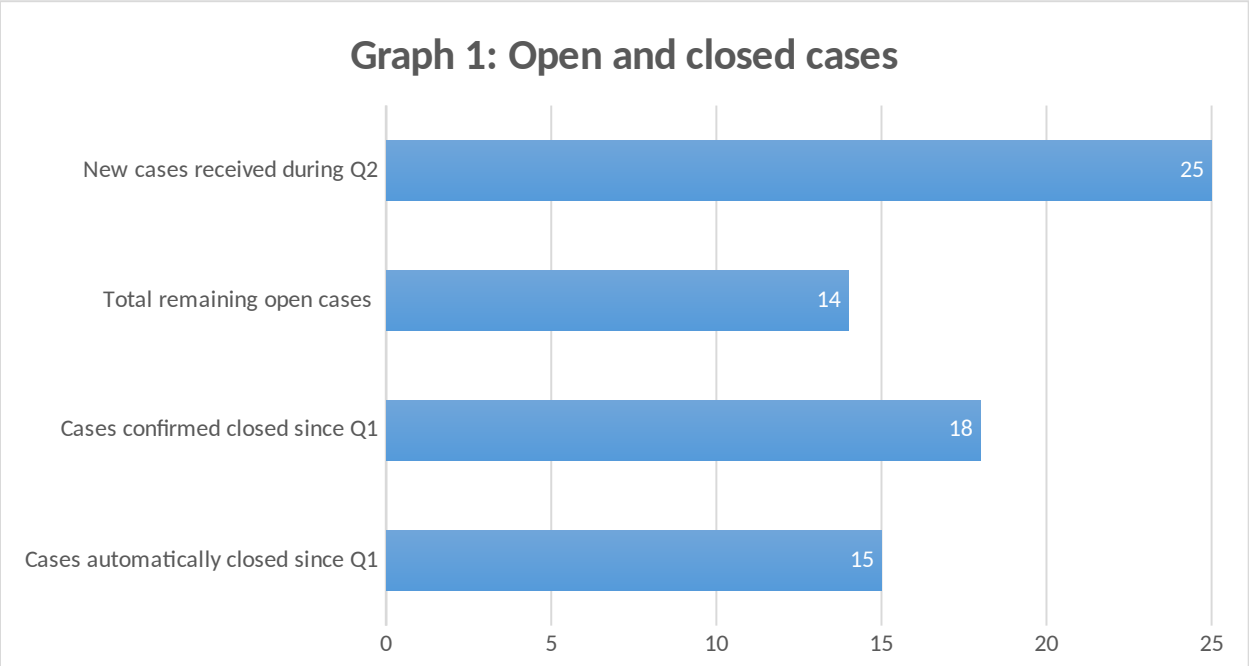
- October is national awareness month Freedom to Speak Up and as part of this, the first Speak Up Champions training will be launched.
- The FTSUG will present a dedicated training session at each of the mandatory 'Let's Get Started' nursing induction programme, for newly qualified nurses and those returning to practice.
- Participation on the 'Bridging the Gap' disability awareness training to further support the role and staff raising disability related concerns.
- The FTSUG has been invited to be a guest speaker at HUTH Staff Disability conference and speak on the theme of psychological safety.

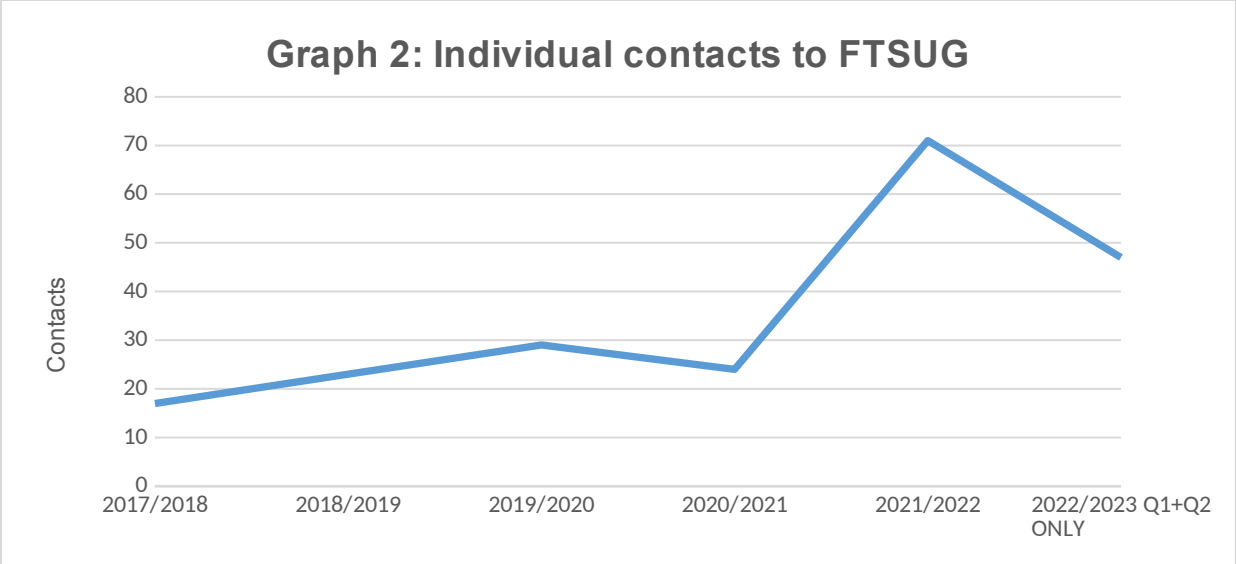
5. Trust contacts during 1st July 2022 to 30th September 2022

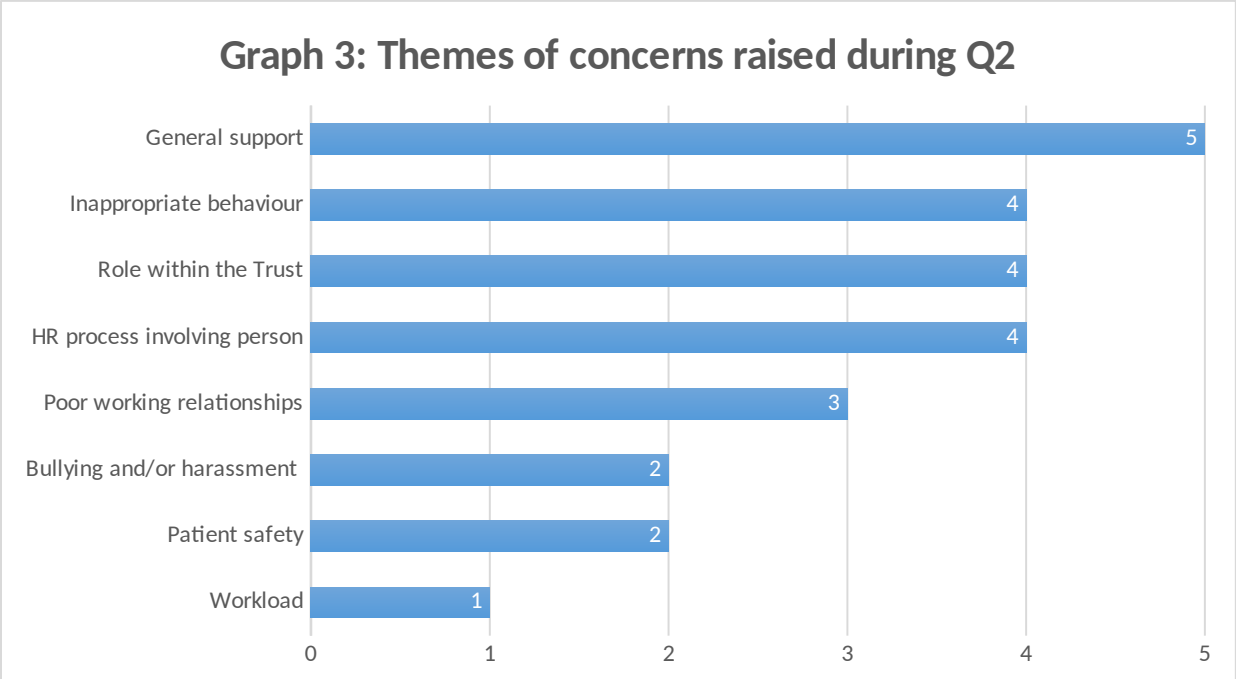
The FTSUG reports on individual contacts received from members of staff, students, trainees and volunteers, to the Trust Board each quarter in the public board meeting. It is also the responsibility of the FTSUG to submit the quarterly data to the National Guardian Office.

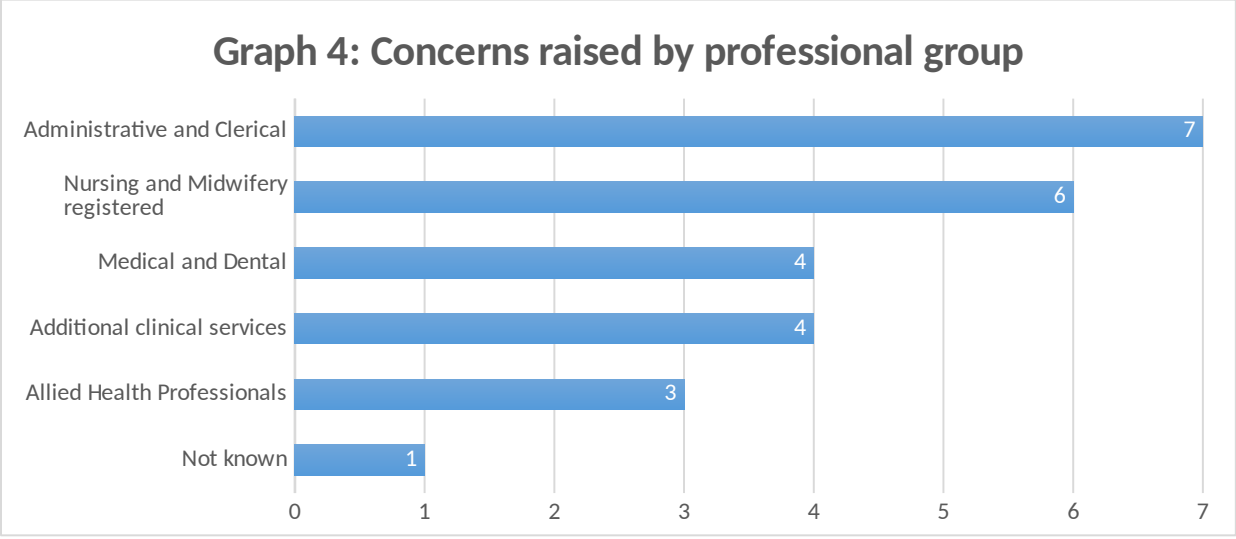
Graph 1 summaries the total numbers of open and closed cases (data extracted at 30.09.2022).

Graph 2 shows a comparison of the number of individual contacts received during Q1 and Q2 combined, on comparison with the annual data since 2017. Graph 3 provides the main theme of the concerns and Graph 4 the professional group of staff making contact with the FTSUG.




Graph 2: Individual contacts to FTSUG
Contacts
80
70
60
50
40
30
20
10
0
2017/2018
2018/2019
2019/2020
2020/2021
2021/2022
2022/2023 Q1+Q2 ONLY


Graph 3: Themes of concerns raised during Q2
General support
5
Inappropriate behaviour
4
Role within the Trust
4
HR process involving person
4
Poor working relationships
3
Bullying and/or harassment
2
Patient safety
2
Workload
1
0
1
2
3
4
5


Graph 4: Concerns raised by professional group
Administrative and Clerical
7
Nursing and Midwifery registered
6
Medical and Dental
4
Additional clinical services
4
Allied Health Professionals
3
Not known
1
0
1
2
3
4
5
6
7

Comments and observations:

- The number of individual concerns received during the quarter continues to increase. The year to date total number of comments is 47 (by comparison, Q1 and Q2 total for 2021/2022 was 17).
- At the time of writing this report 8 of the 25 concerns raised during Q2 remain open and still in progress.
- It was agreed for 5 of the concerns that the FTSUG would escalate the matter and request progress or action was taken.
- The theme of the reason why staff members are contacting the FTSUG is varied, with 'general support' being the most popular reason for the first time. This tended to be when individuals wished to raise concerns about issues or improvement ideas outside of their immediate working area, and were unsure in how to do so.
- Roles that are classified as Administrative and Clerical continue to be the most popular staff group contacting the FTSUG.
- Whilst no concerns were raised directly in relation to 'worker safety', 10 of the contacts were individuals who expressed concerns for the effect the situation had on their own wellbeing. The FTSUG signposted each individual to the Trust staff support services for assistance.
- Two concerns were received anonymously; one by letter and the second by email with a pseudonym name.

6. Conclusions

The number of individuals approaching the FTSUG continues to increase and the themes of the concerns received were varied. The FTSUG continues to be active in raising the profile of the role and during Q2 has focused on the induction and training of new starters in medical and midwifery roles.

7. Recommendations

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
October 2022

NHS
Hull University Teaching Hospitals
NHS Trust

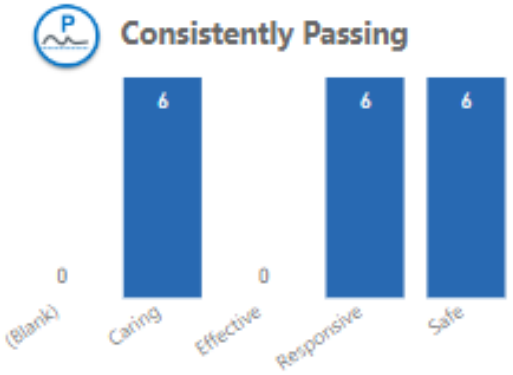
Integrated Performance Report – November 2022

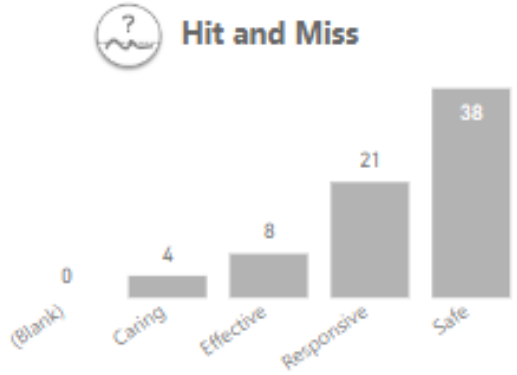
Author: Business Intelligence Analytics Team

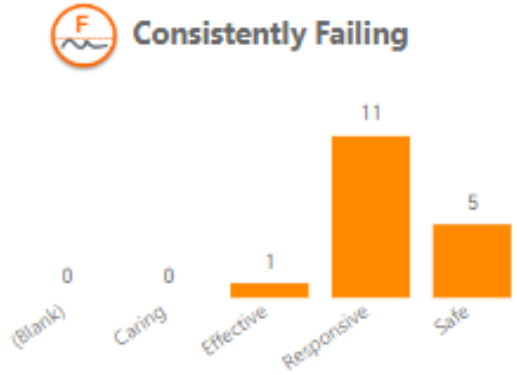
Contact: Karen Ferguson – Information Manager

digital
business intelligence

Executive Summary







Domain	Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)	Unreliable	Not capable	Capable	N/A
Caring	3	2	4	1				4		6	
Effective	9							8	1		
Responsive	22	6	9	3				21	11	6	2
Safe	43	5	2	1	1			38	5	6	3
Total	77	13	15	5	1			71	17	18	5

Scorecard – Caring

SPC Variation Icons

Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)
3	2	4	1	0	0	0
Common cause	Special Cause Concerning variation		Special Cause Improving variation		Neither concern or improvement	

SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
4	0	6	0
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
A&E FFT response rate	August 2022	15.1%	Concern (Low)	Unreliable
A&E Scores FFT (% negative)	August 2022	21.9%	Concern (High)	Capable
A&E Scores FFT (% positive)	August 2022	67.0%	Concern (Low)	Capable
Inpatient FFT response rate	August 2022	11.7%	Concern (Low)	Unreliable
Inpatient Scores FFT - % negative	August 2022	8.2%	Concern (High)	Capable
Inpatient Scores FFT - % positive	August 2022	85.9%	Concern (Low)	Capable
Maternity FFT response rate	August 2022	0.0%	Common Cause	Unreliable
Maternity Scores FFT - % negative	June 2022	0.0%	Common Cause	Capable
Maternity Scores FFT - % positive	June 2022	100.0%	Improvement (High)	Unreliable
Mixed Sex Accommodation Breaches	September 2022	0	Common Cause	Capable

Scorecard - Effective

SPC Variation Icons

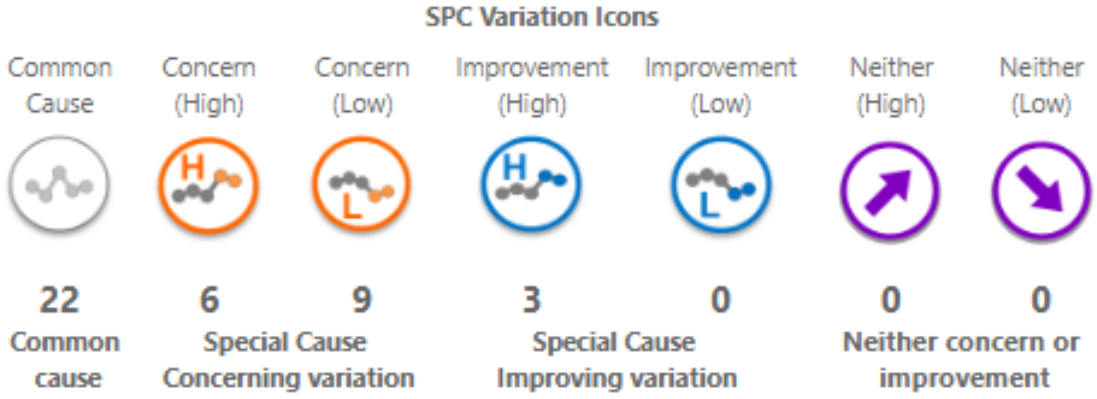
Common Cause	Concern (High)	Concern (Low)	Improvement (High)	Improvement (Low)	Neither (High)	Neither (Low)
9	0	0	0	0	0	0
Common cause	Special Cause Concerning variation		Special Cause Improving variation		Neither concern or improvement	

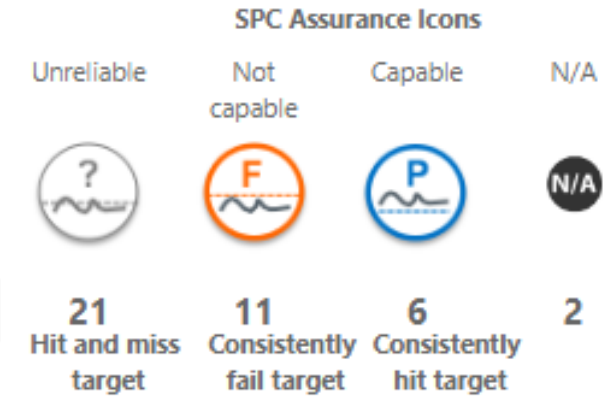
SPC Assurance Icons

Unreliable	Not capable	Capable	N/A
8	1	0	0
Hit and miss target	Consistently fail target	Consistently hit target	

Metric	Month	Result	Variation	Assurance
Crude Mortality (non-elective admissions)	September 2022	3.2%	Common Cause	Unreliable
Emergency C-section rate	September 2022	22.5%	Common Cause	Unreliable
Emergency readmissions within 30 days	August 2022	7.9%	Common Cause	Unreliable
Hospital Standardised Mortality Ratio - Weekend	July 2022	170.31	Common Cause	Unreliable
Hospital Standardised Mortality Ratio - monthly position	July 2022	118.28	Common Cause	Unreliable
PPCI within 150 minutes	August 2022	62.1%	Common Cause	Unreliable
Stroke 60 mins (BPT)	August 2022	45.8%	Common Cause	Unreliable
Stroke PTs >90% stay on a Stroke Ward (BPT)	August 2022	84.7%	Common Cause	Unreliable
Summary Hospital Mortality Indicator (HSCIC)	January 2022	114.57	Common Cause	Not capable

Scorecard – Responsive (1 of 3)





Metric	Month	Result	Variation	Assurance
% Ambulance handovers waiting >60 minutes	September 2022	44.6%	Concern (High)	Not capable
% Ambulance handovers waiting 15-30 minutes	September 2022	18.5%	Concern (Low)	Capable
% Ambulance handovers waiting 30-60 minutes	September 2022	20.2%	Improvement (High)	Capable
Ambulance handovers waiting <15 minutes (number)	September 2022	256	Concern (Low)	Capable
Ambulance handovers waiting >60 minutes (number)	September 2022	681	Concern (High)	Unreliable
Ambulance handovers waiting 15-30 minutes (number)	September 2022	282	Concern (Low)	Unreliable
Ambulance handovers waiting 30-60 minutes (number)	September 2022	308	Common Cause	Unreliable
Cancelled op 28 day breaches % (quarterly)	June 2022	21.5%	Common Cause	Unreliable
Cancelled Operations % of FFCEs (quarterly)	June 2022	1.0%	Common Cause	Unreliable

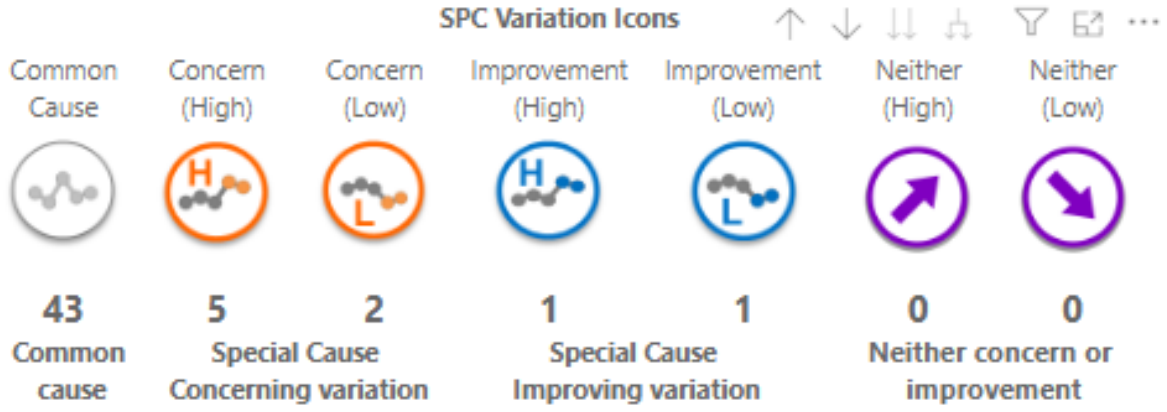
Scorecard – Responsive (2 of 3)

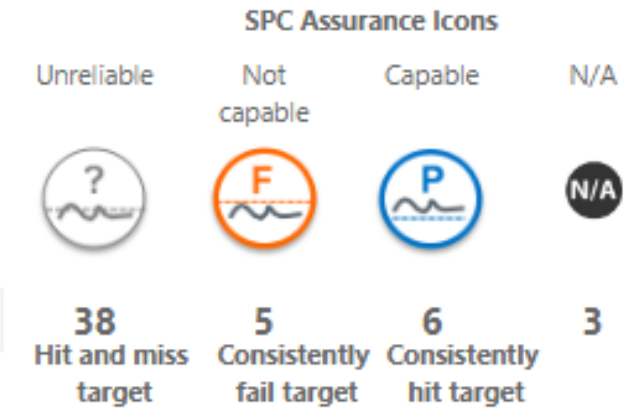
Metric	Month	Result	Variation	Assurance
Cancer 104 Day Waits	September 2022	90	Concern (High)	Not capable
Cancer 2 week (all cancers)	August 2022	91.5%	Common Cause	Unreliable
Cancer 2 week (breast symptoms)	August 2022	93.0%	Improvement (High)	Not capable
Cancer 28 Day Wait - Faster Diagnosis Standard	August 2022	77.9%	Common Cause	Unreliable
Cancer 31 day wait for second or subsequent treatment - drug treatments	August 2022	100.0%	Common Cause	Unreliable
Cancer 31 day wait for second or subsequent treatment - Radiotherapy	August 2022	50.8%	Concern (Low)	Unreliable
Cancer 31 day wait for second or subsequent treatment - surgery	August 2022	71.0%	Common Cause	Not capable
Cancer 31 day wait from diagnosis to first treatment	August 2022	84.3%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	August 2022	61.3%	Common Cause	Unreliable
Cancer 62 Day Waits for first treatment (from urgent GP referral)	August 2022	51.0%	Common Cause	Not capable
Capital forecast against plan	February 2022	(23,322)	Common Cause	Capable
Complaints received	September 2022	20	Common Cause	Unreliable
Complaints reopened	September 2022	6	Common Cause	Unreliable
Complaints: Received rate per 1000 bed days	September 2022	0.63	Common Cause	Unreliable
Diagnostics: Patients waiting 6 weeks or more from referral to test	September 2022	31.3%	Common Cause	Not capable
ED: % of attendees assessed within 30 minutes of arrival	September 2022	83.9%	Concern (Low)	Unreliable
ED: 12 hour trolley waits	September 2022	650	Concern (High)	Not capable
ED: Standard Performance Type 1	September 2022	44.3%	Concern (Low)	Not capable

Scorecard – Responsive (3 of 3)

Metric	Month	Result	Variation	Assurance
ED: Standard Performance Type 1 & 3	September 2022	61.3%	Concern (Low)	Not capable
ED: Standard Performance Type 3	September 2022	87.9%	Concern (Low)	Unreliable
Forecast outturn compared to plan	February 2022	0	Common Cause	Unreliable
Forecast underlying surplus/deficit compared to plan	February 2022	(47,800)	Common Cause	N/A
Outpatients: Hospital Cancelled Outpatient Appointments %	September 2022	10.9%	Common Cause	Unreliable
PALS Complaints	September 2022	350	Concern (High)	Unreliable
Performance against 40 day compliance	September 2022	27.0%	Concern (Low)	Not capable
PHSO Referrals	September 2022	0	Common Cause	N/A
Recurrent efficiencies YTD compared to plan	February 2022	0	Common Cause	Capable
RTT Incomplete Pathways % performance	September 2022	57.9%	Improvement (High)	Not capable
RTT Total Waiting List	September 2022	69,842	Concern (High)	Unreliable
Total efficiencies YTD compared to plan	February 2022	0	Common Cause	Capable
YTD actual compared to plan	February 2022	0	Common Cause	Unreliable

Scorecard – Safe (1 of 4)





Metric	Month	Result	Variation	Assurance
% of staff who have a completed Covid 19 Risk Assessment	August 2022	67.8%	Improvement (Low)	Capable
Absence	September 2022	8.7%	Concern (High)	Not capable
Adjusted Vacancies WTE	September 2022	381	Common Cause	N/A
Adjusted Vacancy Rate WTE	September 2022	4.5%	Common Cause	N/A
Admission of full term babies to neo-natal care	September 2022	16	Common Cause	Unreliable
Agency WTE	September 2022	46	Common Cause	Unreliable
Appraisal complete % (AFC)	September 2022	56.9%	Concern (Low)	Unreliable
Appraisal complete % (Consultant)	June 2022	89.7%	Improvement (High)	Not capable
Bank WTE	September 2022	105	Common Cause	Unreliable

Scorecard – Safe (2 of 4)

Metric	Month	Result	Variation	Assurance
CAS alerts outstanding	August 2022	0	Common Cause	Unreliable
Category 1 Pressure Ulcer	September 2022	0	Common Cause	Unreliable
Category 2 Pressure Ulcer	September 2022	27	Common Cause	Unreliable
Category 3 Pressure Ulcer	September 2022	1	Concern (High)	Unreliable
Category 4 Pressure Ulcer	September 2022	1	Common Cause	Unreliable
Clinical harm reviews - Cancer 104 day wait	September 2022	42	Common Cause	Unreliable
Clinical harm reviews - 104 week waits RTT	September 2022	0	Common Cause	Unreliable
Clostridium Difficile - infection rate (per 1000 bed days)	September 2022	0.10	Common Cause	Unreliable
Clostridium Difficile - number	September 2022	3	Common Cause	Unreliable
Consultant and SAS – Signed off Job Plans %	September 2022	50.6%	Common Cause	Not capable
COVID - Positive Tests	September 2022	51	Common Cause	Unreliable
Covid Absence - Positive and Staff Isolation	September 2022	2.4%	Common Cause	Unreliable
Duty of Candour; investigation compliance	September 2022	0.0%	Common Cause	Unreliable
Duty of Candour; verbal apology	September 2022	0.0%	Common Cause	Unreliable
Duty of Candour; written apology	September 2022	0.0%	Common Cause	Not capable
E.Coli	September 2022	10	Common Cause	Unreliable

Scorecard – Safe (3 of 4)

Metric	Month	Result	Variation	Assurance
Elective C-section rate	September 2022	17.0%	Common Cause	Unreliable
Establishment WTE	September 2022	8,549	Concern (High)	Unreliable
Falls recorded as severe harm or death - rate per 1000 bed days	September 2022	0.25	Common Cause	Unreliable
Klebsiella spp bacteraemia	September 2022	0	Common Cause	Unreliable
Mandatory Training (% completed)	September 2022	80.4%	Concern (Low)	Unreliable
Maternal Deaths	August 2022	0	Common Cause	Capable
Medication errors causing serious harm	September 2022	0	Common Cause	Unreliable
Midwife to birth ratio	May 2022	1.30	Common Cause	Capable
MRSA bactaraemias	September 2022	0	Common Cause	Unreliable
MSSA	September 2022	5	Common Cause	Unreliable
Never Events	September 2022	1	Common Cause	Unreliable
Never events: Incidence Rate (per 1000 bed days)	September 2022	0.03	Common Cause	Unreliable
NEWS Compliance	September 2022	100.0%	Common Cause	Capable
Patient safety incidents that are harmful	September 2022	6.5%	Common Cause	Unreliable
Percentage of harm free care	September 2022	93.5%	Common Cause	Unreliable
Pressure Ulcers (Hospital acquired)	September 2022	51	Common Cause	Unreliable
Pseudomonas aeruginosa bacteraemia	September 2022	0	Common Cause	Unreliable

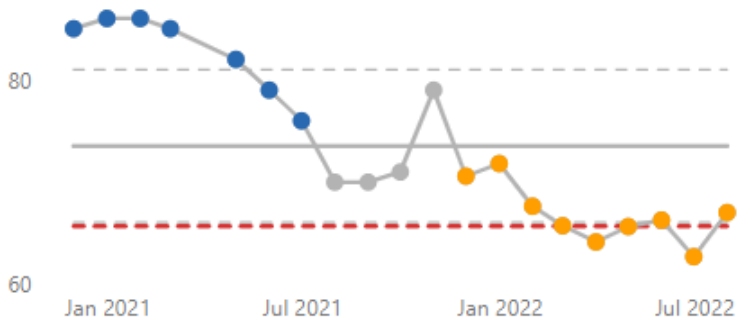
Scorecard – Safe (4 of 4)

Metric	Month	Result	Variation	Assurance
Serious Incidents	September 2022	10	Common Cause	Unreliable
Serious Incidents rate (per 1000 bed days)	September 2022	0.31	Common Cause	Capable
Sickness – Excluding Covid by Health Group and Staff Group	September 2022	4.1%	Concern (High)	Capable
Staff in Post WTE	September 2022	8,018	Common Cause	N/A
Suspected Deep Tissue Injury	September 2022	19	Common Cause	Unreliable
Turnover by Health Group and Staff Group	September 2022	16.3%	Concern (High)	Unreliable
Unstageable	September 2022	3	Common Cause	Unreliable
Vacancy Rate %	September 2022	6.2%	Common Cause	Unreliable
VTE Risk Assessment	June 2022	81.5%	Common Cause	Not capable
WHO Checklist	September 2022	97.6%	Common Cause	Unreliable

Performance Report Review – Caring

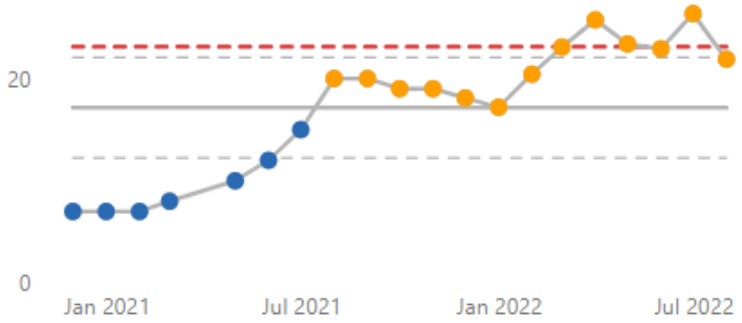
A&E Scores FFT (% positive)

Aug-22: 67.0% Baseline: 65.7%



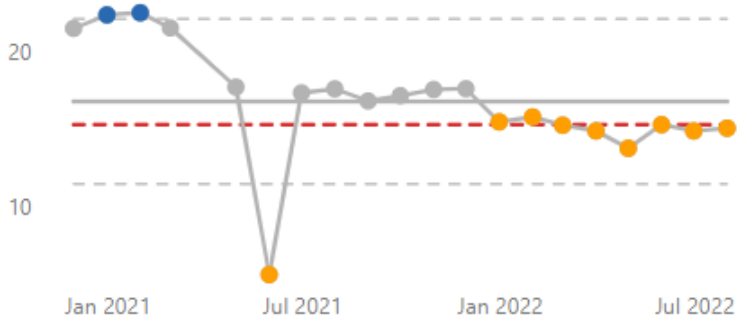
A&E Scores FFT (% negative)

Aug-22: 21.9% Baseline: 23.1%



A&E FFT response rate

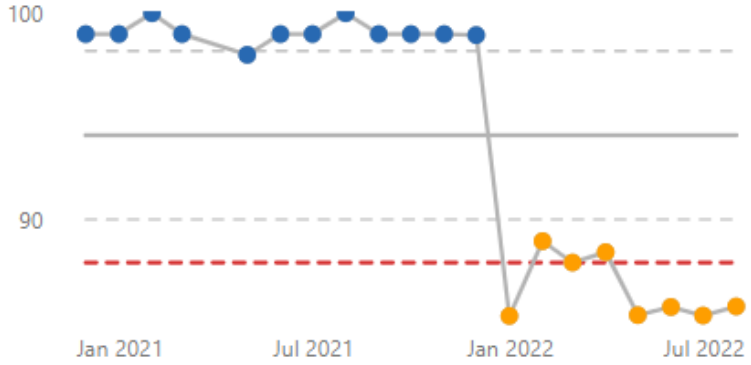
Aug-22: 15.1% Baseline: 15.3%



Performance Report Review – Caring

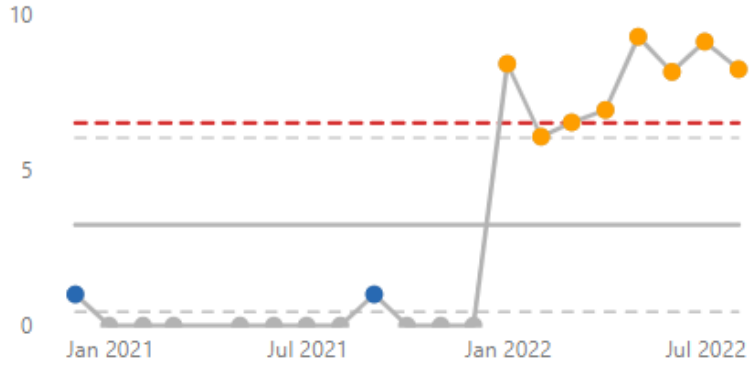
Inpatient Scores FFT - % positive

Aug-22: 85.9% Baseline: 88.0%



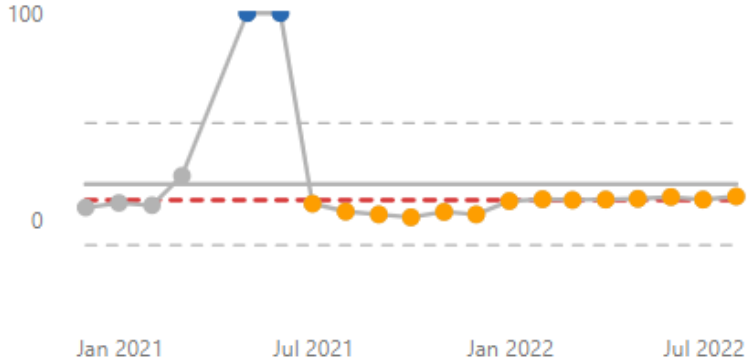
Inpatient Scores FFT - % negative

Aug-22: 8.2% Baseline: 6.5%



Inpatient FFT response rate

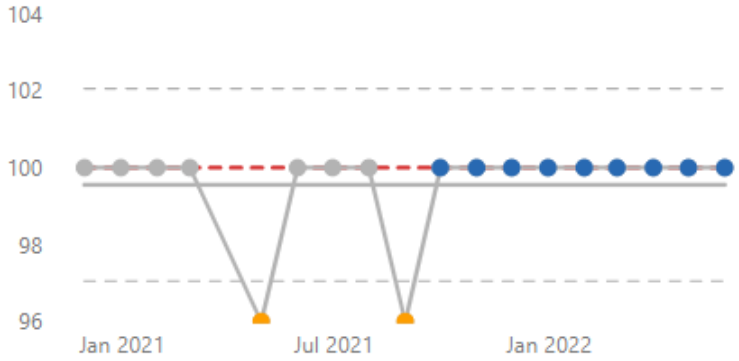
Aug-22: 11.7% Baseline: 10.0%



Performance Report Review – Caring

Maternity Scores FFT - % positive

Jun-22: 100.0% Baseline: 100.0%

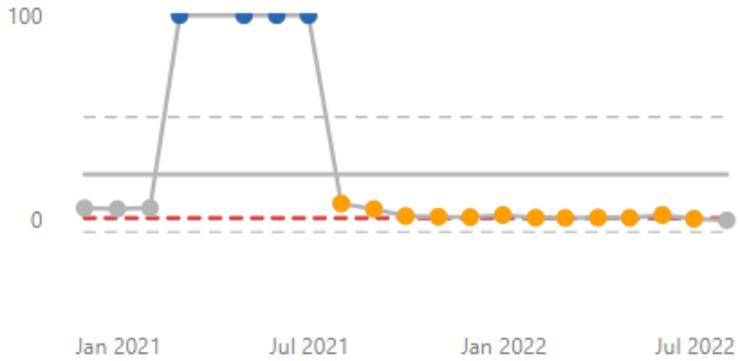


Maternity Scores FFT - % negative

Jun-22: 0.0% Baseline: 0.0%

Maternity FFT response rate

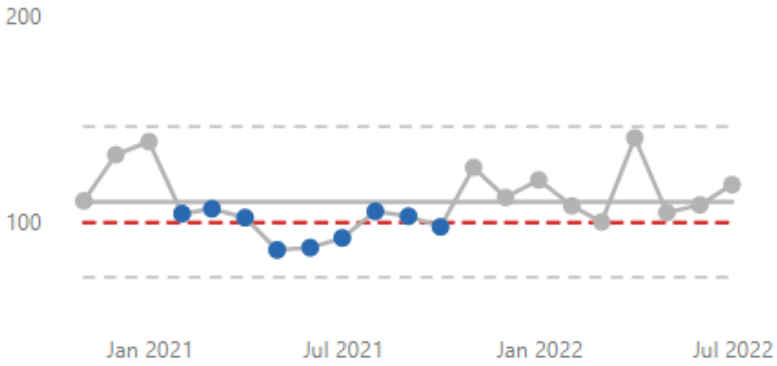
Aug-22: 0.0% Baseline: 1.1%



Performance Report Review – Effective

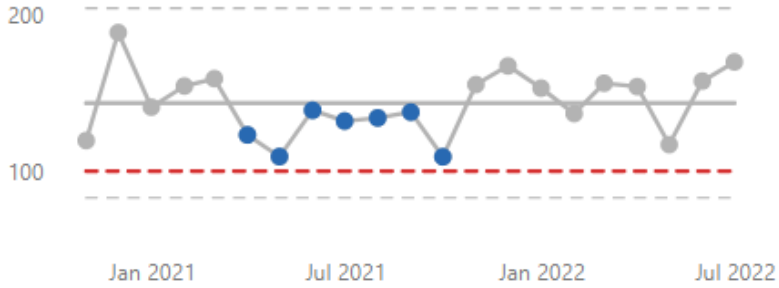
Hospital Standardised Mortality Ratio - monthly position

Jul-22: 118.28 Target: 100.00



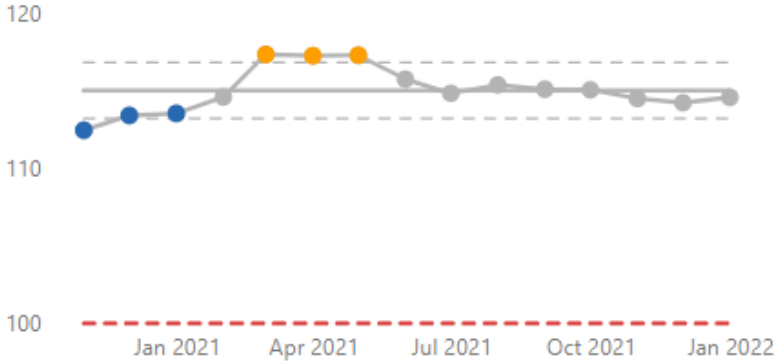
Hospital Standardised Mortality Ratio - Weekend

Jul-22: 170.31 Target: 100.00



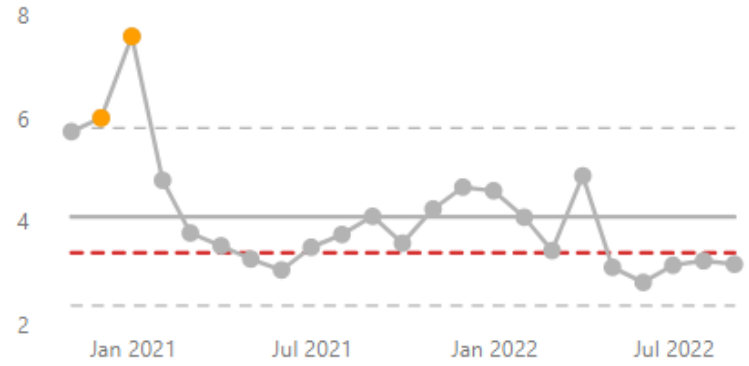
Summary Hospital Mortality Indicator (HSCIC)

Jan-22: 114.57 Target: 100



Crude Mortality (non-elective admissions)

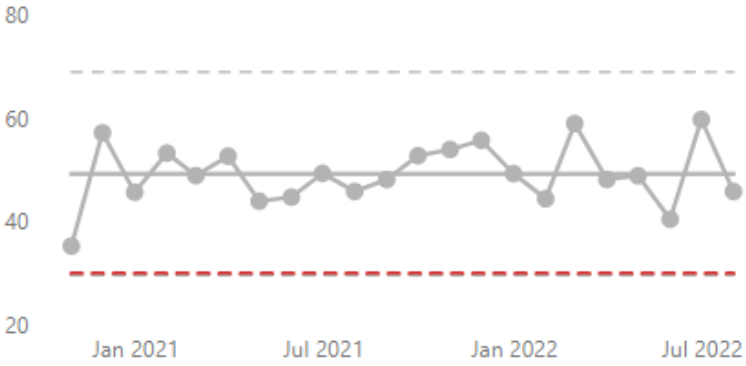
Sep-22: 3.2% Baseline: 3.4%



Performance Report Review – Effective

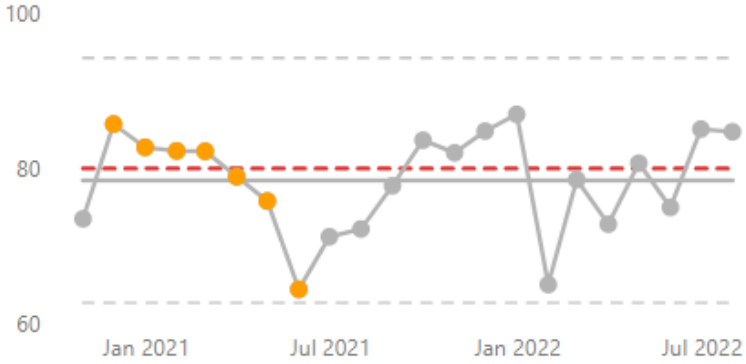
Stroke 60 mins (BPT)

Aug-22: 45.8% Target: 30.0%



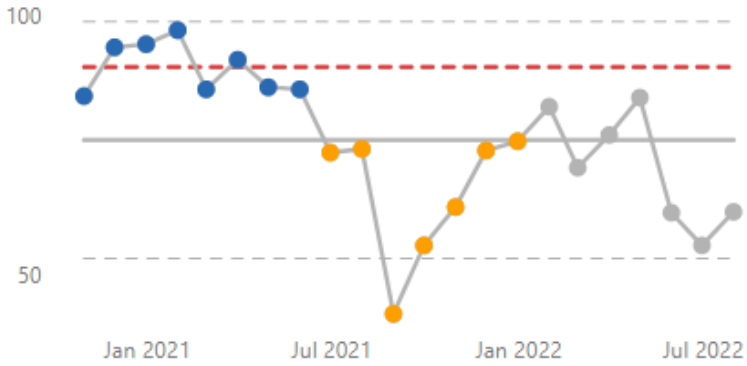
Stroke PTs >90% stay on a Stroke Ward (BPT)

Aug-22: 84.7% Target: 80.0%



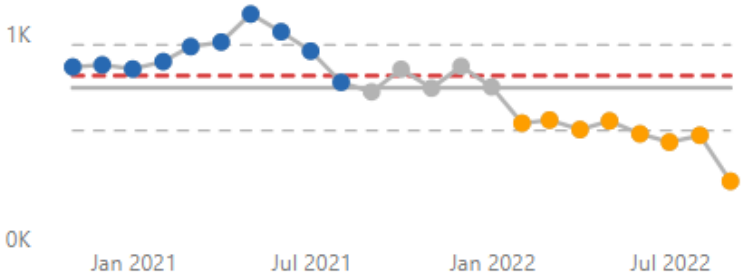
PPCI within 150 minutes

Aug-22: 62.1% Target: 90.0%



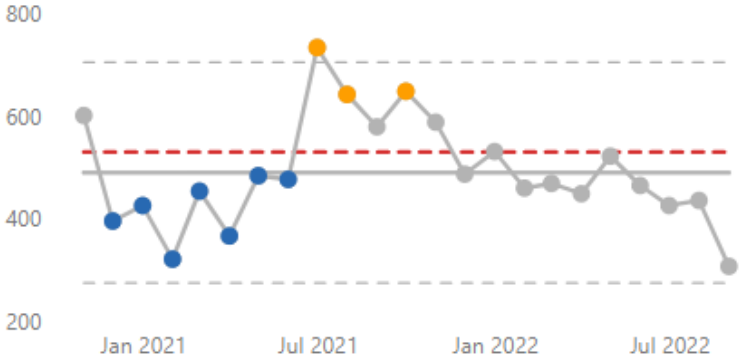
Ambulance handovers waiting 15-30 minutes (number)

Sep-22: 282 Baseline: 795



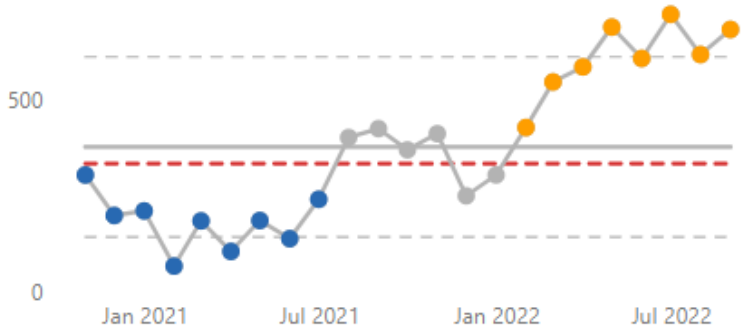
Ambulance handovers waiting 30-60 minutes (number)

Sep-22: 308 Baseline: 530



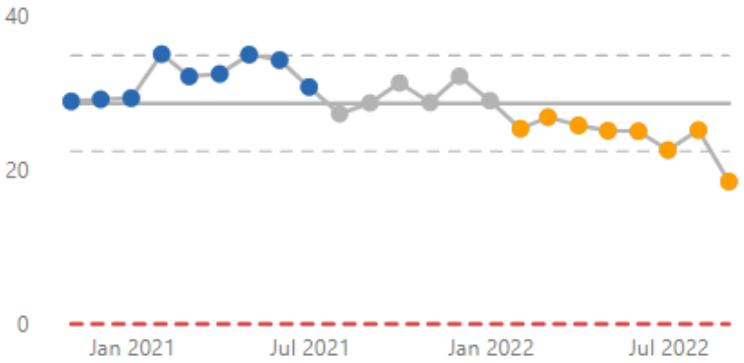
Ambulance handovers waiting >60 minutes (number)

Sep-22: 681 Baseline: 334



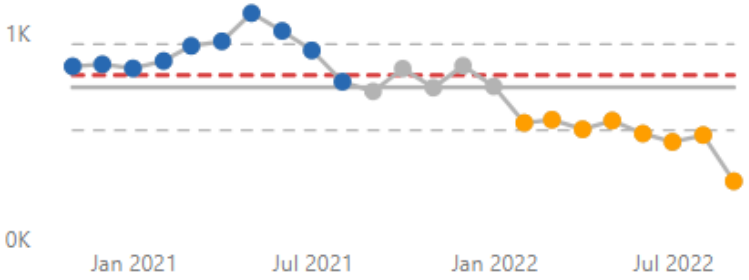
% Ambulance handovers waiting 15-30 minutes

Sep-22: 18.5% Target: 0.0%



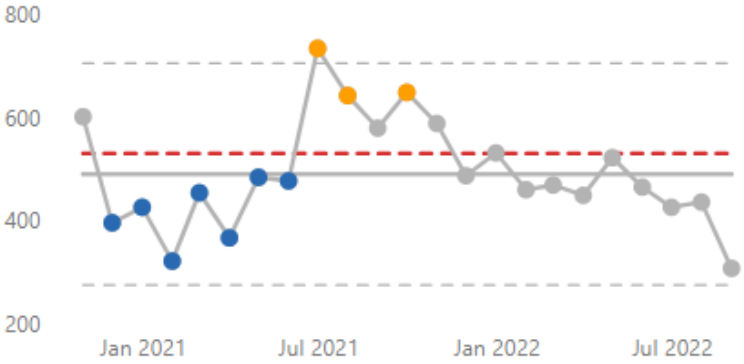
Ambulance handovers waiting 15-30 minutes (number)

Sep-22: 282 Baseline: 795



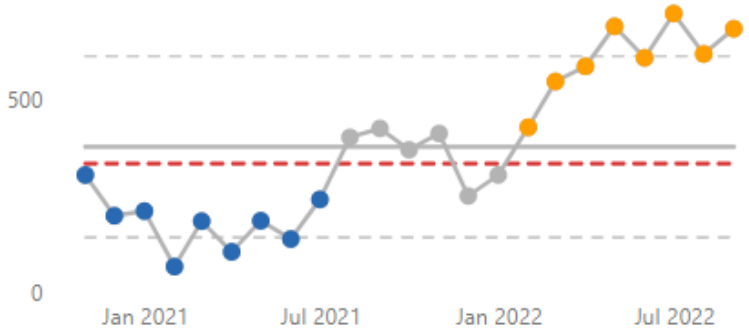
Ambulance handovers waiting 30-60 minutes (number)

Sep-22: 308 Baseline: 530



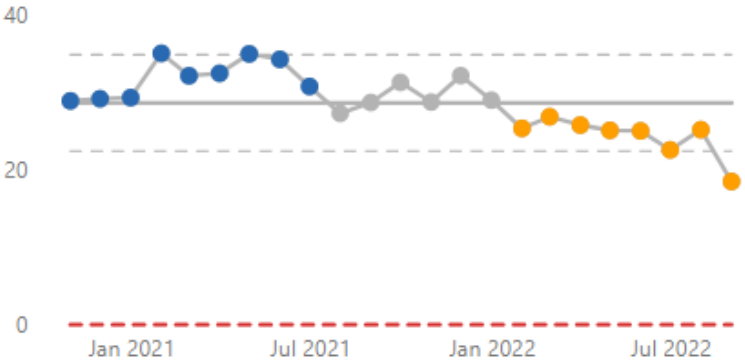
Ambulance handovers waiting >60 minutes (number)

Sep-22: 681 Baseline: 334



% Ambulance handovers waiting 15-30 minutes

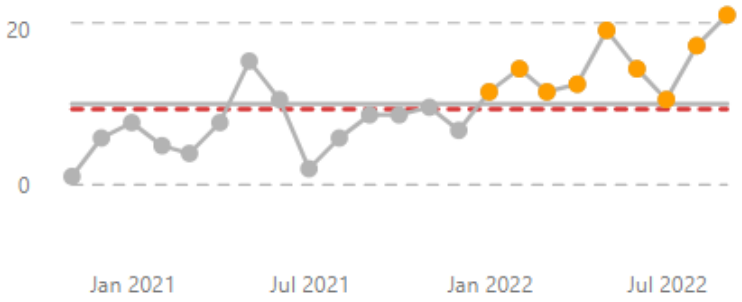
Sep-22: 18.5% Target: 0.0%



Performance Report Review – Responsive

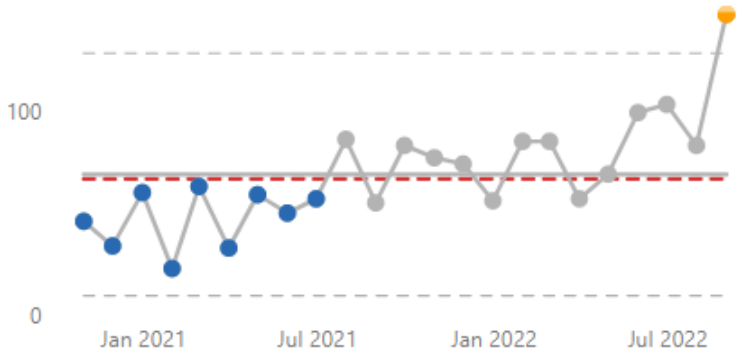
Cancelled op 28 day breaches number

Sep-22: 22 Baseline: 10



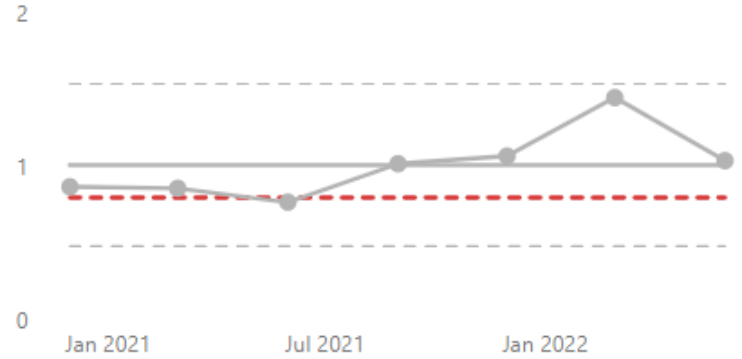
Cancelled Operations number

Sep-22: 147 Baseline: 67



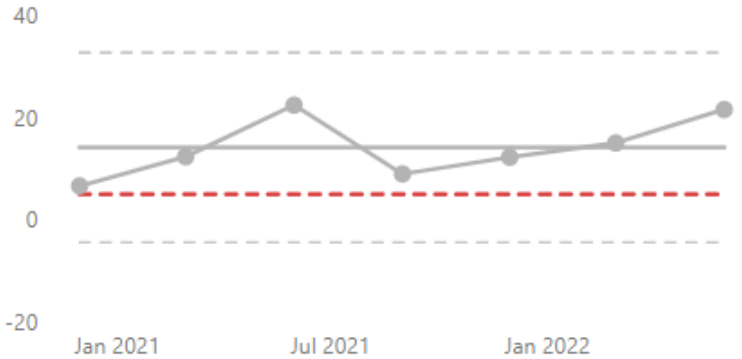
Cancelled Operations % of FFCEs (quarterly)

Jun-22: 1.0% Target: 0.8%



Cancelled op 28 day breaches % (quarterly)

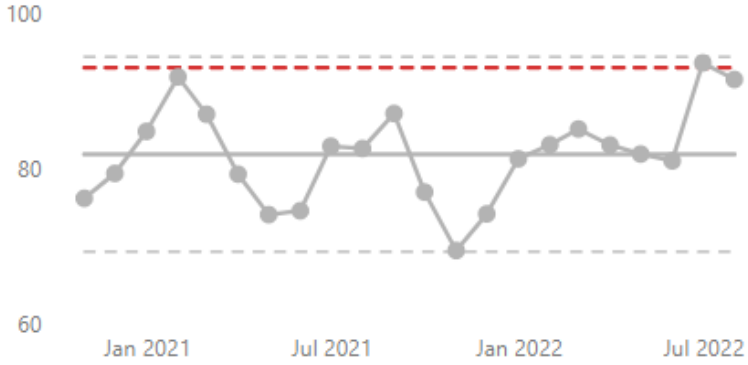
Jun-22: 21.5% Target: 5.0%



Performance Report Review – Responsive

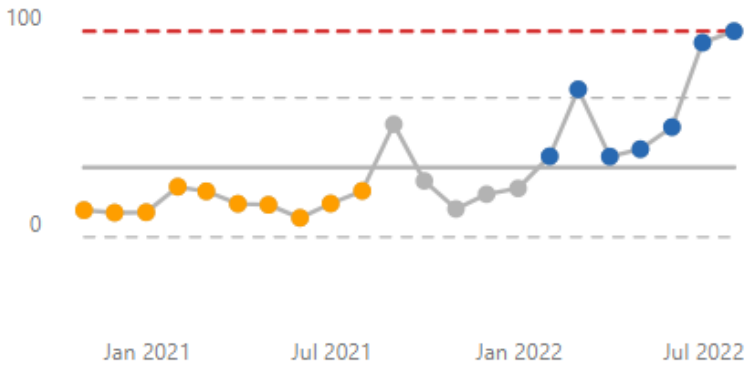
Cancer 2 week (all cancers)

Aug-22: 91.5% Target: 93.0%



Cancer 2 week (breast symptoms)

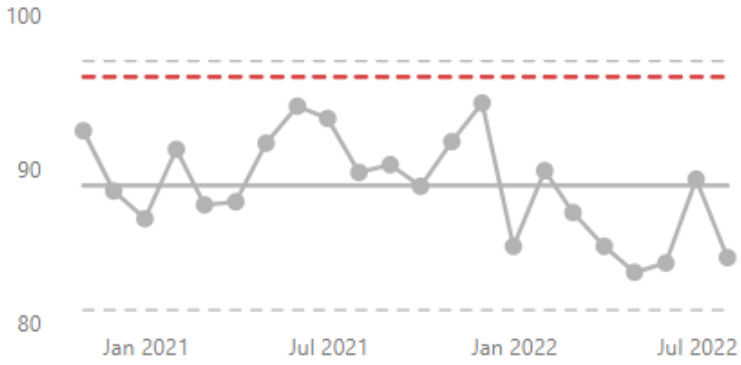
Aug-22: 93.0% Target: 93.0%



Performance Report Review – Responsive

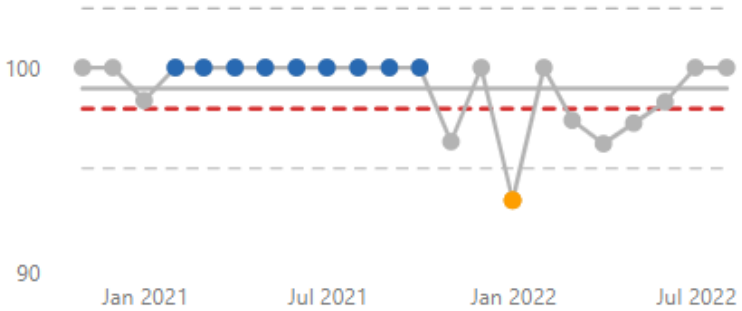
Cancer 31 day wait from diagnosis to first treatment

Aug-22: 84.3% Target: 96.0%



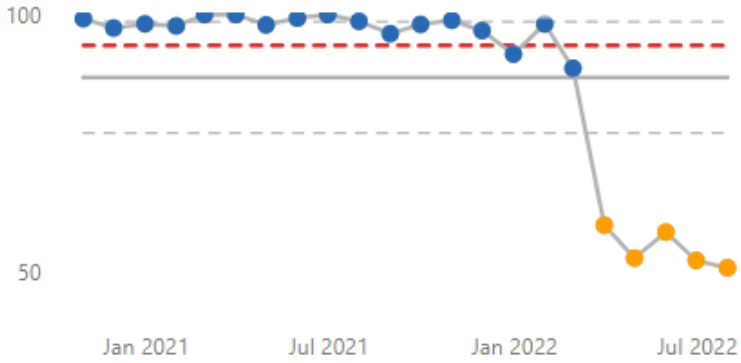
Cancer 31 day wait for second or subsequent treatment - drug treatments

Aug-22: 100.0% Target: 98.0%



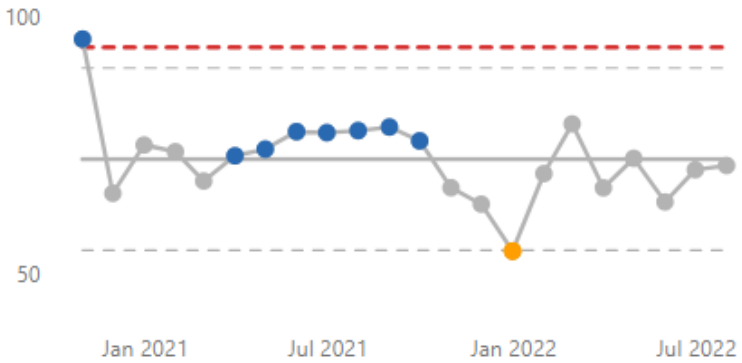
Cancer 31 day wait for second or subsequent treatment - Radiotherapy

Aug-22: 50.8% Target: 94.0%



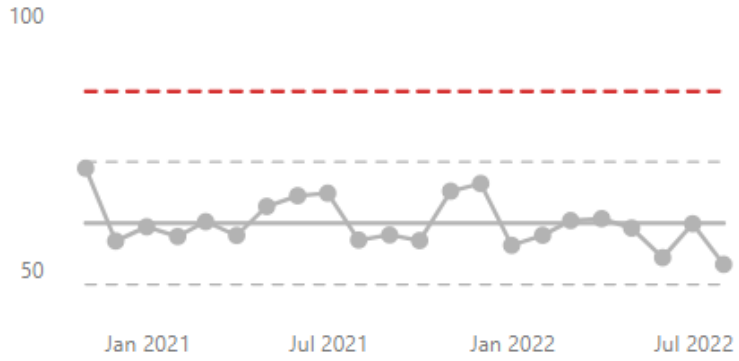
Cancer 31 day wait for second or subsequent treatment - surgery

Aug-22: 71.0% Target: 94.0%



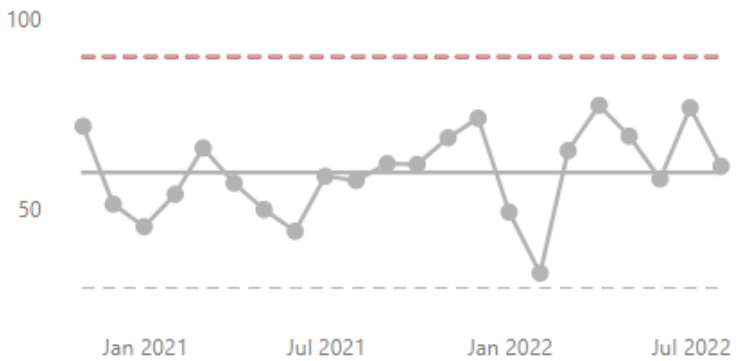
Cancer 62 Day Waits for first treatment (from urgent GP referral)

Aug-22: 51.0% Target: 85.0%



Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)

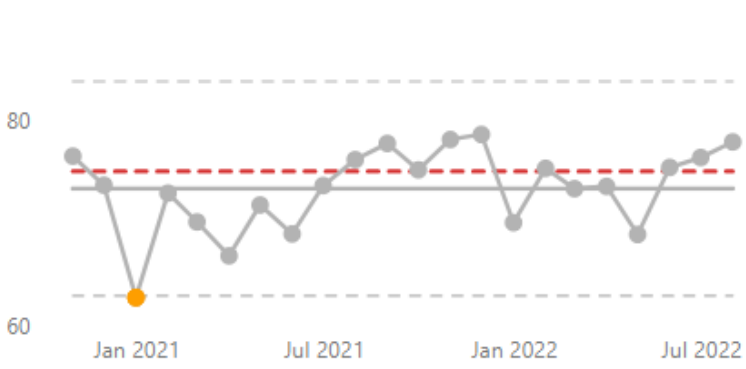
Aug-22: 61.3% Target: 90.0%



Performance Report Review – Responsive

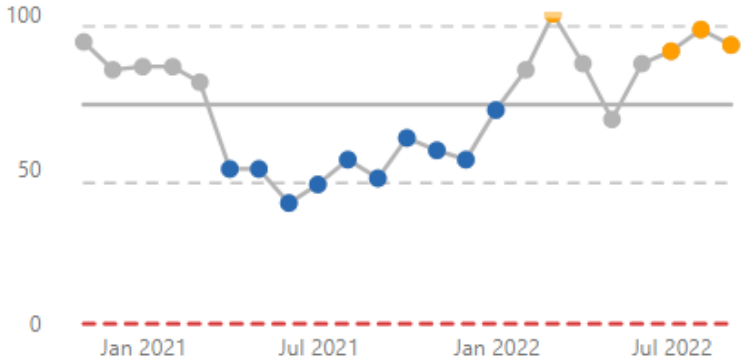
Cancer 28 Day Wait - Faster Diagnosis Standard

Aug-22: 77.9% Target: 75.0%



Cancer 104 Day Waits

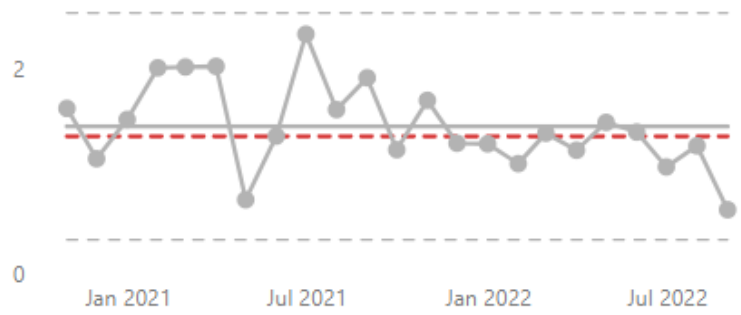
Sep-22: 90 Target: 0



Performance Report Review – Responsive

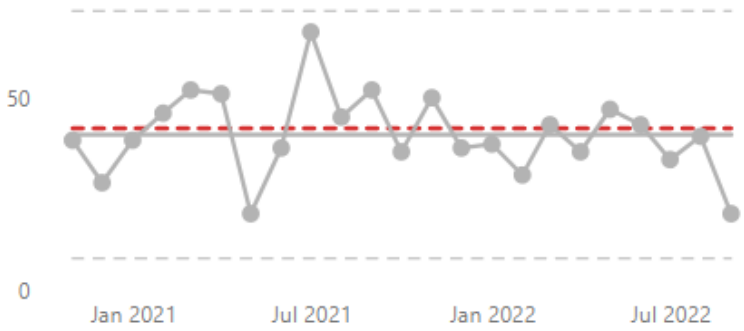
Complaints: Received rate per 1000 bed days

Sep-22: 0.63 Baseline: 1.34



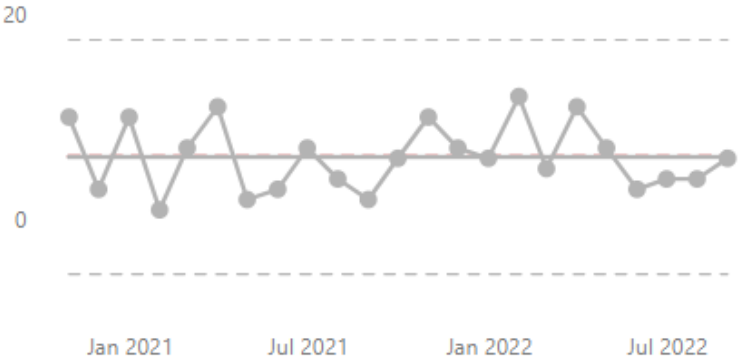
Complaints received

Sep-22: 20 Baseline: 42



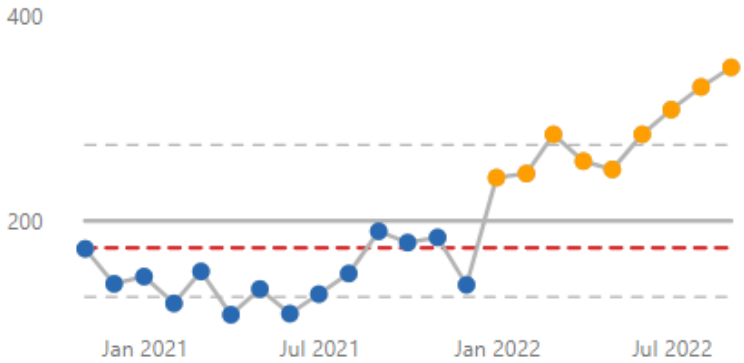
Complaints reopened

Sep-22: 6 Baseline: 6



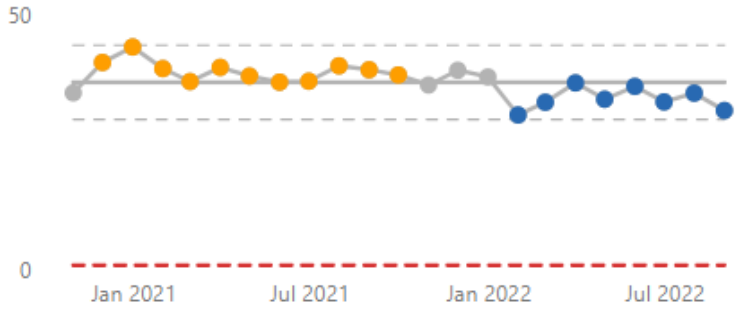
PALS Complaints

Sep-22: 350 Baseline: 175



Diagnostics: Patients waiting 6 weeks or more from referral to test

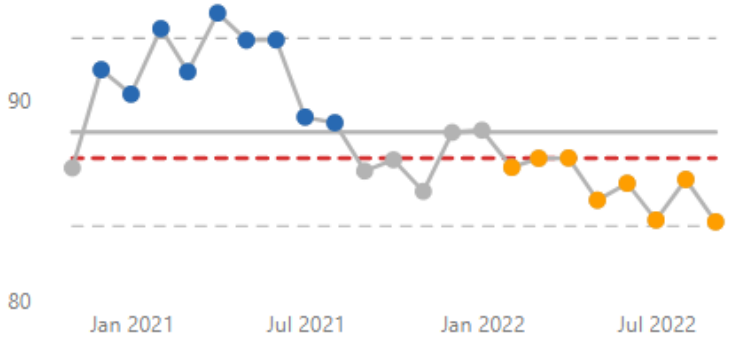
Sep-22: 31.3% Target: 1.0%



Performance Report Review – Responsive

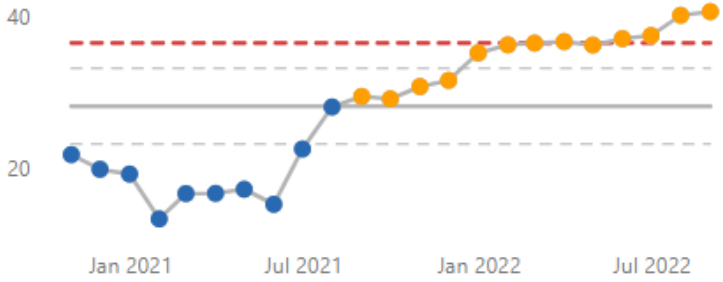
ED: % of attendees assessed within 30 minutes of arrival

Sep-22: 83.9% Baseline: 87.1%



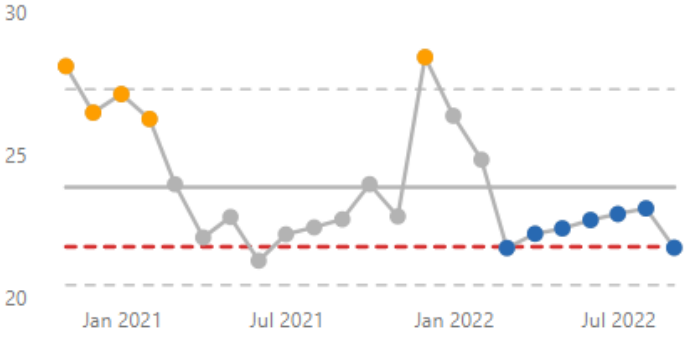
ED: % patients waiting over 6 hours in the departments

Sep-22: 40.8% Baseline: 36.6%



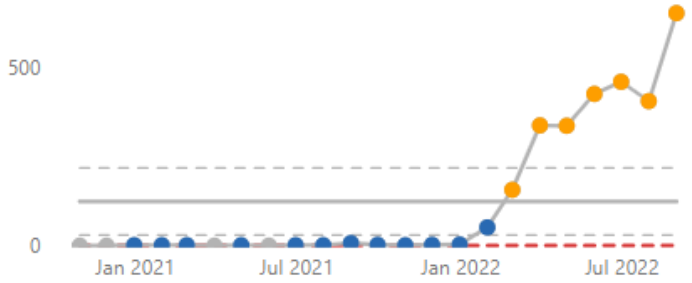
ED: Conversion Rate

Sep-22: 21.8% Baseline: 21.8%



ED: 12 hour trolley waits

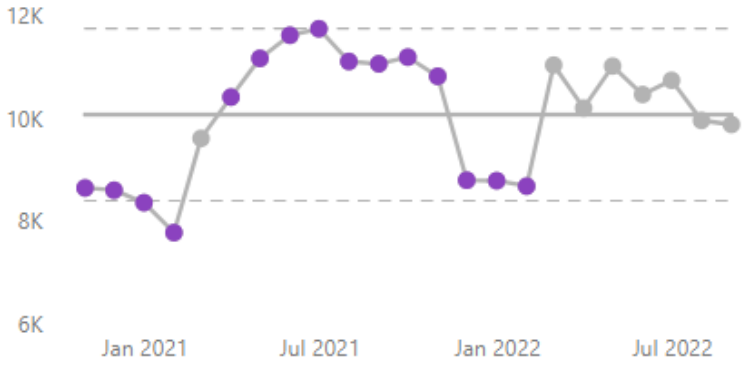
Sep-22: 650 Target: 0



Performance Report Review – Responsive

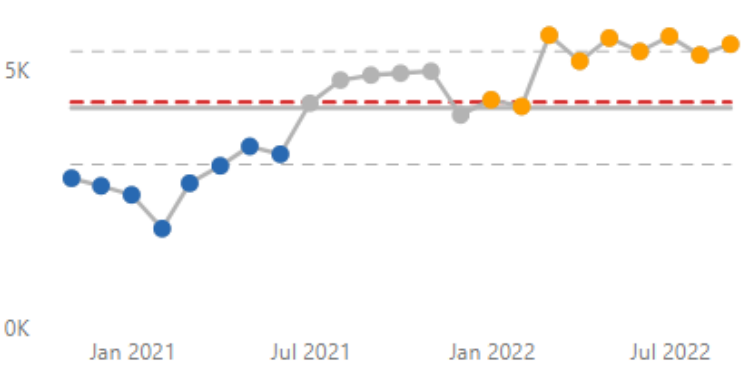
ED: Attendances Type 1

Sep-22: 9,878 Baseline:



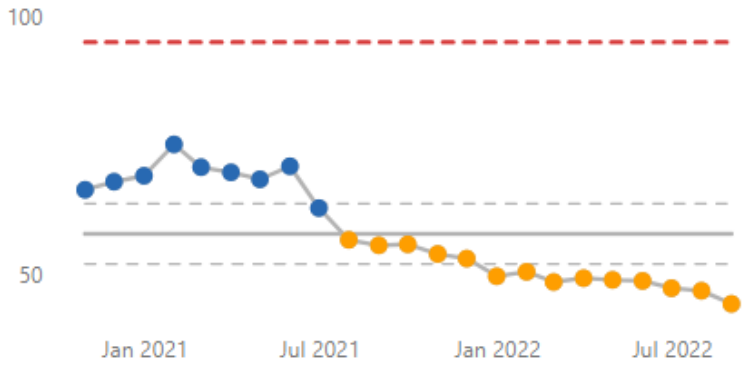
ED: Breaches - Type 1

Sep-22: 5,506 Baseline: 4,382



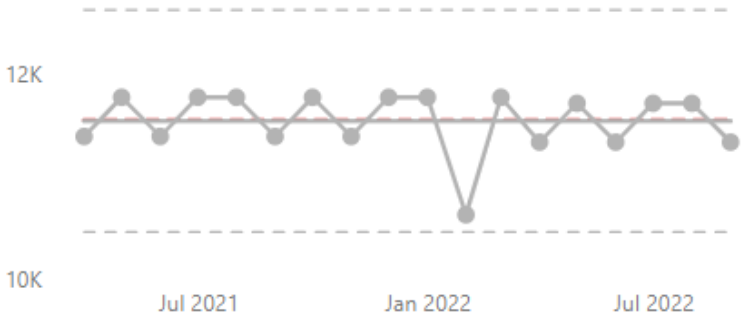
ED: Standard Performance Type 1

Sep-22: 44.3% Target: 95.0%



A&E Monthly Attendance Contract Plan

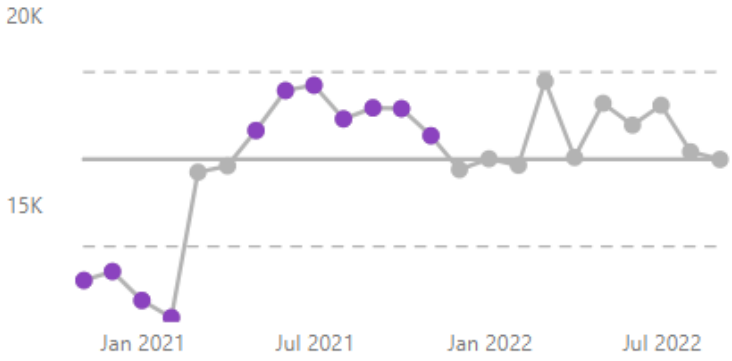
Sep-22: 11,333 Baseline: 11,546



Performance Report Review – Responsive

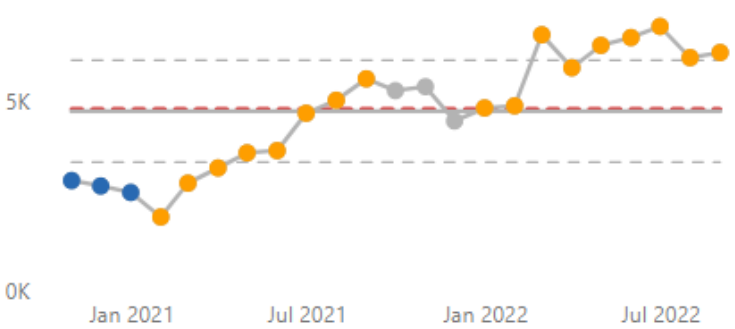
ED: Attendances Type 1 & 3

Sep-22: 16,210 Baseline:



ED: Breaches - Type 1&3

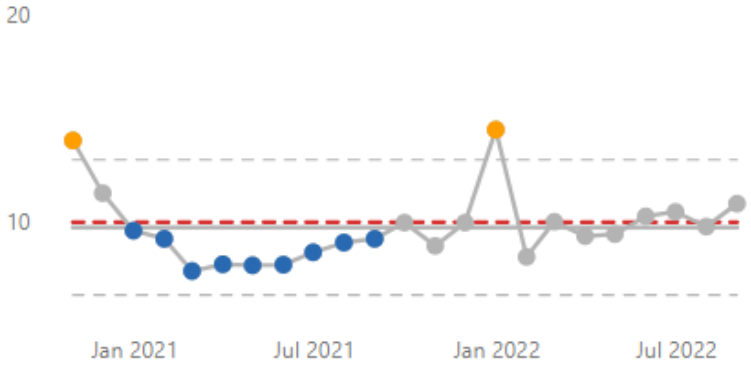
Sep-22: 6,271 Baseline: 4,782



Performance Report Review – Responsive

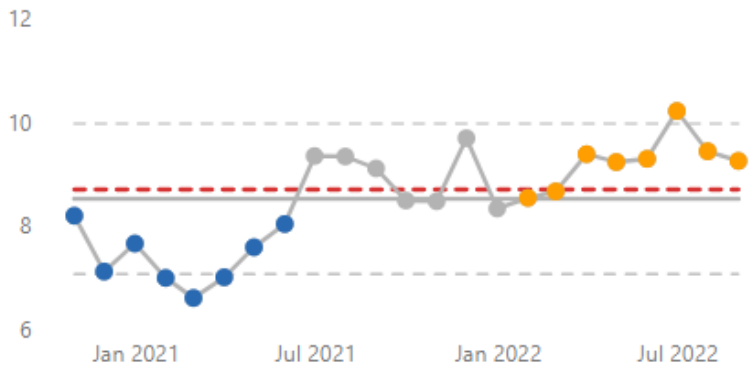
Outpatients: Hospital Cancelled Outpatient Appointments %

Sep-22: 10.9% Baseline: 10.0%



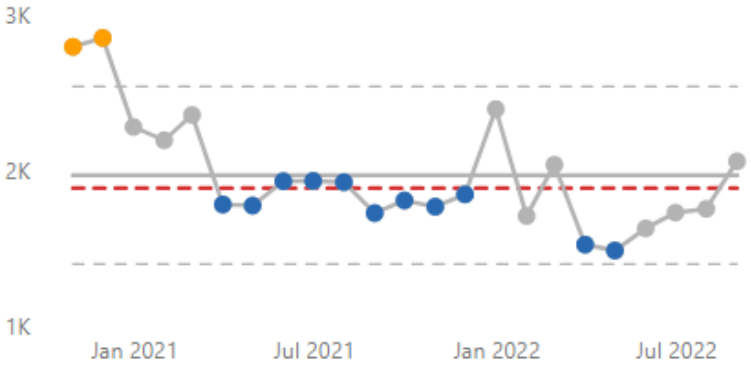
Outpatients: Patient Cancelled Outpatient Appointments %

Sep-22: 9.2% Baseline: 8.7%



Outpatients: Cancelled Clinics 6 weeks notice

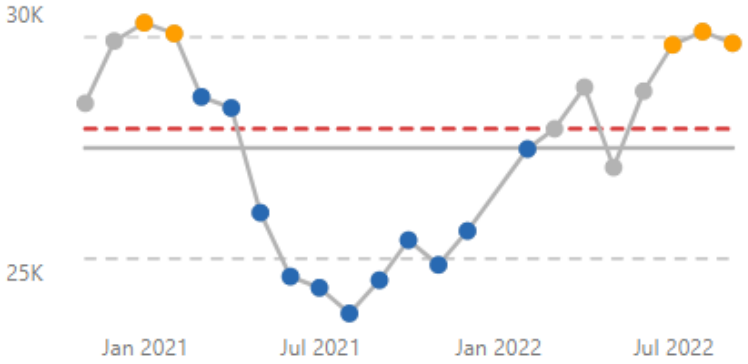
Sep-22: 2,061 Baseline: 1,889



Performance Report Review – Responsive

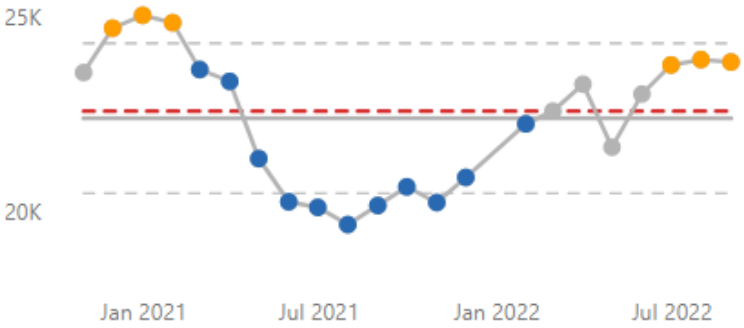
RTT 18+ weeks waiters

Sep-22: 29,432 Baseline: 27,775



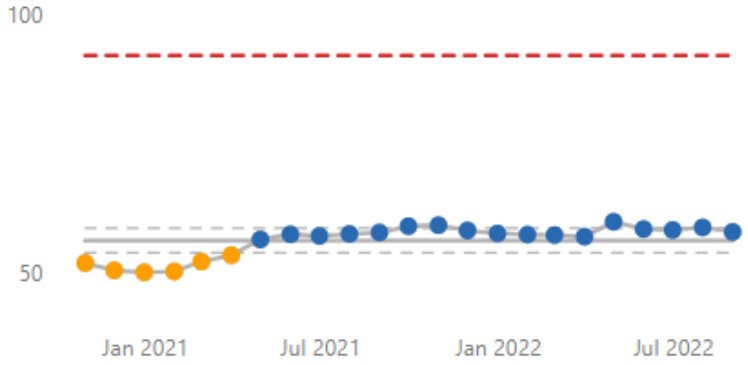
RTT away from 92% traj.

Sep-22: 23,845 Baseline: 22,577



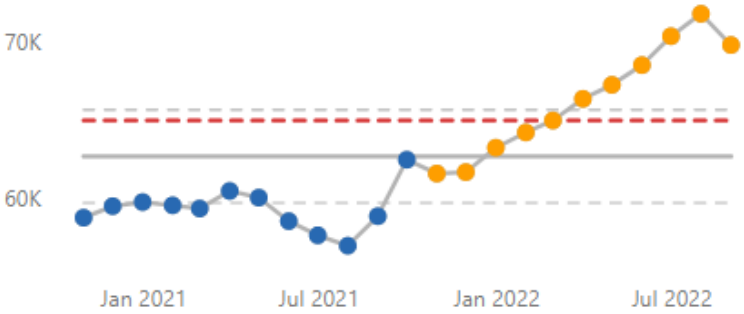
RTT Incomplete Pathways % performance

Sep-22: 57.9% Target: 92.0%



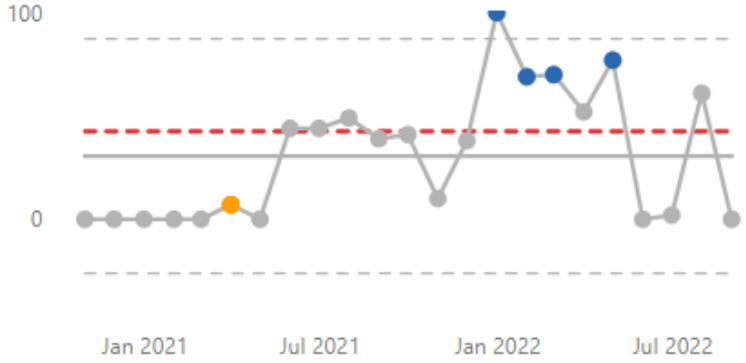
RTT Total Waiting List

Sep-22: 69,842 Trajectory: 64,972



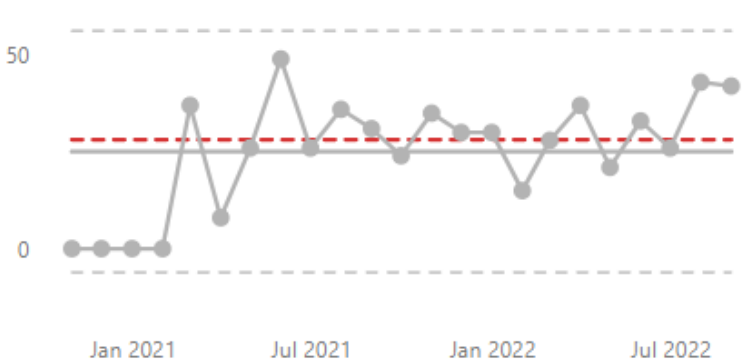
Clinical harm reviews - 104 week waits RTT

Sep-22: 0 Baseline: 43



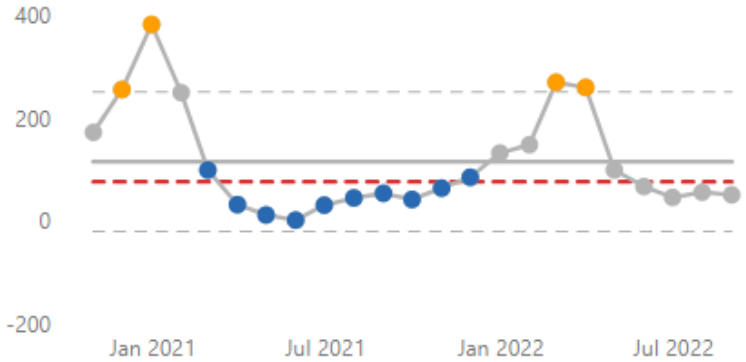
Clinical harm reviews - Cancer 104 day wait

Sep-22: 42 Baseline: 28



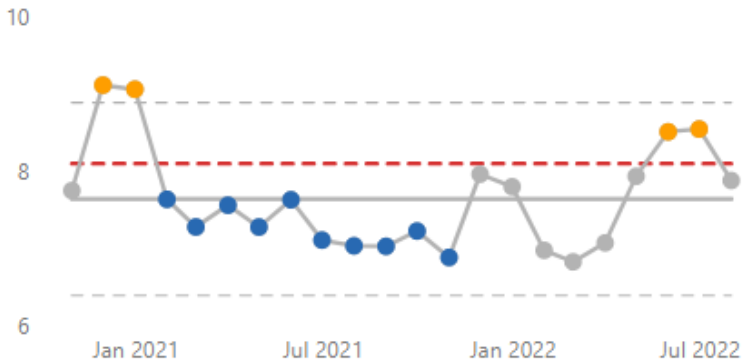
COVID - Positive Tests

Sep-22: 51 Baseline: 76



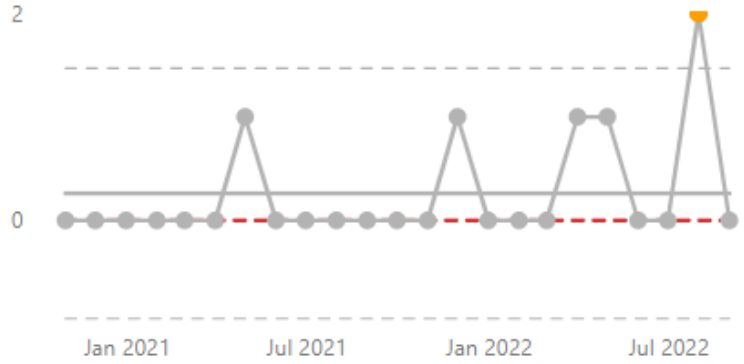
Emergency readmissions within 30 days

Aug-22: 7.9% Target: 8.1%



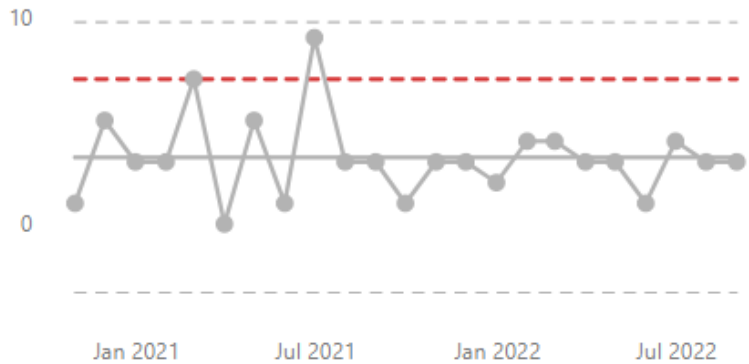
MRSA bactaraemias

Sep-22: 0 Target: 0



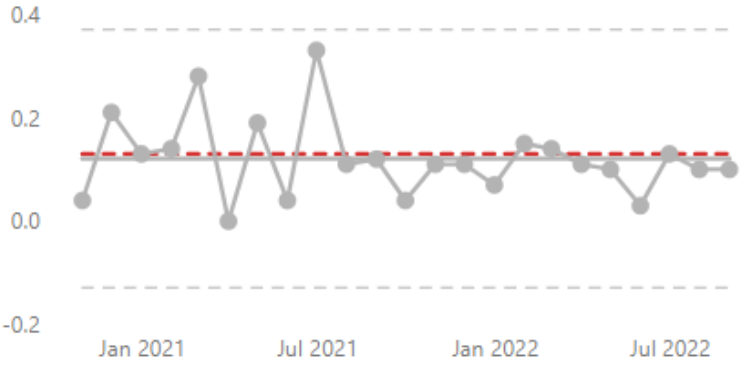
Clostridium Difficile - number

Sep-22: 3 Target: 7



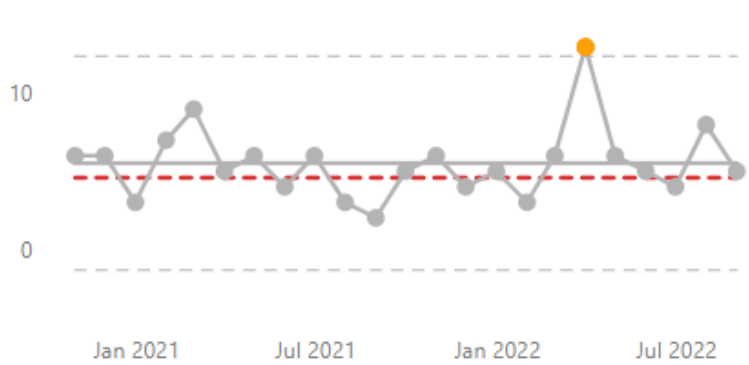
Clostridium Difficile - infection rate (per 1000 bed days)

Sep-22: 0.10 Baseline: 0.13



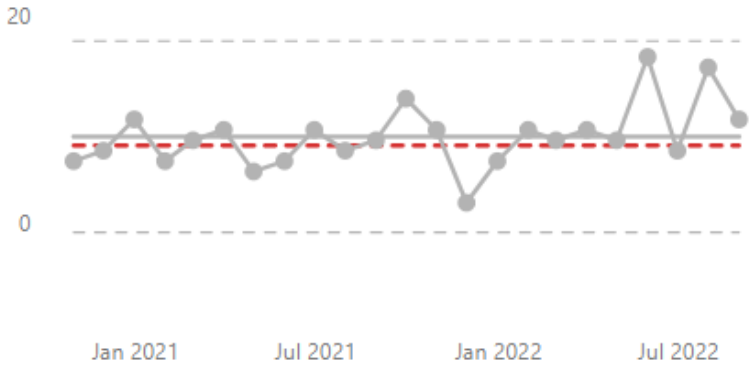
MSSA

Sep-22: 5 Baseline: 5



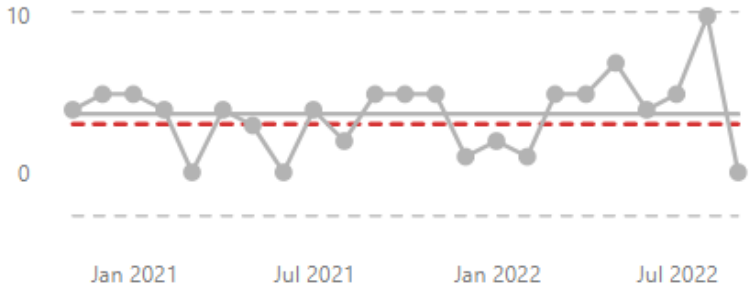
E.Coli

Sep-22: 10 Baseline: 8



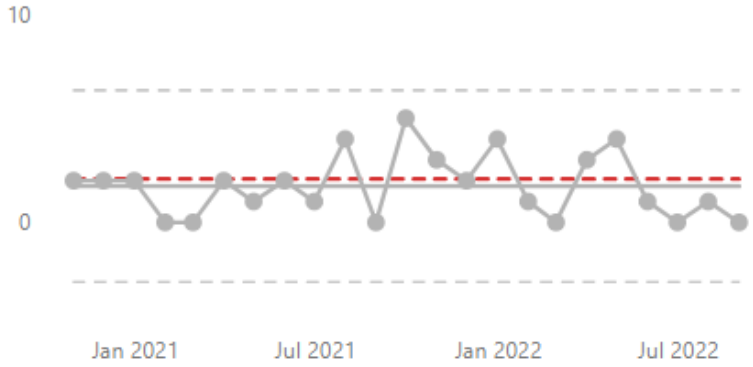
Klebsiella spp bacteraemia

Sep-22: 0 Baseline: 3



Pseudomonas aeruginosa bacteraemia

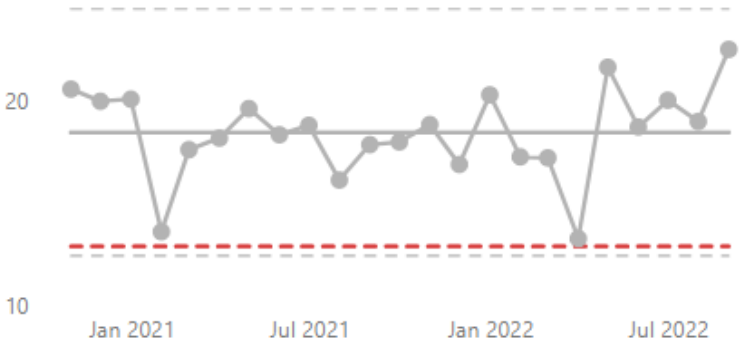
Sep-22: 0 Baseline: 2



Performance Report Review – Safe

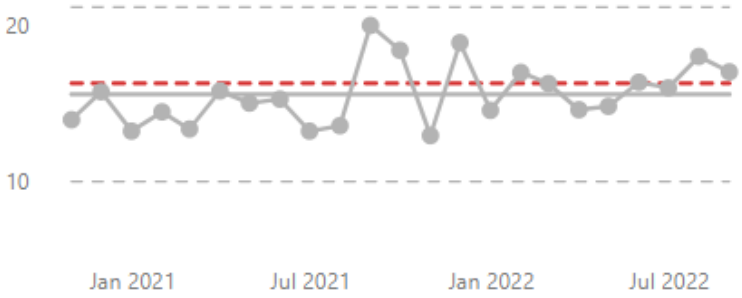
Emergency C-section rate

Sep-22: 22.5% Baseline: 12.9%



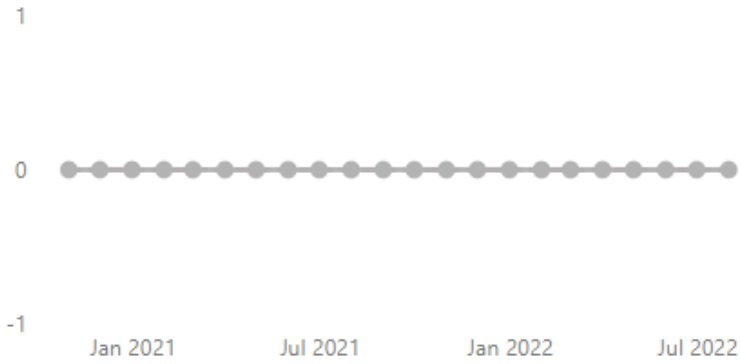
Elective C-section rate

Sep-22: 17.0% Baseline: 16.3%



Maternal Deaths

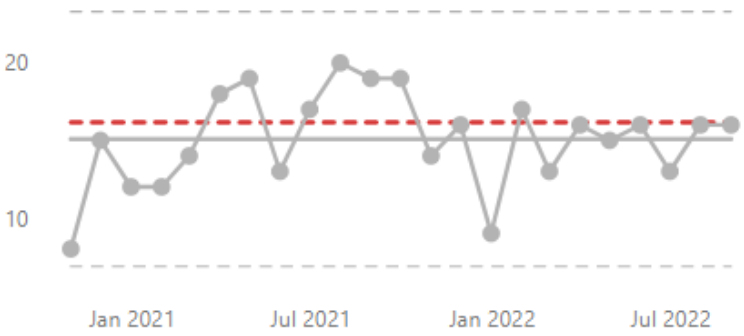
Aug-22: 0 Target: 0



Performance Report Review – Safe

Admission of full term babies to neo-natal care

Sep-22: 16 Baseline: 16



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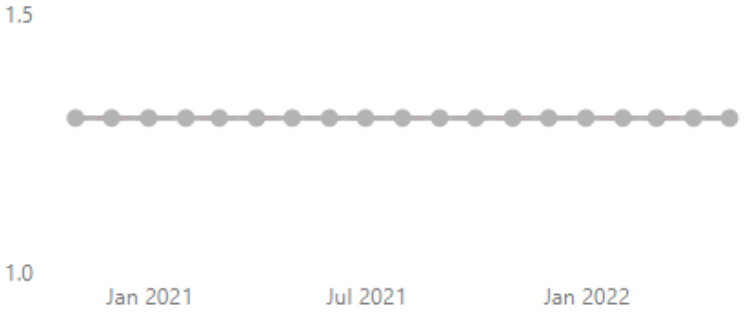
Midwife to birth ratio

May-22: 1.30 Baseline: 1.30



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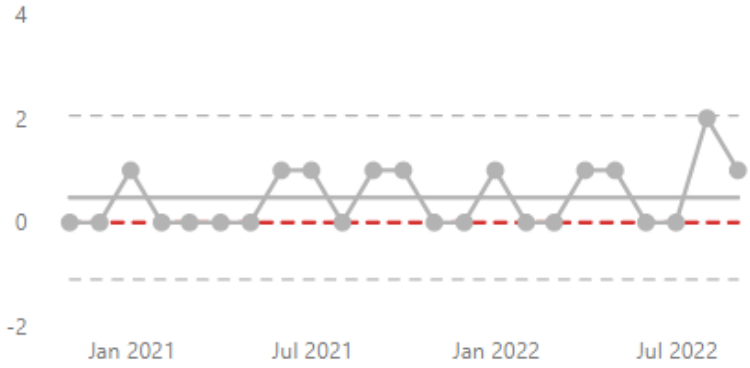
Performance Report Review – Safe

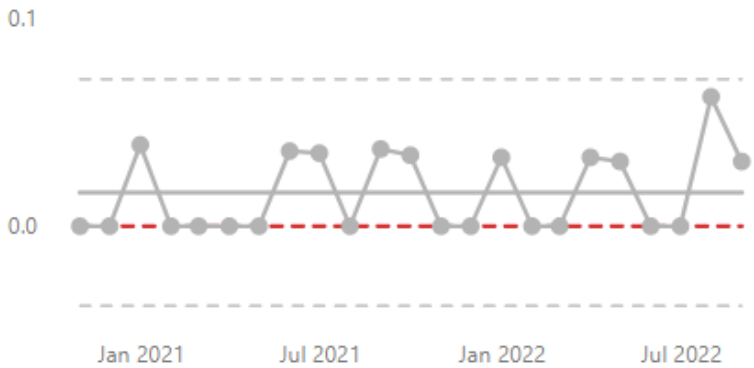
Never Events

Sep-22: 1 Target: 0



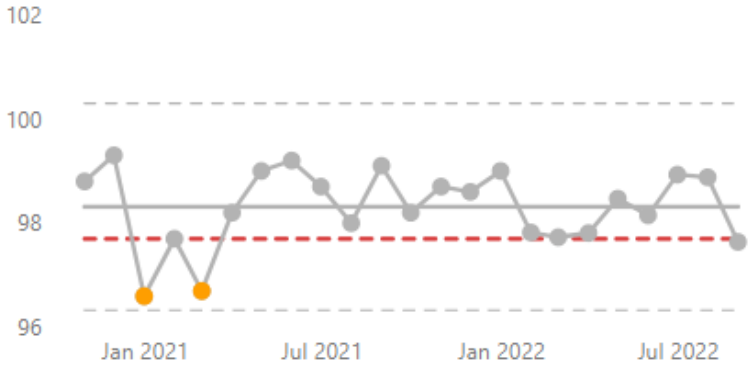
Never events: Incidence Rate (per 1000 bed days)

Sep-22: 0.03 Baseline: 0.00



WHO Checklist

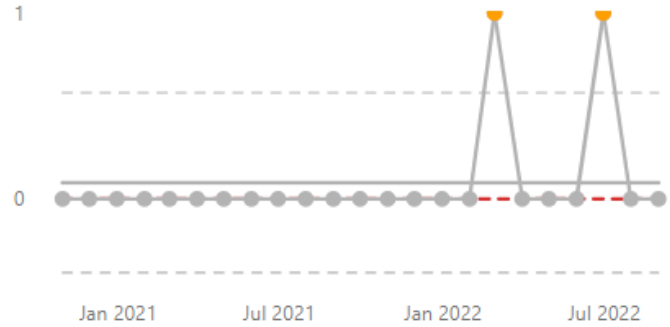
Sep-22: 97.6% Baseline: 97.7%



Performance Report Review – Safe

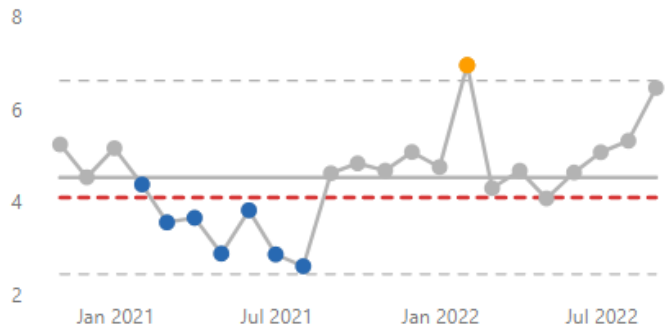
Medication errors causing serious harm

Sep-22: 0 Baseline: 0



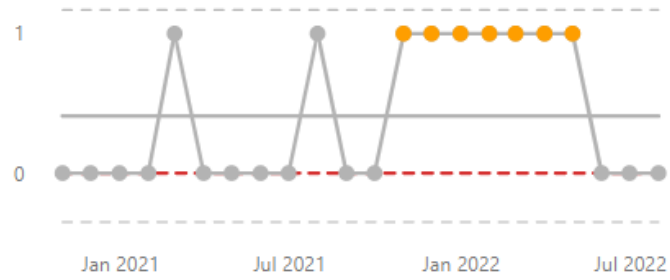
Patient safety incidents that are harmful

Sep-22: 6.5% Baseline: 4.1%



CAS alerts outstanding

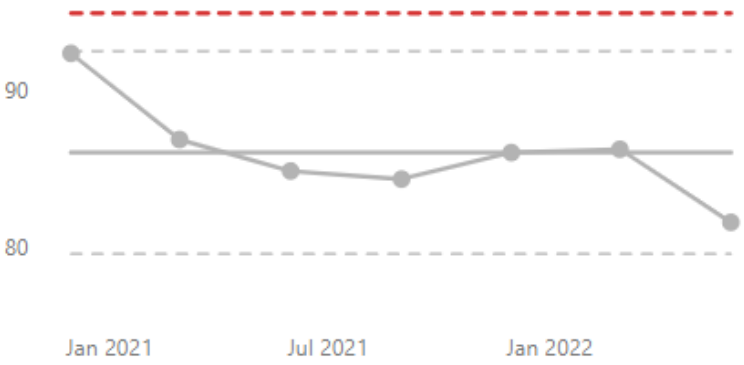
Aug-22: 0 Target: 0 : :



Performance Report Review – Safe

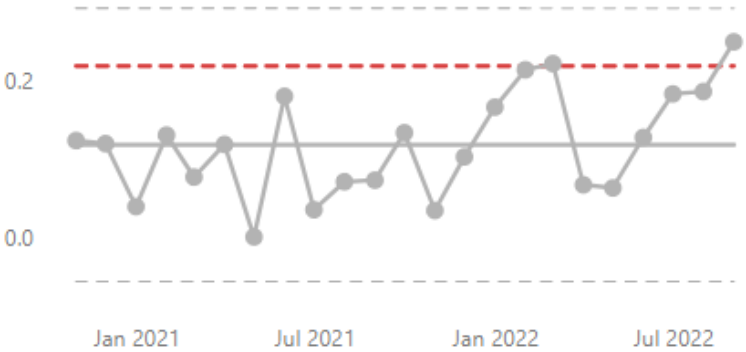
VTE Risk Assessment

Jun-22: 81.5% Target: 95.0%



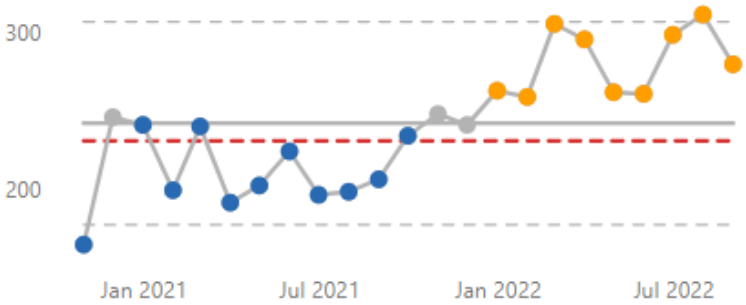
Falls recorded as severe harm or death - rate per 1000 bed days

Sep-22: 0.25 Baseline: 0.22



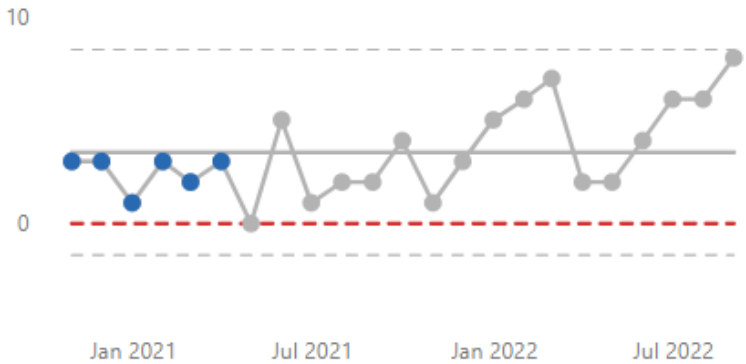
Patient Incidents: Falls

Sep-22: 280 Baseline: 231



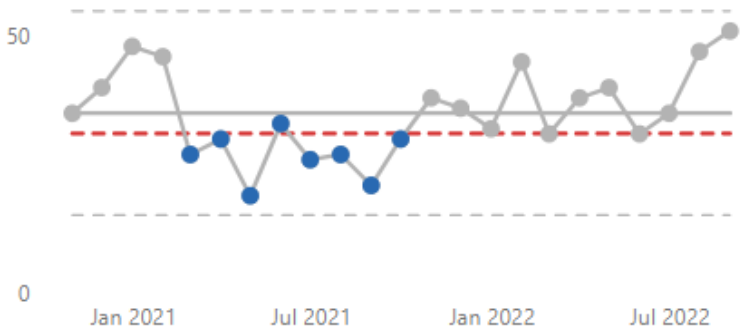
Patient Incidents: Falls resulting in serious/harm or death

Sep-22: 8 Baseline: 0



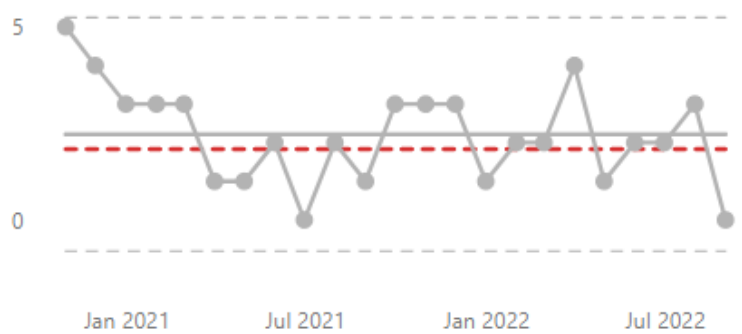
Pressure Ulcers (Hospital acquired)

Sep-22: 51 Baseline: 31



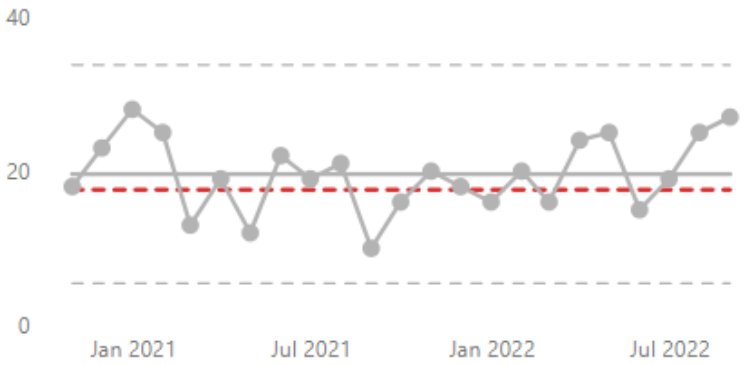
Category 1 Pressure Ulcer

Sep-22: 0 Baseline: 2



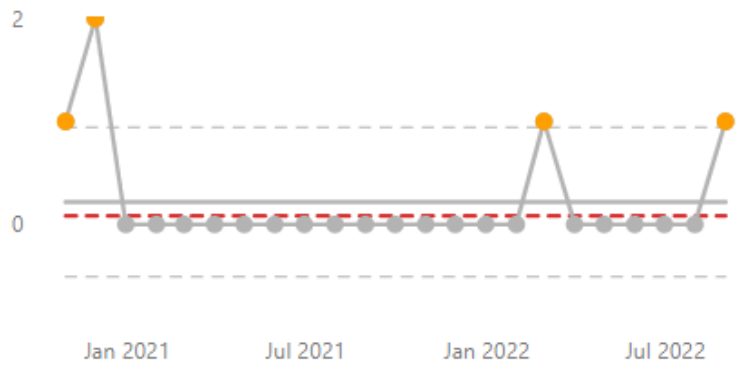
Category 2 Pressure Ulcer

Sep-22: 27 Baseline: 18



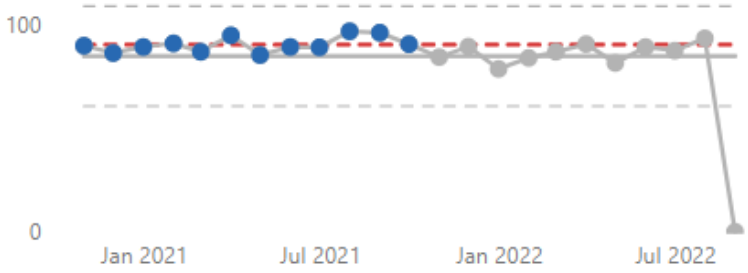
Category 3 Pressure Ulcer

Sep-22: 1 Baseline: 0



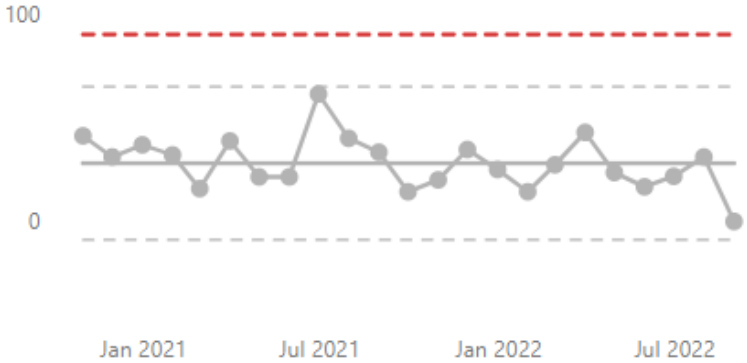
Duty of Candour; verbal apology

Sep-22: 0.0% Target: 90.0%



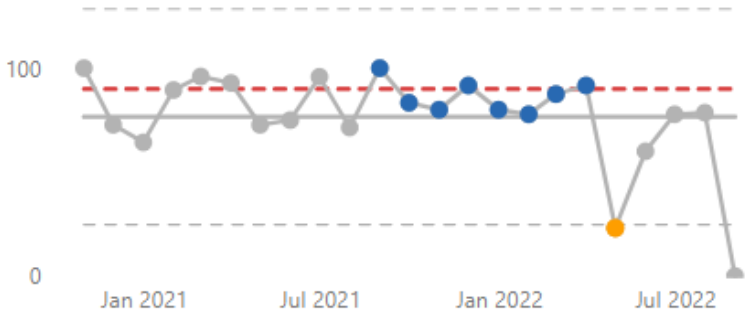
Duty of Candour; written apology

Sep-22: 0.0% Target: 90.0%



Duty of Candour; investigation compliance

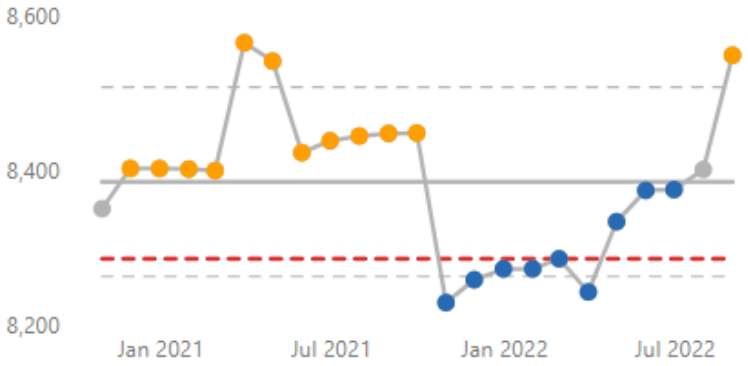
Sep-22: 0.0% Target: 90.0%



Performance Report Review – Safe - Workforce

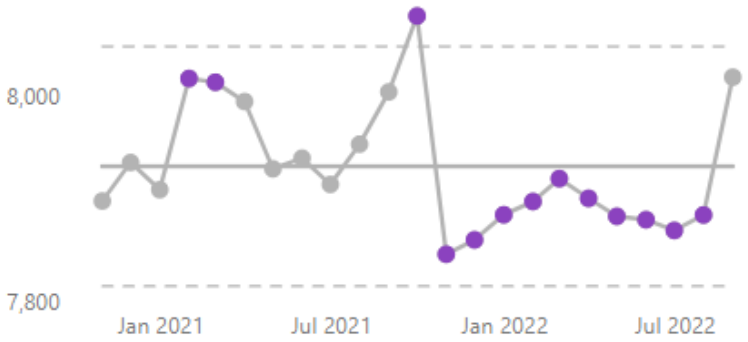
Establishment WTE

Sep-22: 8,549 Baseline: 8,286



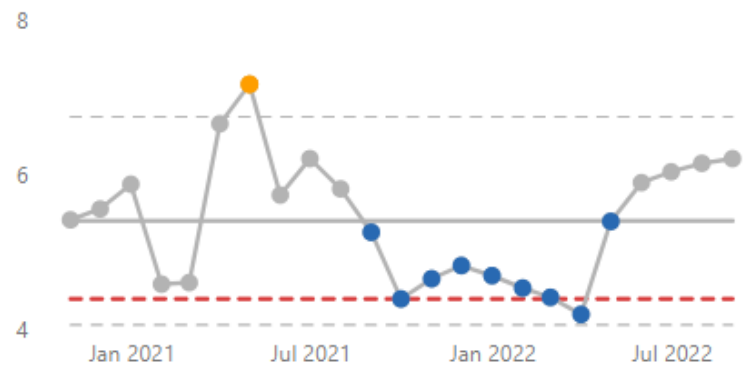
Staff in Post WTE

Sep-22: 8,018 Baseline:



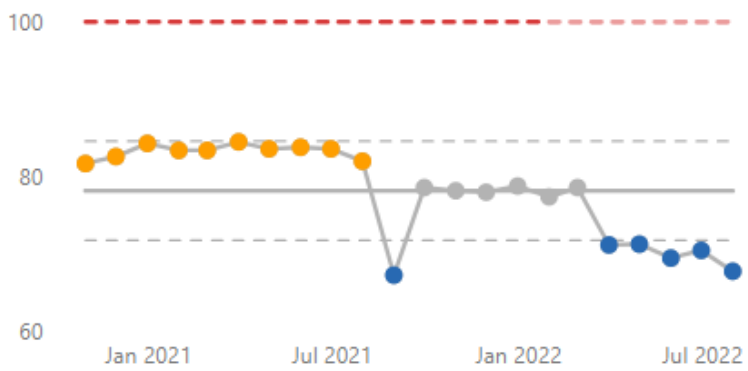
Vacancy Rate %

Sep-22: 6.2% Baseline: 4.4%



% of staff who have a completed Covid 19 Risk Assessment

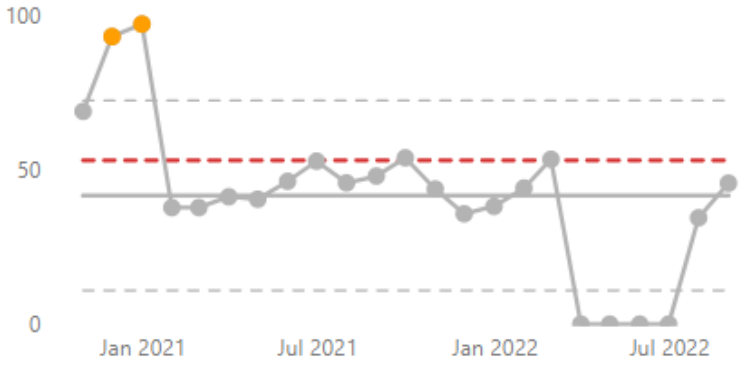
Aug-22: 67.8% Target: 100.0%



Performance Report Review – Safe - Workforce

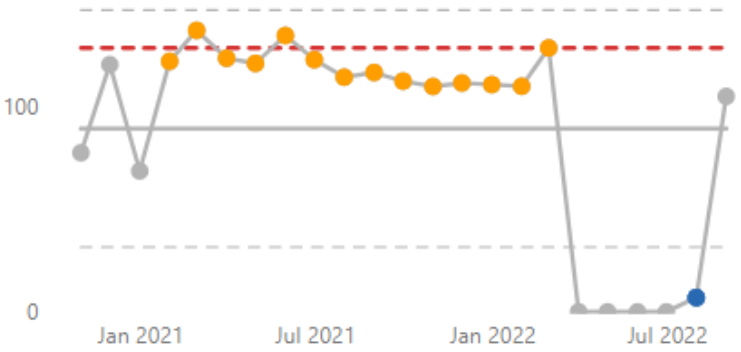
Agency WTE

Sep-22: 46 Baseline: 53



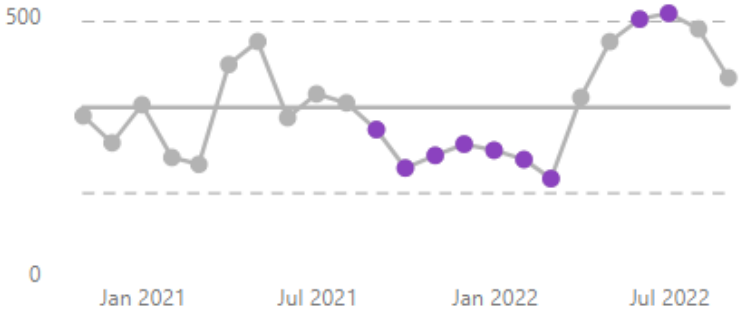
Bank WTE

Sep-22: 105 Baseline: 128



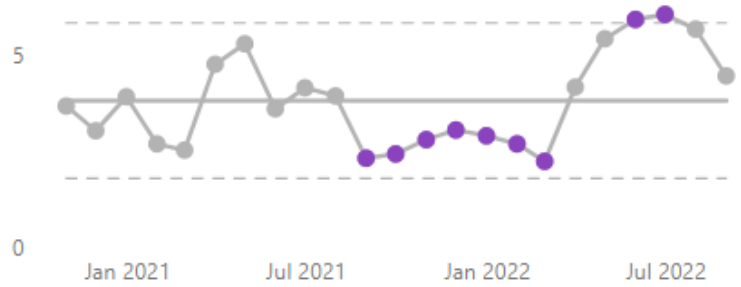
Adjusted Vacancies WTE

Sep-22: 381 Baseline:



Adjusted Vacancy Rate WTE

Sep-22: 4.5% Baseline:



Agenda Item	10	**Meeting**	**Trust Board**	**Meeting Date**	**8 November 22**
Title	Performance Report				
Lead Director	Ellen Ryabov – Chief Operating Officer				
Author	Louise Topliss – Assistant Director of Operations (Operational Performance)				
Report previously considered by (date)	Performance and Finance in October.				

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

Key Recommendations:

The Trust Board members are asked to receive, discuss and accept this update on key performance issues.

Performance and Activity Report

September 2022 Performance

August 2022 for Cancer data

Produced October 2022

Table of Contents

1. Executive Summary

Areas requiring improvement	
Urgent Care performance – ED and Ambulance handovers	• Ambulance handover position remains highly challenged with numbers of lodged patients within ED, routinely between 20 and 30 patients at the start of the day. • Ground floor PDSA cycle continues, post early evaluation work continues to embed the new practice and to incorporate those elements of change that are successful into our Business As Usual (BAU) processes before winter. The teams will continue to refine other aspects of this work in order to maximise the potential benefits for flow and patient turnaround. This work is managed through the Ground Floor Logistics Group – further amendments to the ground floor ways of working are in train with next anticipated changes starting in September and October 2022. • YAS and HUTH continue to work on improving ambulance handover times to enable Ambulance crews to be released to support the community, albeit that there continue to be significant challenges in this area. Minimal cohorting is provided by YAS and the decision to implement cohorting remains with YAS. • The number of patients in September 2022 with No Criteria to Reside continues to be the single largest factor affecting performance with a daily average of 233 (+54 on last month) 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. 2WW referrals have increased by 10% compared to the same period last year and there is no significant increase in confirmed cancers for any tumour site. • 2 of 9 cancer waiting times' national standards were achieved. • The number of patients on the 62 day from referral to treatment pathway (Cancer PTL) has started to reduce (at its highest it was ~1,800 and lowest ~1,500) with the latest PTL number ~1,661; this continues to require focussed support to maintain performance improvement, which is starting to deliver. • In line with the on-going review of long-waiting patients on an RTT pathways, cancer performance is a continued focus of the 2/52 NHSE assurance and recovery meetings – with particular emphasis on those patients +63 days and +104

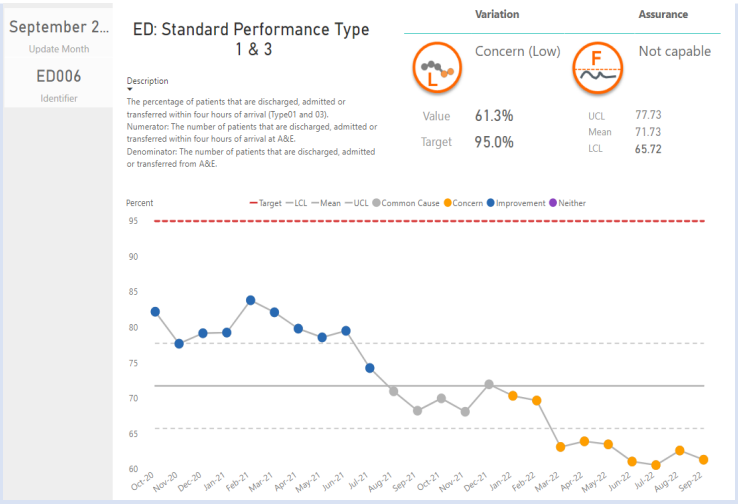
	days; and whilst there have been improvements, further work is required in order to be rated at a much lower risk. • The Trust Cancer Transformation Programme includes support to address diagnostic waiting time issues for colorectal patients. Pathway improvements, improved utilisation of slots and additional CT colon capacity (which came on line in July 2022) and is showing improvement in the Lower GI (colorectal) pathway. Further changes at the front end of the colorectal pathway are subject to approval through the speciality and cancer leadership. • Specific additional performance meetings and support from the Operational Service Improvement Team has been directed to support recovery of CT waiting times more generally; these meetings continue and some progress is being realised (e.g. CTC additional capacity). • Histopathology delays impact on the Skin tumour site performance in particular – revised Cancer Waiting Times guidance is being reviewed; this will enable removal from the Cancer PTL where an excision (treatment) has been completed and where the patient has been told of their expected diagnosis, prior to the histology result being reported. • Deep dives for Gynae-oncology and Urology are planned in order to identify improvement opportunities.
Recovery of elective activity	• Recovery of elective activity in September 2022 against the operational plan was broadly in line with the submitted activity numbers except for Ordinary elective at 80% of plan and new outpatients at 90% 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 September 2022 follow up activity was 103% of baseline and 97% 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 the variance, which equates to 80% shift from new to follow up in Clinical Oncology. • The capacity required to support Covid+ patients increased during late June and into September 2022, which together with the number of patients with No Criteria to Reside (NCTR) across HRI and CHH, has required the opening of a further ward area (H1). • Ward C9 and C9a swapped round in September 2022 to enable essential works at the Queen's Centre to continue

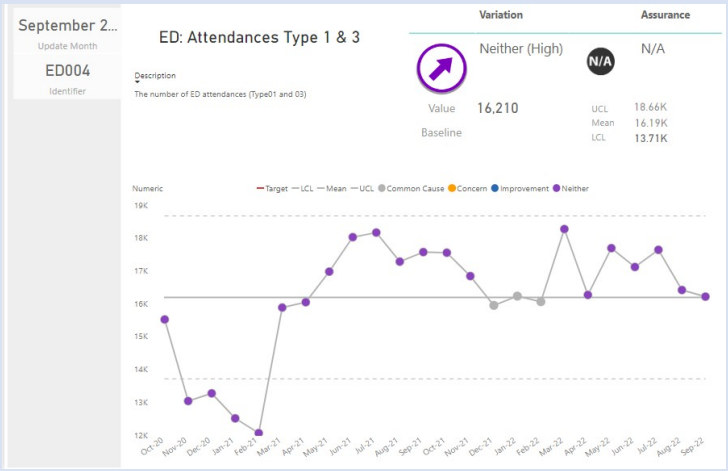
	whilst providing some orthopaedic and spinal elective beds at CHH; however further bed capacity is required to achieve recovery plans for these speciality areas. • Mutual aid continues to progress focussing on any provider with shorter waiting times inside and out with the HNY ICS to not only improve waiting times but to support the reduction of the overall size of the Trust's PTL. • The Trust achieved zero 104-week waits in September 2022 and continues to make good progress against the over 78-week (needs to be zero by 31 March 2023) and over 52-week trajectories.
Improving treatment times for long waiting patients	• For 2022/23 Quarter 1, the starting position was 794 patients to treat, who had breached/or were at risk of breaching 104-weeks by the end of June 2022. The Trust has been designated a Tier 1 organisation and were required to meet weekly with NHSE national leads, as a result of our improvement this has now been reduced to fortnightly meetings. • At the end of September 2022, the Trust reported zero 104 week waits. • Enhanced internal governance processes continue to support the 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 5,497 (+120 on last month) patients who have waited more than one year, although this number has reduced significantly in the last 12 months. • Text validation of 31,000 patients commenced in early July 2022 in order to identify if their listed appointment and/or treatment is still required. To date 26,731 texts have been sent, of which 96% were delivered to a Smart Phone. Of those, 17,222 (67%) have been read with 14,057 (82%) responses. Those patients who have not accessed or responded to a message within 48 hours automatically receive a letter. There is currently a 6.7% removal rate and 2.4% of patients asking to delay treatment. • National leads for elective recovery and cancer, plus representatives from DHSC visited the Trust at the end of August 2022 – good assurance was provided however a formal letter is still awaited. • NHSE has provided a framework for reviewing the progress against long waits and cancer recovery; HUTH is being formally considered as having met the requirements to step down to Tier 2 for elective recovery.

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 September 2022 there were 233 NCTR, around 23% of our general and acute beds as a total and 34% at HRI, (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. • The Interim Deputy Chief Nurse leads a weekly meeting to review any patient who has been delayed for 7-days or more and all patients over 30 days NCTR are discussed weekly between the System Chief Operating Officers and Directors of Adult Social Services. • The CHCP Bee @ Home service is beginning to increase capacity, working towards the target of 50 patients supported at October 2022. • A range of schemes to support increased elective bed and ICU/HOB capacity within the Trust has been funded; work is on-going to progress the delivery of these schemes in addition to the usual winter planning arrangements. • A new meeting has been established with system partners; the 'Improving Hospital Flow' meeting was held on 15th September 2022. Senior leaders of the Trust, Local Authorities, Community Partners, Collaborative and Place Directors will work collectively in taking appropriate actions to improve hospital flow, improve patient safety and reduce crowding, and more importantly to lead the work that will deliver an agreed reduction in the number of patients with No Criteria to Reside (NCTR) within the Trust. • Rachel Kemp the newly appointed Hull & East Riding System wide Single Co-ordinator has started in post.

2. Emergency Care Standards – 4 hour Performance

	What the chart tells us 4-hour performance has been relatively stable for the last six months, albeit that it is significantly below the required standard and in September 2022 was 61.3% for all Types. ED attendances are just above the mean at 16,210 (mean 16,000) in September 2022.
	Intervention and Planned Impact





- From W/C 17th October 2022, a Rapid Assessment and Treatment model (having a senior clinician at the front door) will begin for the Emergency Care area, initially this will be Monday to Friday while the EMHG explore potential options for a 7-day service.

- Work continues through the ICB to create a co-located UTC, with a potential interim plan to use the National Streaming Tool to increase the volume of patients appropriately directed away from the Emergency Department.

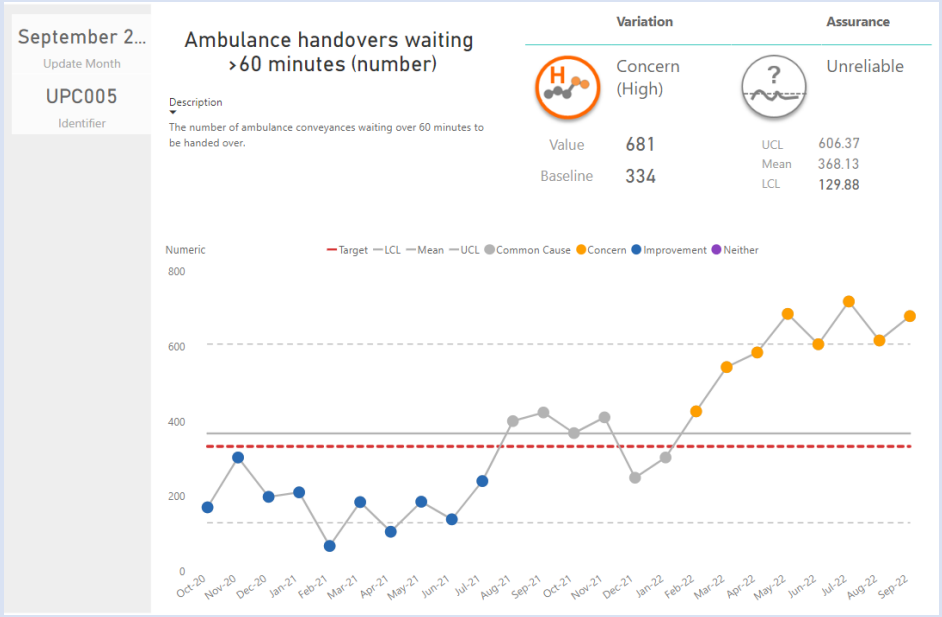
Risks / Mitigations

- Continued delays in flow and discharge are a significant impediment to an improvement in the initial assessment and majors area, with some impact on ECA – patients are lodging in ED in excess of 12 hours/13% of the time, which significantly compromises flow and ability to work to the four-hour target

- The continued bed pressure is reducing the availability of Medical SDEC as it is used for admitted patients overnight which then prevents patients being streamed away from ECA impacting further of performance.

- The static number of Covid inpatient numbers continues to require a bed base to support these patients' needs. All ward areas are currently in-use in the Trust – flow is very difficult each day in respect of achieving the number of discharges needed from the medical bed base to admit the required number of patients. There are delays in moving patients into the surgical bed base but the acute surgical bed base remains sufficient.

3. Ambulance Handovers waiting over 60 minutes



What the chart tells us

There were 681 (+76 on previous month) over 60 minute ambulance handover delays in September 2022 which equated to 44.6%; this is a significant deterioration on the previous month of 22%

Intervention and Planned Impact

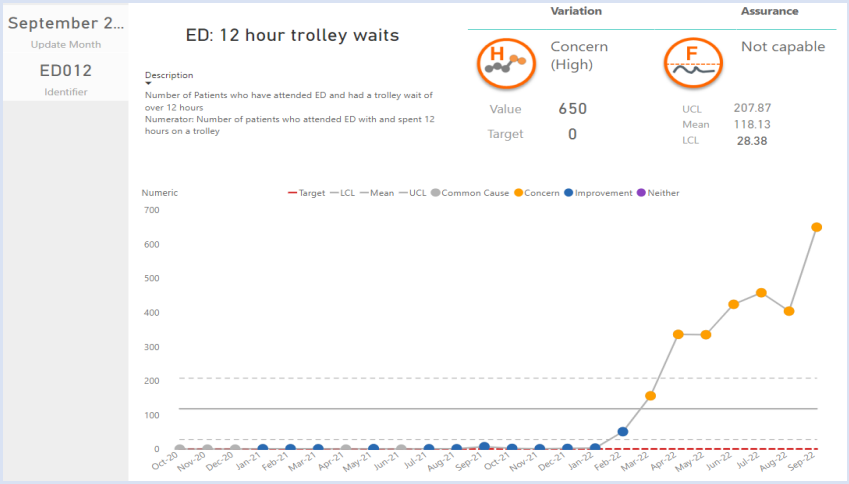
- Long Stay Wednesday reviews of all patients delayed in hospital over 7-days continues and is conducted by the DCN/DCOO and Senior Matrons/Divisional Managers. This is augmented by a new group focused on Improving Hospital Flow, which has system wide representation and therefore requires system action to support.

- A full update to the System-wide Hull and East Riding Ambulance Improvement Plan took place in September 2022 as part of a system-wide refresh of plans for winter; it is recognised that further actions in-hospital and out of hospital are necessary to impact on ambulance handover times.

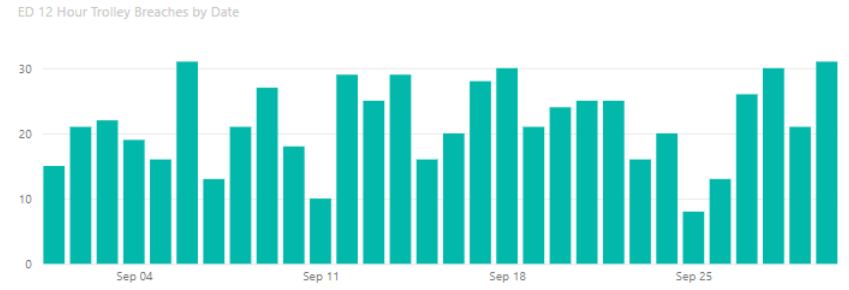
Risks / Mitigations

- No Criteria to reside patients continue to occupy a significant number of acute beds thereby reducing availability of capacity and an ability to appropriately manage flow in a timely manner out of the ED
- Continued delays in flow and discharge delays are a significant impediment to improvement in the initial assessment and majors area, with some impact on ECA – patients are lodging in ED in excess of 12 hours/13% of the time, which significantly compromises flow and ability to work to the four-hour target
- This lack of flow, however, impacts directly on ambulance handover times, which are increasing, as is the acuity of the patients conveyed and walking in to ED. Whilst the conversion rate of ED attendances to admissions remains the same, the acuity of patients in majors and ECA is increasing, requiring more medical and nursing input per patient, as well as ongoing cares for the significant amount of time patients remain in ED waiting for beds, making normal ED practices and workload management less efficient
- The additional wards remain open thereby placing additional pressure on Nurse and Medical Staffing

4. 12 Hour Trolley Waits (from DTA to Depart)



Day of Week Number	1	2	3	4	5	6	7	Total
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	
ED Departures (Type 01)	1,331	1,389	1,414	1,604	1,630	1,248	1,262	**9,878**
ED 12 Hour Trolley Breaches	79	106	97	98	115	88	67	**650**
ED 4 Hour Standard Performance (Type 01)	38.8%	46.6%	43.3%	43.3%	45.8%	44.5%	47.5%	**44.3%**



What the chart tells us

There were 650 x12 hour trolley wait breaches in September 2022 with the longest wait from Decision to Admission (DTA) of 31 hours. In September 2022, Friday was the highest daily figure for patients affected by trolley waits in excess of 12 hours.

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 September 2022 was that 15.7% of patients (1,550 patients) waited over 12 hours against a national tolerance of 2%.

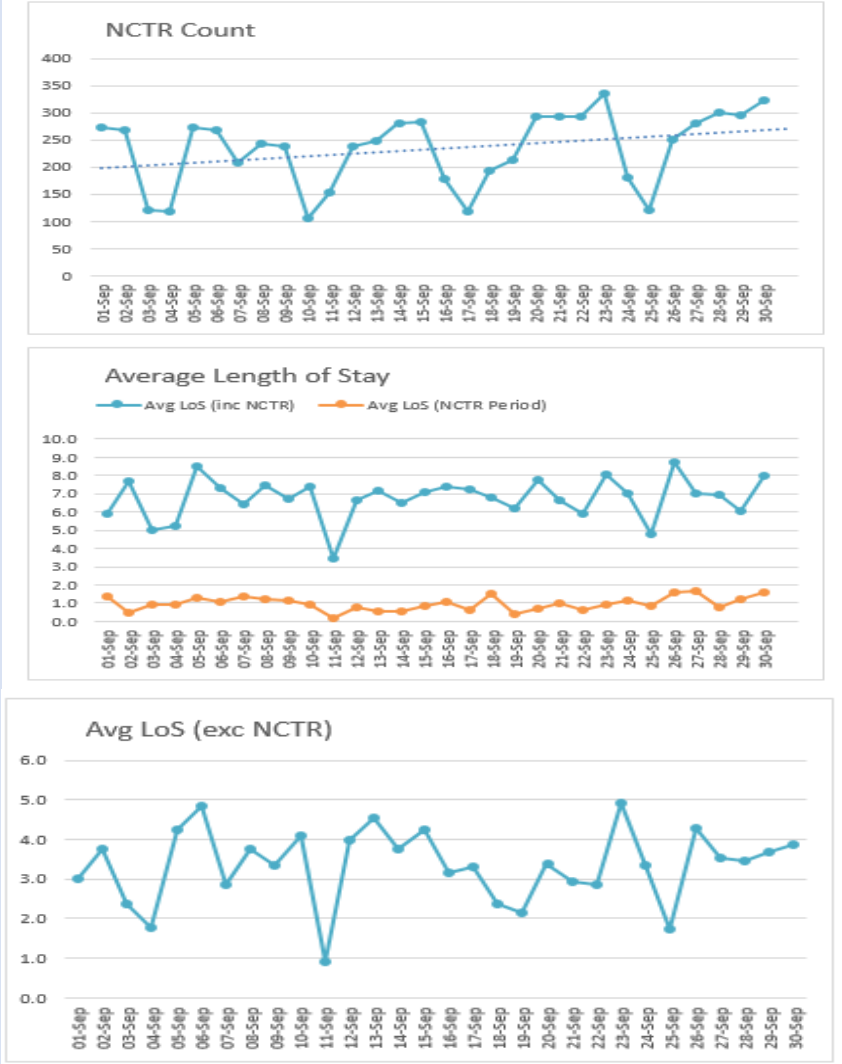
Intervention and Planned

- Following the ground floor workshop, all patients referred via GP after contact with a speciality will be streamed directly to the specialty assessment area away from ED.
- Moving to a Continuous Flow Model (Bristol) where patients are moved to the appropriate location based on standard discharges rather than current capacity.
- Standardisation of Board and Ward rounds in Medicine will be embedded within DME through October 2022 – rollout to other medical wards to commence from November 2022.

Risks / Mitigations

- High numbers of No Criteria to Reside patients continue to occupy 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.
- Board round process will take time to embed; there is a risk that the pace of change is not sufficient to get the benefits of shorter lengths of stay to aid flow before winter

5. No Criteria to Reside



What the chart tells us

On average, there were 233 patients per day with No Criteria to Reside in September 2022. There was an average impact of 4 days increase on Length of Stay due to the NCTR.

The NCTR accounted for 3,913 lost bed days in September 2022, which is an increase of 238 on August 2022.

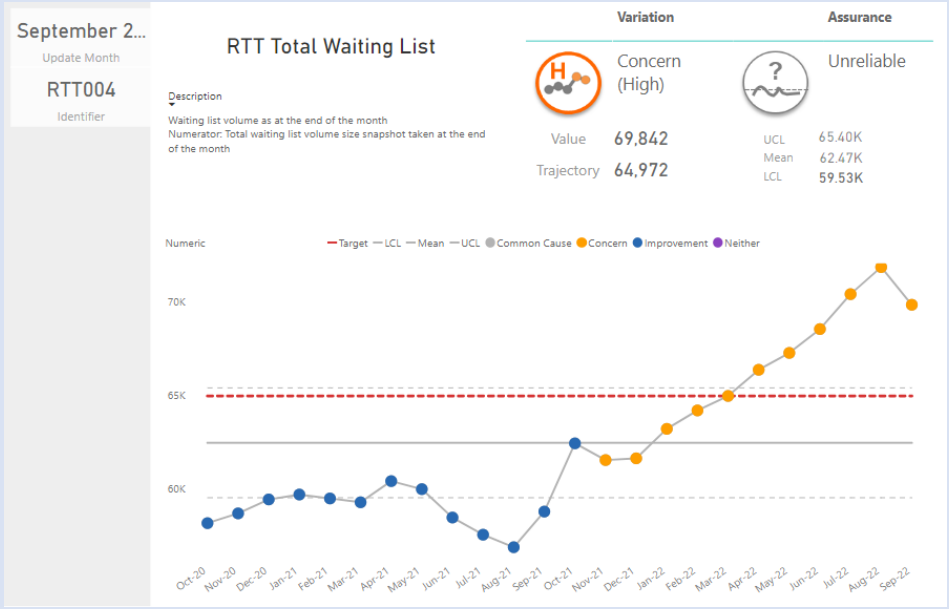
Intervention and Planned Impact

- System CEO's have agreed an indicative plan to increase community capacity across all pathways to achieve no more than 50 patients with NCTR as the sustainable level. A formal trajectory to be agreed by end of October 2022.
- HUTH have requested 25 designated beds for Covid positive patients and 15 for Fracture Neck of Femur beds are commissioned into community capacity to provide non acute recovery time.

Risks / Mitigations

- Domiciliary capacity remains lower than demand.
- Care home take up of new assessments/residents is reduced across the Hull and EY system – this is being investigated by Hull and ER Place Directors
- Covid outbreaks closing community capacity continues through September 2022 with community transmission increasing in the older population.

6. Referral to Treatment – Total Waiting List Volume



What the chart tells us

The Trust's total waiting list volume (WLV) has reduced. At the end of September 2022, the position was 69,842 (-2,013 on last month). The total WLV is above the trajectory of 66,258. The sustainable list size to achieve 92% incomplete performance is circa. 36k.

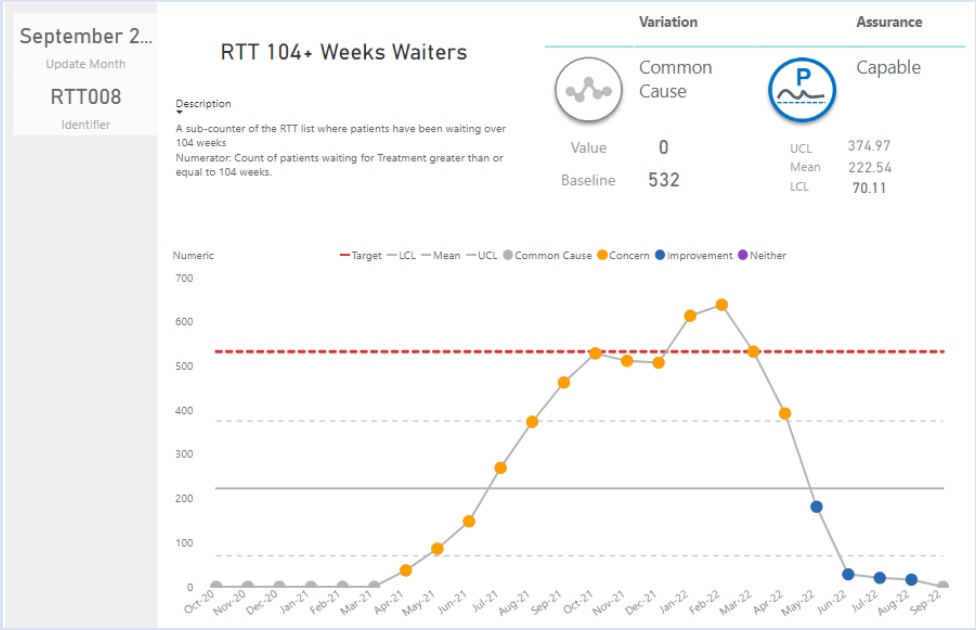
Referrals in September 2022 were lower than the same period last year (September 2021) by -4.9%. The operational plan for 2022/23 assumes no further increase in referrals.

Intervention and Planned Impact

- Continued focus and achievement of zero 104-week breaches.
- Targeted speciality meetings continue to support the achievement of a Trust internal milestone of no patient waiting more than 70-weeks at 31 March 2023 (national target is zero +78-week at 31 March 2023).
- Additional internal milestones have been set:
  - zero x 90 week waits at 30 October 2022
  - leading to zero x 80-week waits at 31 December 2022
  - And, zero x +52 week non-admitted waits at 31 March 2023. All of these initiatives will progress reductions on the Total WLV
- Mutual aid from other providers is supporting the total WLV reduction overall.
- Capacity alerts in x6 pressured specialities are live – with monitoring arrangements to consider the effectiveness and impact.
- Continuing with patient transfers (outsourcing) to Independent Sector Providers and insourcing from a range of providers. Additional support for Gynaecology is a priority.
- Reduced (70%) theatre timetable for summer aimed to protect pressured specialities wherever possible; risk for on-going timetable is anaesthetic cover.
- Text validation to patients on 31,000 pathways commenced at the end of June 2022 delivered by Healthcare Communications; this process will focus on patients confirming whether they still require treatment. Good progress being made – removal rate at circa 7%.
- RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management has commenced through Learn RTT e-learning.

	Risks / Mitigations • Further increase in GP referrals – referral triage and A&G in place to mitigate • Orthopaedic bed base reduction (-12) due to oncology using C9 offset by support from C15 – Executives have confirmed that C9/9A (35 beds) will be returned to orthopaedics/neurosurgery in September 2022. • Patients with No Criteria to Reside does not reduce • Covid and Covid Contacts does not start to increase, staff absence does not increase • Increase in non-elective demand displacing elective capacity

7. 104 Week Waits & Planned Trajectory



What the chart tells us

At the end of September 2022 the Trust reported zero 104-week waits.

Intervention and Planned Impact

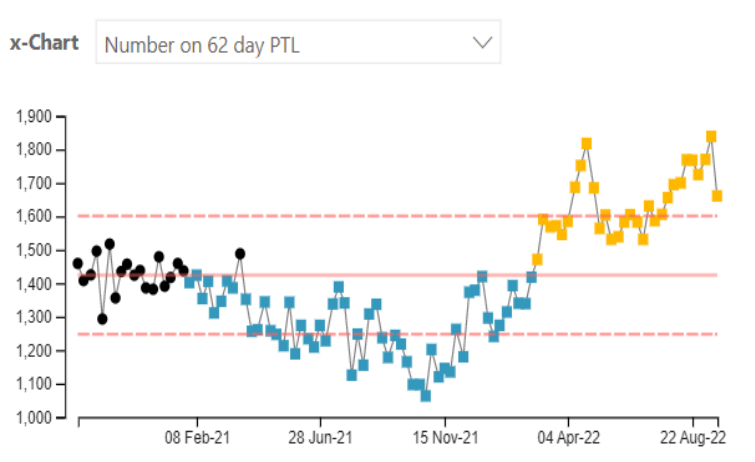
- Continued focus at speciality level of patients dated and/or risks now focussed through to 31 December 2022 to achieve and maintain zero 104-week waits during October.
- Internal milestone set to achieve zero x 90 week waits at 30 September 2022, however due to capacity constraints in some challenged specialties (mainly Colorectal and Gynaecology), and some element of patient choice, the final position was 91 patients waiting over 90 weeks.
- 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
- Progressing mutual aid support from providers within and without of H&NY and continuing to in-source capacity where possible to support pressured specialities.

Risks / Mitigations

- Current patients dated are treated as planned – delivered through micro-management
- Covid (staff absence & patient numbers), NCTR and/or non-elective (winter) demand increases – impacting on elective bed base
- Staff absence increases or does not reduce
- Priority 2, cancer and trauma demand – including ICU capacity & delays in repatriation (in & out of network)
- Patient choice & willingness to accept alternative providers and/or do not meet criteria
- Validation – no long wait "pop-ups"
- October 2022 much reduced risk of patients tipping to 104- weeks, actual patients are 9 (at 20/10/22 – and being tracked).
- Speciality capacity risks:
  - Gynaecology (capacity and obstetric clinical prioritisation
  - Colorectal (cancer demand & HOB bed requirements)
  - ENT (surgeon & complex operating time)
  - Plastic Surgery (ward based enhanced monitoring requirements)

	• Orthopaedics (bed base) • Neurosurgery (P2/acute demand, theatres & bed base) • Orthodontics (clinical capacity) • Oral Surgery (surgeon capacity) • Cardiac Surgery (acute demand, P2 volume and ICU capacity) • Procurement issues (global and nationally)

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 increased over the last month and was 1,768 at the end of August 2022. The impact of annual leave and unplanned absence for the tracking team has been an issue over the 6-week summer holiday period. At the time of writing, the PTL was 1,578 and therefore demonstrating a reduction. Colorectal continues to improve as a result of the additional CTC capacity; new skin cancer removal guidance is beginning to have a positive impact on the PTL volume.

The pre-Covid sustainable list size was c.900 – work is underway to calculate a new sustainable list size based on referrals and national cancer waiting times.

At week commencing 10 October 2022, the PTL had reduced in size to 1,578.

Colorectal, Skin, Gynae and Urology tumour sites continue to make up the largest percentage of the overall PTL, as follows:

- Colorectal 549/34%) with 30% over 63 days; to note this PTL is reducing every week as are the number of long waiting patients
- Skin 280/17.7% a reduction of 1%; 63+ days = 18.5%
- Gynaecology 272/17% an increase of 5.8%, 63+ day = 21.7%
- Urology 189/12% an increase of 2.5%, 63+ days = 9.9%

Subsequent Radiotherapy 31 day target failed to achieve the target of 94% for the first time in the life of the Cancer Waiting Times targets in May 2022. Performance is not expected to improve for the remainder of the calendar year. Performance in August 2022 was 50.8%

Intervention and Planned Impact

The capacity and/or pathway issues fall into 5 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:

- CT Colon additional capacity continues internally with short-term capacity at the Spire. Waiting times are reducing with a positive impact for patients.
- CT backlog of reporting is being reviewed by the service with a view to reducing the number of outstanding reports
- Colonoscopy capacity still being monitored for improvement

Histology capacity/delays – continue to be significant for skin and gynae-oncology, the following actions remain current

- Daily results file has been made available to tracking staff
- Escalations to the SHYPS manager are communicated where results remain outstanding
- Support to identify mutual aid for histology through the NEY Regional Clinical Leads continues with monthly meetings however the impact is yet to be seen in the backlog
- Funding bid to provide pathology with temporary administration support to reduce the reporting backlog is being considered by the national team (outcome expected by the end of October)

Tracking capacity and decision making

- Tracker annual leave is noticeable – consideration for a "floating" tracker to manage planned absences is now essential. The persistent volume of the PTL is now having a significant impact on the ability for tracking staff to cross cover each other for planned absences. A business case is being developed to support an additional B4 Cancer Patient Coordinator role that will be specifically assigned to unplanned leave cover and when not required the role will support the largest volume tumour site PTL
- Transfers to other cancer specialities centres i.e. Leeds will be removed from the HUTH have now been implemented as per national guidance
- Skin tumour site removals from the PTL when excisions are complete and before histology results are available has been progressed as per the National Cancer Team. A manual process has been implemented to allow these removals to accurately reflect the PTL numbers. The process, whilst labour intensive, ensures safety netting for patients until result are available and conclusive in relation to first treatment. Automation of the process will be further explored to reduce the manual burden

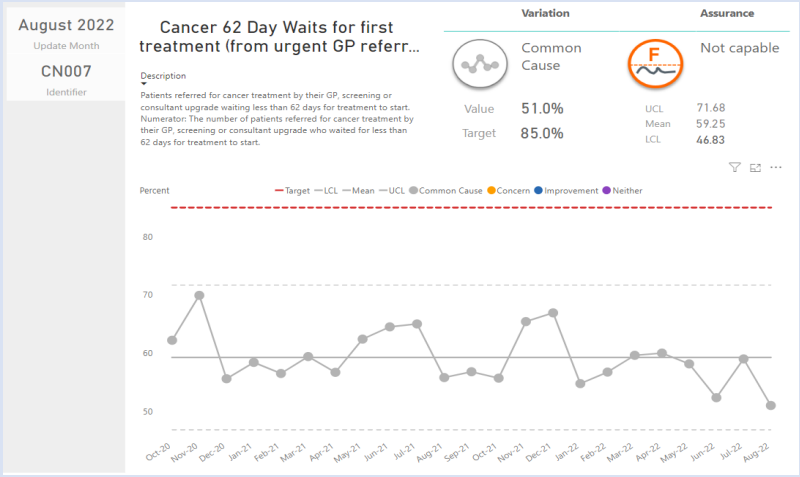
Radiotherapy capacity/delays

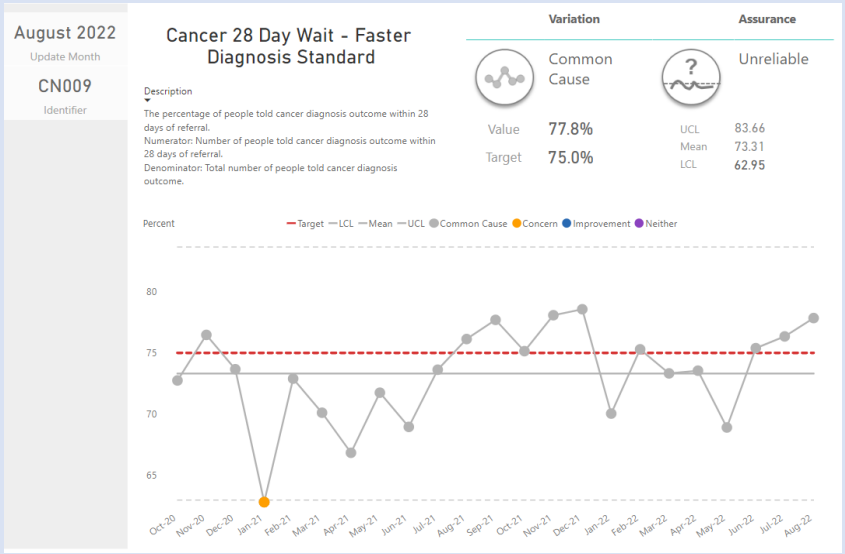
- Staffing vacancies and long term sickness continue to be a considerable challenge albeit recruitment has been successful with new starters due to commence in November 2022
- Increased workload since the recovery plan was developed and implemented during COVID-19 (2021/22)
- Clinical Oncology workforce shortages remains a challenge

The result of these challenges is that Radiotherapy and Chemotherapy waiting times for treatment has declined to a point where the Cancer Waiting Times performance is adversely affected. As a result, Subsequent Radiotherapy 31 day target failed to achieve the target of 94% for the first time in the life of the Cancer Waiting Times targets in May 2022. Performance is not expected to

	improve for the remainder of the calendar year. No significant change to report this month. In August the performance was 50.8% **Transformation Opportunities** • Improvement in the Lower GI triage processes will shorten the pathway and lead to performance improvement • Increasing numbers of 2WW referrals received with a FIT test result will enable more patients to be effectively triaged • Gynae-oncology and Urology deep dive sessions planned for October 2022 Meeting held with national cancer lead – good assurance that the Trust is addressing all the improvement opportunities. Additional capacity, non-recurrent bid submitted to the national team on 27 September 2022 – outcome expected late October 2022.
	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 • Histology tracking systems implemented locally to prioritise long-wait patients • Mutual aid sourced for CT Colon with some success • Additional internal CT Colon capacity has been secured and implemented from beginning of July 2022 and further capacity has been secured from the Spire and patients are attending for their test • Mobile CT capacity continues to be provided by the IS • Radiotherapy delivery continues to be a considerable challenge

9. Cancer 62 day Performance





What the chart tells us

Performance for August 2022 was 51%, which is lower than July 2022 (59%), performance has not been achieved for some time.

The Faster Diagnosis Standard (combined) August 2022 achieved the target with performance of 77.85%.

Intervention and Planned Impact

Largely the same as Section 8. Above.

- Additional CT Colon capacity has been secure to address the backlog of patients
- Administration processes continue to be reviewed and actions implemented
- CT colon mutual aid from the Spire
- Improved access to CT Colon internally should have a direct impact on FDS performance for colorectal which in turn will support the overall Trust performance.
- Radiotherapy capacity and patient prioritisation continues to adversely affect performance with no mutual aid available in the region
- New/changed guidance for skin will, when applied, enable real-time delivery of the 62-day treatment target

Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times
- Staff gaps (vacancies and absence) further impact on diagnostic capacity, radiotherapy & waiting times)
- Histology tracking systems implemented locally to prioritise long-wait patients – concern that improvements in timeliness of results have not yet been seen
- Mutual aid sourced for CT Colon with some success – the Spire will come on line in early September 2022
- Additional internal CT Colon capacity has been secured throughout the summer
- Mobile CT capacity continues to be provided by the IS

10. Elective Recovery Fund

	Target	104%	104%	104%	104%	104%	104%			
POD	DATA	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Q1 Total	Q2 Total	Grand Total
01 Day Case	2019-20 M10 FOT Baseline	4,064,529	4,251,589	4,035,185	4,424,695	3,933,473	4,185,873	12,351,302	12,544,041	24,895,343
	22-23 Baseline Plan	3,906,999	4,234,233	4,366,939	4,403,058	4,285,264	4,681,734	12,508,170	13,370,057	25,878,227
	Actuals	3,636,679	4,565,042	4,204,393	4,415,696	3,901,182	4,360,428	12,406,114	12,677,307	25,083,421
	Baseline 19/20 %	89%	107.4%	104%	100%	99%	104%	100%	101%	101%
	Plan %	93%	108%	96%	100%	91%	93%	99%	95%	97%
	Indicative Gain/Loss	(442,823)	107,542	5,851	(139,490)	(142,222)	5,340	(329,430)	(276,372)	(605,802)
02 Elective	2019-20 M10 FOT Baseline	5,384,834	5,516,684	5,872,456	5,800,723	5,258,063	5,728,404	16,773,974	16,787,190	33,561,164
	22-23 Baseline Plan	5,729,794	6,139,715	6,018,835	6,247,034	6,316,762	6,382,956	17,888,344	18,946,753	36,835,097
	Actuals	4,180,244	5,035,246	5,138,556	5,042,067	4,694,563	5,149,233	14,354,045	14,885,863	29,239,908
	Baseline 19/20 %	78%	91%	88%	87%	89%	90%	86%	89%	87%
	Plan %	73%	82.0%	85%	81%	74%	81%	80%	79%	79%
	Indicative Gain/Loss	(1,064,987)	(526,580)	(726,599)	(743,014)	(580,367)	(606,231)	(2,318,166)	(1,929,611)	(4,247,777)
05 Outpatient Firsts	2019-20 M10 FOT Baseline	2,629,015	2,751,586	2,653,832	2,938,694	2,369,592	2,762,511	8,034,433	8,070,797	16,105,230
	22-23 Baseline Plan	2,616,069	2,860,128	2,815,280	2,902,657	2,869,938	3,042,354	8,291,477	8,814,950	17,106,426
	Actuals	2,672,806	3,136,939	2,843,944	2,858,686	2,738,929	2,744,847	8,653,689	8,342,462	16,996,151
	Baseline 19/20 %	102%	114%	107%	97%	116%	99%	108%	103%	106%
	Plan %	102%	109.7%	101%	98%	95%	90%	104%	95%	99%
	Indicative Gain/Loss	(46,028)	206,467	62,969	(148,167)	205,915	- 96,123	223,409	- 38,375	185,034
06 Outpatient Followups	2019-20 M10 FOT Baseline	2,530,059	2,731,330	2,568,256	2,902,402	2,391,083	2,720,015	7,829,645	8,013,500	15,843,145
	22-23 Baseline Plan	2,734,448	3,030,075	2,968,762	3,018,997	3,047,752	3,207,216	8,733,285	9,273,965	18,007,250
	Actuals	2,880,599	3,221,174	3,024,226	2,954,397	3,010,319	2,978,848	9,125,999	8,943,564	18,069,563
	Baseline 19/20 %	114%	118%	118%	102%	126%	110%	117%	112%	114%
	Plan %	105%	106%	102%	98%	99%	93%	104%	96%	100%
	Indicative Gain/Loss	-	-	-	-	-	-	-	-	-
Outpatient Procedures	2019-20 M10 FOT Baseline	1,269,319	1,382,587	1,252,082	1,483,288	1,265,508	1,349,013	3,903,988	4,097,808	8,001,796
	22-23 Baseline Plan	980,854	1,083,721	1,049,219	1,052,373	1,058,076	1,134,265	3,113,794	3,244,713	6,358,506
	Actuals	1,015,936	1,207,758	1,073,725	1,092,613	1,114,584	1,199,410	3,297,419	3,406,606	6,704,025
	Baseline 19/20 %	80%	87%	86%	74%	88%	89%	84%	83%	84%
	Plan %	104%	111%	102%	104%	105%	106%	106%	105%	105%
	Indicative Gain/Loss	(228,117)	(172,599)	(171,331)	(337,505)	(151,158)	(152,673)	(572,046)	(641,335)	(1,213,382)
Trust Overall	2019-20 M10 FOT Baseline	15,877,755	16,633,776	16,381,810	17,549,801	15,217,718	16,745,815	48,893,342	49,513,335	98,406,677
	22-23 Baseline Plan	15,968,163	17,347,872	17,219,034	17,624,120	17,577,793	18,448,525	50,535,069	53,650,437	104,185,507
	Actuals	14,386,264	17,166,158	16,284,843	16,363,459	15,459,578	16,432,765	47,837,266	48,255,802	96,093,068
	Baseline 19/20 %	91%	103%	99%	93%	102%	98%	98%	97%	98%
	Plan %	90%	99%	95%	93%	88%	89%	95%	90%	92%
	Indicative Gain/Loss	(1,781,955)	(385,169)	(829,109)	(1,368,175)	(667,832)	(849,686)	(2,996,233)	(2,885,693)	(5,881,926)

What the chart tells us

Recovery of elective activity in September 2022 against the operational plan was broadly in line with the submitted activity numbers except for Ordinary elective at 80% of plan. The indicative activity requirement of 110% of 19/20 baseline was not delivered in any of the PODs.

Overall financial position delivered 89% of the plan in September 2022.

Intervention and Planned Impact

Increases in the elective bed base have supported recovery improvement in colorectal however the fragile nature of the access to HOB and ICU capacity is limiting further increase in IP, as is the use of C9A for oncology rather than orthopaedics.

Day case delivered 92% of plan in September 2022 (104% of 19/20) – however the summer theatre timetable reduced to 70% of pre-Covid levels until September 2022 largely due to anaesthetic shortfalls, which has impacted on performance.

OP 1st attendances achieved 90% of the plan in September 2022 and 99% of 19/20 baseline.

OPFU continue to over-perform at 93% of the plan and 110% of the 19/20 baseline, an improvement on previous months – income is capped at 85% of 19/20 baselines. Focussed review of OPFU rates and comparison to regional and national performance is continues with the development of OP Transformation Plans at speciality level.

Risks / Mitigations

- Theatre timetable reductions for summer 2022 and on-going anaesthetic staff shortfalls
- Elective activity and elective bed base is not ring-fenced through winter or Covid surges
- OPFU continue to be in excess of 75% of 19/20 baseline at March 2023
- The new day surgery centre does not come on line in January 2023

Agenda Item	10.1	**Meeting**	Trust Board	**Meeting Date**	08 November 22
Title	Finance Report – 2022/23 - Month 6				
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) Reported deficit of £0.2m at month 6, £1.1m away from plan chiefly driven by unidentified CRES and additional wards to support NCTR patients.

b) Risk on elective recovery income if NHSEI enact clawback in the second half of the year.

c) Uncovered risk of £5.9m in the year-end forecast and the actions needed if the Trust is to deliver its plan.

d) Need to increase in-house productivity and to continue to identify CRES opportunities to reduce the unidentified balance.

a) Underlying deficit of £50m - £56m.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE COMMITTEE: MONDAY 31st OCTOBER 2022

FINANCIAL UPDATE 2022/23 – MONTH 6

1. Purpose of Paper

To update the Trust Board on the financial position at month six and the year-end forecast.

2. Background

The Trust has submitted a balanced financial plan for 2022/23. This included agreement to release £9.7m from the balance sheet and non-recurrent income of £28.1m. With additional full-year effects of agreed slippage and developments (£5.7m), this meant that the Trust began the year with an underlying deficit of £43.5m.

3. Month 6

The table in appendix 1 shows the month 6 reported position against the revised NHSI plan, at health group level. The Trust is reporting a deficit of £0.2m at month 6, which is £1.1m worse than the plan. This is an improvement of £0.1m in month.

Income

Confirmation has been given that, there will be no clawback of Elective Recovery Funding (ERF) in the first six months of the financial year. This removes the risk of the Trust losing up to £6m in the first half of the year due to activity value being below 104% target. Details of the process for months 7 – 12 are still to be confirmed.

The Trust is £0.3m above plan on interest receivable.

The Trust plan assumes receipt of Salix grant income but this is now not expected to happen until 2023/24. This does not affect the Trust reported performance position.

Expenditure

Health groups and corporate areas are reporting that they have a deficit of £3.9m at month 6. This is an improvement of £0.2m in month.

CRES shortfall is £1.4m at month 6. This is an increased shortfall of £0.2m in month with Clinical Support (£0.1m) and Medicine (£0.1m) increasing and others showing close to plan. The overall forecast for CRES delivery has improved and the Trust is reporting that it will achieve 96% delivery by year-end. £4.7m of this is non-recurrent and Health Groups need to continue focusing on identifying recurrent schemes. The breakdown by Health Group is as per the following table:

	Annual CRES Target £'k	YTD CRES Plan £'k	YTD CRES Actual £'k	YTD CRES Variance £'k	% Achieved YTD	Forecast CRES Achievement £'k	Forecast CRES Variance £'k	% Achieved Forecast
Medicine	1,825	1,349	1,095	-254	81%	1,480	-345	81%
Emergency Medicine	397	183	133	-50	73%	297	-100	75%
Surgery	3,070	1,308	1,012	-296	77%	2,764	-306	90%
Family & Womens Health	1,814	799	625	-174	78%	1,542	-272	85%
Clinical Support Services	2,150	1,075	488	-587	45%	1,738	-412	81%
Corporate	1,709	849	849	0	100%	1,709	0	100%
Estates, Facilities & Development	865	402	402	0	100%	1,665	800	192%
Energy	5,149	2,575	2,575	0	100%	5,149	0	100%
Central	357	179	179	0	100%	357	0	100%
TOTAL	**17,336**	**8,719**	**7,358**	**-1,361**	84%	**16,701**	**-635**	96%

Excluding CRES the overall HG position improved by £0.5m.

Surgery Health Group has the biggest pressure excluding CRES delivery with a further £1.3m overspend (£0.1m increase in month). The main areas are the pressures on Junior Doctors (£0.8m up £0.1m in month) which remains under review, Anaesthetic Consultant sessions to support theatre lists (£0.7m, up £0.1m in month) and loss of private patient income (£0.2m). There is also pressure on non-pay costs (£0.5m) and work is being undertaken to determine how much relates to inflation and what is activity related. There are staffing vacancies (£0.8m) that are offsetting some of the other pressures.

Medicine has cost pressures due to the opening of two unfunded wards to support NCTR patients (£0.7m) offset by staff vacancies in other areas. Deficit reduced by £0.2m in month due to the number of vacancies. The two NCTR wards, totalling 45 beds, will be funded from additional capacity funding from month 7 onwards.

Clinical Support Health Group position improved by £0.3m in month due to number of vacancies and small reduction in non-pay spend.

Family and Women's Health Group is £0.5m over-spent, excluding CRES. This is unchanged in month.
Main driver is the high level of Wet AMD cases (£0.7m) but there are also pressures on junior doctors and paediatric devices. These are being offset by the high level of vacancies, especially in nursing staff.

High cost drugs within the block commissioner contract remained at £0.4m overspent with no movement in month.

EF&D have shortfalls on Catering (£0.5m) and car parking income (£0.5m), which have not returned to pre-Covid19 levels. The Trust reintroduced staff car parking charges from 1st October 22. These cost pressures are being offset, to some extent by vacancies. 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 £2.5m.

In summary the month 6 position is:

Unidentified CRES	(£1.4m)
Other Health Group Pressures	(£2.5m)
Reserves and other areas	£2.8m
Total shortfall	(£1.1m)

The key actions needed are to continue to reduce the level of unidentified CRES and the need to increase in house productivity to ensure the Trust delivers the ERF income in the second half of the year.

4. Agency Spend

NHSEI have re-established controls on Trust agency expenditure. They have set targets for individual Trusts to reduce agency expenditure by a minimum of 10% in 2022/23 compared to 2021/22 levels. The targets for HUTH are as follows:

2021/22 Expenditure	£10.6m
Expected Reduction	£1.1m
Maximum expected spend	£9.5m

The Trust initial plan had forecast expenditure of £11.0m for 22/23 so £1.5m above the new target.

Expenditure to Month 6 was £5.1m with year-end forecast of £10.1m. This would be £0.6m above the revised target but is £0.9m below the Trust initial plan. The main reduction has been on Consultant expenditure but there is pressure on use of agency to cover trainee grades.

5. Forecast

The Trust is currently reporting that it will deliver its financial plan for 22/23. This includes two major risks.

a) £5.9m of uncovered risk within Health Group expenditure plans.
b) ERF target of 104% activity value is delivered or funding is not clawed back in second half of the year.

The £5.9m expenditure risk can be broken down into the following areas.

ERF Capacity	£4.5m
Pay Award	£1.0m
NCTR wards	£0.8m
High Cost Drugs	£0.8m
Virtual Ward	£0.2m
Various Underspends	(£1.4m)
Total	£5.9m

Action will need to be taken to address the risk. This will include:

a) Review expected IS usage in final quarter to bring expected spend back down in line with annual funding. This will include increasing in-house productivity to reduce the need to outsource.
b) Continue to push for identification and delivery of CRES schemes through Productivity and Efficiency Board
c) Continue to review reserves/balance sheet for further slippage/offsets.

The Trust started the year with an underlying deficit of £43.5m (assuming ERF and Covid19 income are non-recurrent). Including the level of non-recurrent CRES (£4.5m) and additional in-year pressures will move this to a position of between £50m - £56m.

The in-year pressures are being reviewed to determine the final position. The position will be affected by assumptions around levels of income that may be received in 23/24 (ERF and Covid). The ICB is holding a strategy meeting at the beginning of November to discuss 23/24 plans and set guidelines for planning, including assumptions for underlying run rates.

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

The SOFP and SOCF for month 6 are reported in appendices 2 and 3.

Capital

The reported capital position at month 6 shows gross capital expenditure of £7.8m against a plan of £11.6m. The main areas of expenditure relate to the Digestive Disease Scheme, Day Surgery Scheme and PFI lifecycle costs. The main variance from plan relates to the Salix Grant scheme, which has now slipped to 2023/24.

The planned capital expenditure for 2022/23 (incl PFI/IFRIC12 impact) is £26.5m; this has reduced from month 5 due to the removal of the Salix Grant scheme (£10m). The revised total now includes two confirmed PDC schemes relating to Lung Health check (£1.135m) and Endoscopy (£0.4m). It does not include other PDC bids the Trust has submitted in relation to a CT scanner; Gamma Camera; NICU, CDC, EPR and Phase 2 of the Day Surgery scheme (TIF2). These are all awaiting approval.

Cash

The Trust's liquidity position remains healthy with a cash balance of £72m at the end of September. This has reduced in month following the payment of the pay award, back dated to April 22. Further reduction is expected in month 7 as the increased tax, national insurance and pension contributions on the pay award are paid. The estimated forecast cash balance by the end of March 23 remains at £55m but this is dependent on the timing of expected PDC.

To date the Trust has paid 95.5% by volume and 85.5% by value of non-NHS invoices within best practice terms. In September, the figures were 91.4% and 82.1% respectively.

Debtors

The Trust currently has £3.6m of debt that is over 90 days, an increase of £0.5m from month 5. The main debtors are as follows:

	August 22	September 22	Change
Debtors over 90 days	**£**	**£**	**£**
Northern Lincolnshire And Goole Nhs Ft	394,012	548,600	154,588
York & Scarborough Teaching Hospitals Nhs Ft	353,336	355,831	2,495
City Health Care Partnership	216,218	171,289	-44,929
Humber Teaching Nhs Foundation Trust	155,958	151,758	-4,200
Spire Healthcare Group	135,503	138,503	3,000
East Riding Of Yorkshire Council	-183,278	96,082	279,360
Fresenius Medical Care Renal Services Ltd	77,505	77,505	0
Crawford & Company Adjusters (Uk) Ltd	60,720	60,720	0
East Riding Fertility Services Ltd	59,007	60,051	1,044
Ge Healthcare	51,962	51,962	0
Other	1,818,848	1,905,429	86,581
Total	3,139,792	3,617,731	477,939

NLAG increase related to the 1st quarter invoice for Max Fax services (£196k) for which a partial credit note is required of around £60k. The Spire invoices were paid on 10th October 22. Fresenius have confirmed they will pay the invoices as soon as possible and have apologised for the delay. East Riding Fertility services have agreed a payment plan to reduce their outstanding balance and final payment is due on 31st October 22.

Stocks

Stock levels are at £16.3m, a small decrease of £0.2m in month but still £0.5m higher than year-end.

Health Group	Mar 22 £000	Aug 22 £000	Sep 22 £000	In Month Change £000
Clinical Support	7,178	7,383	7,160	(223)
Surgery	4,489	4,736	4,762	26
Medicine	2,326	2,542	2,555	14
F & WH	1,096	1,070	1,085	15
Other	434	435	440	5
PPE Stock	345	345	345	0
Total	15,867	16,511	16,347	(164)

7. Recommendations

The Trust Board is asked to note the following:

a) The reported deficit of £0.2m at month 6, which is £1.1m away from plan chiefly driven by unidentified CRES and additional wards to support NCTR patients.

b) The risk on elective recovery income if value of activity is below plan and NHSEI enact the clawback in the second half of the year.

c) The uncovered risk of £5.9m in the year-end forecast and the actions needed if the Trust is to deliver its plan.

d) The need to increase in-house productivity and to continue to identify CRES opportunities to reduce the unidentified balance.

e) The underlying deficit of £50m - £56m

Stephen Evans
Deputy Director of Finance
October 2022

APPENDIX 1

Financial Year 2022/23 Month 6

	Annual Budget £000	Budget £000	Actual £000	Variance £000	Month 5 £000	Change In Month £000	Month 6 Forecast £000	Month 5 Forecast £000	Change In Month £000
Nhs Contract Income	651,560	326,367	331,531	5,164	47	5,117	13,324	(102)	13,426
ERF Income	19,718	9,859	9,859	0	0	0	0	0	0
Nhs Other Clinical Income	209	104	116	12	10	2	24	24	0
Education + Training Income	21,556	10,657	10,757	100	104	(4)	1,074	825	249
Other Income	2,320	1,160	1,223	63	24	39	127	59	68
Donated/Grant Income	10,460	4,260	0	(4,260)	(3,000)	(1,260)	(10,000)	0	(10,000)
Total Income	**705,823**	**352,407**	**353,486**	**1,079**	**(2,815)**	**3,894**	**4,549**	**806**	**3,743**
Surgery	(149,899)	(75,901)	(77,523)	(1,622)	(1,560)	(62)	(3,601)	(3,605)	4
Medicine	(93,690)	(46,479)	(46,695)	(216)	(389)	173	(1,526)	(1,737)	211
Clinical Support Services	(103,340)	(52,184)	(52,213)	(29)	(263)	234	(443)	(750)	307
Pass through drugs	(68,284)	(34,142)	(34,573)	(431)	(431)	0	(835)	(902)	67
Family + Womens Health	(89,534)	(45,443)	(46,153)	(710)	(763)	53	(1,449)	(2,020)	571
Corporate Directorates	(79,242)	(39,744)	(39,855)	(111)	78	(189)	(749)	(653)	(96)
Reserves	(8,167)	(3,131)	(613)	2,518	2,575	(57)	(1,656)	1,280	(2,936)
Pay Award	10,622	5,311	0	(5,311)	0	(5,311)	(10,622)	0	(10,622)
Other Operating Expenditure	(6,842)	(3,436)	(3,344)	92	17	75	(115)	(37)	(78)
Emergency Care Health Group	(19,012)	(9,461)	(9,370)	91	28	63	(130)	(103)	(27)
Estates Facilities & Developmt	(52,740)	(25,026)	(26,009)	(983)	(873)	(110)	1	152	(151)
Unaddressed Risk	0	0	0	0	0	0	5,904	7,000	(1,096)
Total Operating Expenditure	**(660,128)**	**(329,636)**	**(336,348)**	**(6,712)**	**(1,581)**	**(5,131)**	**(15,221)**	**(1,375)**	**(13,846)**
Donated Asset Income	(10,460)	(4,260)	0	4,260	3000	1,260	10,000	0	10,000
EBITDA	**35,235**	**18,511**	**17,138**	**(1,373)**	**(1,396)**	**23**	**(672)**	**(569)**	**(103)**
Depreciation	(22,161)	(11,082)	(11,084)	(2)	(3)	1	0	0	0
Interest Payable	(6,236)	(3,080)	(3,203)	(123)	(105)	(18)	(158)	(156)	(2)
Interest Receivable	217	108	404	296	202	94	590	484	106
Pdc Dividends	(8,195)	(4,097)	(4,098)	(1)	0	(1)	0	0	0
Total Non Operating Expenditure	**(36,375)**	**(18,151)**	**(17,981)**	**170**	**94**	**76**	**432**	**328**	**104**
Net Surplus/Deficit	**9,320**	**4,620**	**(843)**	**(5,463)**	**(4,302)**	**(1,161)**	**(10,240)**	**(241)**	**(9,999)**
Donated Asset Adjustment (NEW)	(9,320)	(3,690)	690	4,380	3,100	1,280	10,240	241	9,999
Adjusted Financial Performance before Profit/Loss Adjustment	**0**	**930**	**(153)**	**(1,083)**	**(1,202)**	**119**	**0**	**0**	**0**
Profit/Loss Disposal Assets Adjustment	0	0	0	0	0	0	0	0	0
Adjusted Financial Performance Surplus/Deficit	**0**	**930**	**(153)**	**(1,083)**	**(1,202)**	**119**	**0**	**0**	**0**

APPENDIX 2

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF FINANCIAL POSITION

	Accounts 31/03/2022 2021/22 £000	Actual 31/07/2022 YTD £000	Actual 31/08/2022 YTD £000	Actual 31/09/2022 YTD £000	Movement from 31/03/22 £000
Non-current assets					
Intangible assets	8,790	9,433	9,323	9,213	423
Property, plant and equipment: on-SoFP IFRIC 12 assets	63,165	62,664	62,501	62,369	(796)
Property, plant and equipment: other	322,078	316,737	317,039	317,919	(4,159)
Right of use assets - leased assets for lessee (excludes PFI/LIFT)	0	8,728	8,562	8,408	8,408
Investment property	100	100	100	100	0
Investments in joint ventures and associates	0	0	0	0	0
Other investments / financial assets	536	536	536	536	0
Receivables: due from NHS and DHSC group bodies	1,338	1,398	1,398	1,398	60
Receivables: due from non-NHS/DHSC group bodies	1,953	1,887	1,887	1,887	(66)
Other assets	0	0	0	0	0
Total non-current assets	**397,960**	**401,483**	**401,346**	**401,830**	**3,870**
Current assets					
Inventories	15,867	16,200	16,511	16,347	480
Receivables: due from NHS and DHSC group bodies	17,732	16,486	12,794	13,618	(4,114)
Receivables: due from non-NHS/DHSC group bodies	15,227	18,279	15,166	16,254	1,027
Other investments / financial assets	0	0	0	0	0
Other assets	0	0	0	0	0
Non-current assets for sale and assets in disposal groups	0	0	0	0	0
Cash and cash equivalents: GBS/NLF	79,415	89,975	79,094	72,272	(7,143)
Cash and cash equivalents: commercial / in hand / other	13	20	14	10	(3)
Total current assets	**128,254**	**140,960**	**123,579**	**118,501**	**(9,753)**
Current liabilities					
Trade and other payables: capital	(32,732)	(8,494)	(9,175)	(7,842)	24,890
Trade and other payables: non-capital	(108,479)	(134,844)	(115,416)	(115,806)	(7,327)
Borrowings	(2,989)	(5,179)	(5,239)	(5,115)	(2,126)
Other financial liabilities	0	0	0	0	0
Provisions	(3,997)	(3,949)	(3,949)	(3,949)	48
Other liabilities: deferred income including contract liabilities	(3,277)	(12,316)	(13,354)	(10,728)	(7,451)
Liabilities in disposal groups	0	0	0	0	0
Total current liabilities	**(151,474)**	**(164,782)**	**(147,133)**	**(143,440)**	**8,035**
Total assets less current liabilities	**374,740**	**377,661**	**377,792**	**376,892**	**2,152**
Non-current liabilities					
Trade and other payables	0	0	0	0	0
Borrowings	(51,377)	(55,655)	(55,294)	(54,370)	(2,993)
Other financial liabilities	0				0
Provisions	(2,924)	(2,924)	(2,924)	(2,924)	0
Other liabilities	0	0	0	0	0
Total non-current liabilities	**(54,301)**	**(58,579)**	**(58,218)**	**(57,294)**	**(2,993)**
Total assets employed	**320,439**	**319,082**	**319,574**	**319,598**	**(842)**
Financed by					
Taxpayers' equity					
Public dividend capital	330,863	330,863	330,863	330,863	0
Revaluation reserve	26,537	26,538	26,538	26,538	1
Financial assets at FV through OCI reserve	536	536	536	536	0
Other reserves	0	0	0	0	0
Merger reserve	0	0	0	0	0
Income and expenditure reserve	(37,497)	(38,855)	(38,363)	(38,339)	(842)
Others' equity					
Non-controlling Interest	0	0	0	0	0
Charitable fund reserves	0	0	0	0	0
Total taxpayers' and others' equity	**320,439**	**319,082**	**319,574**	**319,598**	**(841)**

APPENDIX 3

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF CASH FLOWS

	Accounts 31/03/2022 £000	Actual 31/08/2022 YTD £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	14,669	6,065
Operating surplus/(deficit) of discontinued operations		
Operating surplus/(deficit)	**14,669**	**6,065**
Non-cash or non-operating income and expense:		
Depreciation and amortisation	18,210	11,084
Impairments and reversals	15,919	0
Income recognised in respect of capital donations (cash and non-cash)	(17,454)	(1)
Amortisation of PFI deferred income / credit	0	0
On SoFP pension liability - employer contributions paid less net charge to the SOCI	0	
(Increase)/decrease in receivables	(11,730)	3,087
(Increase)/decrease in other assets	0	0
(Increase)/decrease in inventories	(885)	(481)
Increase/(decrease) in trade and other payables	38,392	(16,825)
Increase/(decrease) in other liabilities	2,547	7,143
Increase/(decrease) in provisions	1,031	(48)
Corporation tax (paid) / received		
Movements in operating cash flows of discontinued operations		
Other movements in operating cash flows	(1)	
Net cash generated from / (used in) operations	**60,698**	**10,024**
Cash flows from investing activities		
Interest received	41	404
Purchase of financial assets / investments		
Proceeds from sales / settlements of financial assets / investments		
Purchase of intangible assets	(3,062)	(533)
Proceeds from sales of intangible assets		
Purchase of property, plant and equipment and investment property	(71,910)	(7,272)
Proceeds from sales of property, plant and equipment and investment property	136	0
Receipt of cash donations to purchase capital assets	12,249	0
Prepayment of PFI capital contributions (cash payments)		
Cash flows attributable to investing activities of discontinued operations		
Cash movement from acquisitions of business units and subsidiaries (not absorption transfers)		
Cash movement from disposals of business units and subsidiaries (not absorption transfers)		
Net cash generated from/(used in) investing activities	**(62,546)**	**(7,401)**
Cash flows from financing activities		
Public dividend capital received	38,616	0
Public dividend capital repaid	0	0
Movement in loans from the Department of Health and Social Care	(1,260)	(630)
Movement in other loans	0	0
Other capital receipts		0
Capital element of finance lease rental payments	(56)	(998)
Capital element of PFI, LIFT and other service concession payments	(1,583)	(832)
Interest on DHSC loans	(395)	(181)
Interest on other loans		
Other interest (e.g. overdrafts)		
Interest element of finance lease	(4)	(29)
Interest element of PFI, LIFT and other service concession obligations	(5,520)	(3,000)
PDC dividend (paid)/refunded	(7,450)	(4,098)
Cash flows attributable to financing activities of discontinued operations		
Cash flows from (used in) other financing activities		
Net cash generated from/(used in) financing activities	**22,348**	**(9,768)**
Increase/(decrease) in cash and cash equivalents	**20,500**	**(7,145)**
Cash and cash equivalents at 1 April - brought forward	58,927	79,427
Prior period adjustments		
Cash and cash equivalents at 1 April - restated	**58,927**	**79,427**
Cash and cash equivalents at start of period for new FTs	0	
Cash and cash equivalents transferred by absorption	0	
Unrealised gains/(losses) on foreign exchange		
Cash transferred to NHS foundation trust upon authorisation as FT	0	0
Cash and cash equivalents at Month (Year) End	**79,427**	**72,282**

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

End of Life Steering Group

ANNUAL REPORT

2021 – 2022

INDEX PAGE NUMBER

1. PURPOSE

The purpose of this Annual Report is to inform Trust Board Members of the progress with regard to its responsibilities for End of Life Care for adults within the acute Trust. The report will identify End of Life activity collected within the Specialist Palliative Care Service for the Trust over 2020/2021 raise awareness of key issues affecting practice and service delivery, and identify key priorities for 2022.

2. EXECUTIVE SUMMARY

The Trust has mapped its End of Life Care priorities to the Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2021. This framework builds on the Strategy for End of Life Care (2008) identifying six key areas for focus of care and has been refreshed for 2021-2026.

The Ambitions framework advocates a collaborative approach to Palliative and End of Life Care and Services for all to reflect the upcoming changes to our health and social care systems with the development of Integrated Care System Health and Care Partnerships. Learning and experience from the recent Covid-19 pandemic has seen a focus to personalised palliative and end of life care drive down health inequalities and improve support of all including bereavement care. This cannot be achieved without the collaborative and cooperation of many partners including primary and secondary care providers, voluntary and charitable organisations.

2.1 KEY ACHEIVEMENTS AND OUTCOMES

- Maintaining 98% response rates within 1 working day for referrals into the Specialist Palliative Care Team
- Continuing provision of specialist palliative care services to patients at weekends (7 day service)
- Participated in the National Audit for Care at the End of Life (NACEL)
- Ensure that as a team we record the diagnosis accurately on S1, use High Priority Reminders onto S1 and record Electronic Palliative Care Coordination Systems (EPaCCS) to capture and share information from patient's discussions about their care.
- Regular psychology sessions for the team.
- Continue regular SPCT teaching sessions and reflective case discussions to ensure we are up to date with evidence base medicine. We also started giving feedback from conferences we attend and share the knowledge with others.
- Reviewed the SPCT meetings and having these quarterly.

- Collaboration with the local and regional End of Life groups, sharing good practice and improving communication between different services providers

- Collaboration with Hull community service. Dr Hannah Leahy attends Hull community MDT meeting and supports the team, again supporting the communication between providers

- Development of the EOL care plan for the Trust to be used when there is a recognition of the dying patient.
- Palliative Care Consultants engaging and attending Mortality Committee meetings
- Syringe driver safety; checklists, monitoring and solving any issues arising with the transfer of patients between service providers.

- Staff education delivered via the Big Blue Button via hey247.
- Published paper in BMJ Supportive Palliative Care 2022 Mar; 12(1):38-41.doi: 10.1136/bmjspcare-2020-002795. Epub 2021 Feb 18. *Palliative medicine in the intensive care unit: needs, delivery, quality.* Stephanie A Hill , Abdul Dawood , Elaine Boland , Hannah E Leahy , Fliss EM Murtagh

2.2 KEY ACTIONS CONTINUING INTO 2021/22

- To continue to develop work streams mapped to the Ambitions Framework.
- Discussion around use of portable syringe drivers within the Trust including discharging patients home on a driver, buying more drivers, obtaining drivers back and storing them.
- Re-start face to face teaching and education in the hospital as allowed
- Continue the implementation of an Electronic Palliative Care Coordination System (EPaCCS) in the trust which links with other service providers across Humber Coast and Vale Integrated Case System
- To continue work streams to address service improvement from the NACEL results

3 BACKGROUND

The Ambitions Framework seeks to benchmark local services, to develop and support educational opportunities, business plans and develop local strategies. It identifies six ambitions to be achieved or progressed advocated by the National Palliative and End of Life Care Partnership. Within the Trust, the End of Life Steering Group has mapped the Ambitions to their work plan and aspiration for EOL care within the acute setting. The

progress of this work has been affected by Covid -19 pandemic; staff shortages and operational pressures have directly impacted on key members of the steering group's ability to attend the meetings.

4. LOCAL CONTEXT

Hull University Teaching Hospitals NHS Trust (HUTH) is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs over 10,000 staff (headcount) and delivers its services on two main sites; Castle Hill Hospital and Hull Royal Infirmary. Outpatient services are also delivered from across locations across the local health economy area. The Trust provides a full range of urgent and planned general hospital specialities, routine and specialist diagnostic services and other clinical support services. These secondary care services are provided to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The Trust provides specialist services to a catchment population of 1.5-1.8 million extending from York and Scarborough in North Yorkshire to Grimsby and Scunthorpe in North Lincolnshire and sits within the Humber Coast and Vale Health and Care Partnership.

Hull is a geographically compact city of circa 270,000 and has been identified as the 2nd most deprived local authority in England in 2015. The health of the people is also worse than the England average with life expectancy for both men and women below the England average.

The East Riding of Yorkshire is a predominantly rural area which causes difficulties with access to essential services for some of its 340,000 residents. Life expectancy for men is higher than the England average in the East Riding.

Hull and the East Riding are served by separate Clinical Commissioning Groups (CCG's) that are largely co-terminus with their local authorities. The Trust provides virtually all of its Hull CCG's secondary services and around 60% of the East Riding's. Community services are provided by City Health Care Partnership (CHCP) in Hull and for some services in the East Riding and Humber NHS Foundation Trust providing other services in the East Riding.

The regulatory environment for the Trust remains exacting with regular, rigorous inspections by the care Quality Commission (CQC). Our current rating is 'Requires Improvement' although in the Caring category we achieved a "Good rating". National guidance pertaining to safe nurse staffing levels adds to existing challenges regarding recruitment difficulties.

National standards for waiting times, emergency care, elective and cancer patients have proven difficult to achieve however the trust has made rectifying this a key priority.

As an organisation we value the contribution our patients, their families and carers can make to the improvement of our services. We have a Patient Experience Forum and a Patient Council to ensure their voices are heard.

5. MANAGEMENT AND ORGANISATIONAL ARRANGEMENTS

5.1 Overview of the Service

The team is based in the Queen's Centre for Oncology and Haematology and visit inpatients at Castle Hill Hospital and Hull Royal Infirmary on a flexible as needed basis. The team provide a 7-day face-to-face service across both sites. Two Specialist Palliative Care Nurses cover the weekend. Out of hours advice can be sought from Dove House Hospice and Palliative Medicine consultant input via the regional on call rota.

The Specialist Palliative Care Service ensures holistic assessment and advance care planning. It enables access to specialist support and therapy for physical, psychological, spiritual, social and family problems by virtue of its links with the following services;

- Macmillan Specialist Palliative Care Social Worker
- Welfare Rights Officer
- Chaplaincy
- Pain team for interventional analgesia
- Pharmacist
- Physiotherapy
- Occupational therapy
- Specialist dietitian
- Oncology Health Service
- Cancer Information Centre
- Local hospices
- Local Community Palliative Care Teams
- Site specific Clinical Nurse Specialists
- Supportive Care Services Clinical Nurse Specialists

Patients are referred to appropriate services following assessment utilising local guidelines for referral.

5.2 Roles and responsibilities of the Specialist Palliative Care Team

The Specialist Palliative Care Team for Hull University Teaching Hospitals NHS Trust provides specialist palliative care to all patients identified with specialist palliative care needs, as defined above, and it also has a key role in improving the provision of generalist palliative care, including end of life care, within the acute trust.

The Specialist Palliative Care team provides:

- an advisory and liaison service for patients with specialist palliative care needs within the Hull University Teaching Hospitals NHS Trust
- education throughout the trust regarding palliative care symptom management, end of life care and communication skills
- support for all other professionals working with patients with palliative care and end of life needs including links with site-specific MDTs
- clinical governance support by the development of protocols to ensure safe practice and patient safety

- support for the implementation of the End of Life Care Strategy 2008 and NICE guidelines: Care of dying adults in the last days of life 2015
- clinical governance support through regular audit
- support for research in palliative care

5.3 Specialist Palliative Care Team Structure

The Specialist Palliative Care (SPC) Multidisciplinary Team (MDT) is a multi-professional group serving the city of Hull and the surrounding areas in the Hull and East Riding of Yorkshire. The hospital-based team work within the Hull University Teaching Hospitals NHS Trust, serving a population of 1.25 million people.

The team consists of four Palliative Medicine Consultants (2 WTE for HUTH). Four Band 7 Palliative Care Clinical Nurse Specialists (3.6 WTE), four band 6 CNS (3.6 WTE) and the Team Co-ordinator (35 hours per week).

5.4 Specialist Palliative Care MDT meetings

The MDT is held weekly on a Wednesday mornings from 9.15am-11.30am in Queens Centre, Castle Hill Hospital. Members attend in person and attendance is recorded by signing a register. Attendance data is collated by the MDT Co-ordinator.

All new referrals to the service (both in-patient and out-patient) and ongoing complex patients are discussed at the MDT. The list is compiled by the MDT co-ordinator in conjunction with the team from the current caseload as documented on SystmOne.

All new referrals have an initial assessment (which may be a telephone assessment with referring team) within one working day of receiving the referral. Face to face assessment is arranged accordingly. Urgent treatment decisions are discussed within the team and with one of the consultants in Palliative Medicine outside of the MDT as needed. Urgent treatment plans are initiated as soon as necessary on a clinical basis and patients are discussed at next available MDT.

At the MDT, the specialist Palliative Care Nurses present an outline of the patient's issues including physical, psychological, social and spiritual needs. We also aim to promote advance care planning by considering preferred place of care and death and resuscitation status and ReSPECT form completions where appropriate. The MDT agrees the ongoing management plan for the patient and all of the above information is documented electronically in SystmOne. Patients who are being discharged home have an MDT proforma completed which is sent to the GP via a task on S1 and copied into Lorenzo from SystmOne for information.

5.5 INTERNAL GOVERNANCE

The End of Life Steering group oversees the mapping the Ambitions Framework and the work programme to achieve the ambitions. The Lead Cancer Nurse for the Trust chairs the steering group. The delegated Non- Executive Director for End of Life Care is Una MacLeod and the Chief Nurse is the Executive Director for End of life Care.

The group meet bi-monthly and reports into the Patient Experience Group (PEG) for escalation and discussion of arising matters and quality issues. A quality report is produced for the PEG to update on progress against the six ambitions and discuss complaints and compliments.

5.6 EXTERNAL GOVERNANCE

Key members of the EOL Steering Group attend the Hull and East Riding End of Life Locality meeting and key areas of work such as the Ambitions Framework form the basis of the meetings and collaborative work streams.
This meeting feeds into the regional group which is attended by the Palliative Care Consultants. National and local updates and feedback are distributed through this network.

5.7 SERVICE USER AND STAKEHOLDER FEEDBACK/INVOLVEMENT

Feedback for the Specialist Palliative Care team is undeniably difficult to gauge. Compliments to the team are many as are charitable donations made in gratitude to the service provided. Complaints are held by the patient experience team and dealt with in a timely manner as per Trust timescales where possible.

There is no service user representation on the Steering Group at this present time.

6. ACTIVITY and REFERRALS

For inpatient assessments, an electronic referral system is in place in Lorenzo. These are prioritised according to urgency. The team has reviewed & updated the format of the referral form following an audit of electronic referrals.

6.1 Referral data

There were 1787 referrals to the team in 2021, of which 1504 were seen.

161 patients were advice only to professionals.

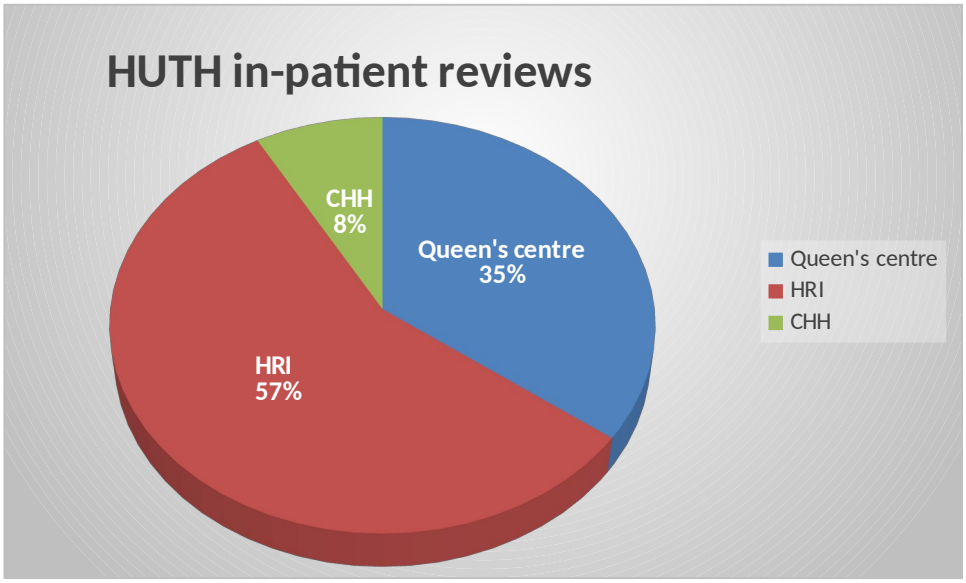
Reasons for patients not seen include:

1. Patient died before visit.
2. Patient discharged home before visit.

3. Patient already known to site specific CNS.
4. Telephone advice given to treating team and visit not required.
5. Telephone assessment with treating team and decision made for referral to District Nursing Team on discharge.
6. Inappropriate referral to team.

The number of patients seen throughout the whole trust in 2021:

QUEENS CENTRE	**529 (35%**
HRI	**854 (57%**
CASTLE HILL HOSPITAL	**123 (8%)**



The aim of the SPC team is to see over 90% of patients within one day of referral.

All new patients are discussed in MDT unless patient died or transferred to a hospice. 998 patients were discussed in MDT in 2021:

Jan 21: 64 patients	July 21: 78 patients
Feb 21: 58	Aug 21: 102
Mar 21: 95	Sept 21: 95
Apr 21: 75	Oct 21: 91
May 21: 88	Nov 21: 76
June 21: 100	Dec 21: 76

Patients seen with cancer diagnosis recorded is as follows:-

Breast	43 Patients
Digestive Organs	240
Eye, Brain and other	21
Female Genital Organs	58
Ill Defined secondary unspecified	36
Lip, oral cavity and pharynx	22
Lymphoid, Haematology	59
Male Genital	33
Urinary Tract	80
Other Specified sites	50
Intra Abdominal (unspecified)	6
Independent Multiple Sites	4
Respiratory Disease	178

= 830

Other non-cancer Diagnoses:

Other non cancer	453
Respiratory and Intrathoracic Disease	48
Heart/Circulatory Disease	99
Degenerative Nervous System Disease	52

= 652

Unrecorded diagnosis total – 22.

6.2 Referrals from the acute trust to hospice inpatient services

183 referrals were made to 8 hospices from January to December 2021. Of these referrals 151 (82%) were for end of life care, 29 (16%) for symptom management and the remaining 3 (2%) were for future care or assessment. 136 patients (74%) had a diagnosis of malignant disease and 47 patients (26%) had non-malignant disease. 127 patients (69%) of the patients referred were transferred to the preferred hospice of their choice.

Hospice	No of referrals made	No of patients transferred
Dove House Hospice (Hull)	147	101
St Andrews Hospice (Grimsby)	9	7
Lindsey Lodge Hospice (Scunthorpe)	13	10
St Leonards Hospice (York)	2	1
St Catherines Hospice (Scarborough)	8	6
St Barnabas (Lincoln)	1	1
St Ann's Hospice (Manchester)	1	0
St Gemmas (Leeds)	2	1
Totals	183	127

56 patients (30%) of the patients were not transferred as they became too unwell to move, died before the bed became available or the patient changed their mind and decided to go home or to an alternative care setting. 3 of these patients were not transferred as they were referred for future care following discharge from hospital (respite care, breathlessness clinic or day therapy).

73% of patients were transferred same day or next day as hospices were still running at a reduced capacity due to the ongoing COVID19 pandemic.

- Same day – 41 patients (33%)
- Next day - 50 patients (39%)
- 48hrs and > - 36 patients (28%)

120 of the 127 patients from the acute trust died at a local hospice following their transfer. The remaining 7 patients were well enough to be discharged from the hospice.

Hospice transfers had an impact on the hospital length of stay by reducing the number of days they would have potentially remained in hospital. It was calculated that the 127 patients transferred from the acute trust to the local hospices spent a total of 1351 days at the hospice of their choice before they either died or were discharged home or to an alternative care setting.

The length of stay in the hospice ranged from 0 (died on the day of transfer) to the longest being 64 days. Assuming the average cost per day of a palliative care patient in an acute hospital trust is £323.09, an approximate cost saving of £436,495 can be demonstrated for 2021. *(Reference for costings – Robert Dyer HUTH Clinical Support Finance Manager (January 2022) costs have increased again from last year due to the ongoing COVID pandemic.)*

7 AUDITS

7.1 Heart Failure End of Life audit (supporting foundation Dr) started in 2021 but not completed until 2022.

7.2 The National Audit of Care at the End of Life

Our Trust participates in NACEL which is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute and community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland.

Results

The dashboard below shows the national scores in the left hand column with the Trusts scores in the right hand column. The needs of familes and others and experience of care scores are missing; this is predominantly due to the recording of carer details at the point of admission prior to death. Carer feedback is gained through a postal survey and next of kin addresses are not generally sought and may change in the time from death to the survey commencing. Although a solution had been thought to be found this requires further exploration and therefore the results will be missing from 2022 results.

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Key areas of work from 2019 NACEL

- Ongoing implementation of the end of life care plan for adults in last days of life across HUTH which promotes documentation of symptoms and plan of care -**partially achieved**
- Update end of life guidance to ensure clear indications are written for anticipatory medications and amend prescribing on ePMA where able. To ensure education provided to prescribers regarding anticipatory medications – **achieved**
- To explore option of expansion of specialist palliative care CNS team to ensure 7 day service delivery can continue to be provided with staffing levels in line with national average - **not achieved**
- To ensure end of life training is included in induction training and priority training for staff who will be caring for patient at EOL – **not achieved**

- To ensure e-learning for EOL care is available to all staff via hey247 **– available but not fully implemented**
- To ensure EOL annual report is fed back to the Executive Board**- in progress**
- HUTH and other providers of EOL care to implement EPaCCS to increase the number of ACP's documented and visible within each organisation **– in progress**

Current focused areas of work

- End of Life care to be included in the Trust's Quality Strategy
- Relaunching the End of Life Steering Group
- NACEL 2022 in progress
- Carer feedback was absent from the 2019 audit and again is not able to be sought in a consistent way due to the collection of carer information data in hospital systems. A process to address this is being sought.
- Continue to embed and promote the use of EPaCC's.

7. RESEARCH

Professor Fliss Murtagh works on day at week at HUTH and is based at the newly established Wolfson Palliative Care Research Centre, University of Hull and provides the team links with information regarding local studies & trials that would be appropriate for palliative care patients.

REPORT END

Report Authors: Elaine Boland: Specialist Palliative Care Consultant
Liz Lawson: Palliative Care Team Co-ordinator
(Specialist Palliative Care Team Annual Report)
Additional editing
Julie Watson – Lead Cancer Nurse

Date: July 2022

Report to the Board in Public
Performance and Finance Committee
October 2022

Item: Performance Report	Level of assurance gained: Limited

Performance remains stable with continued pressures;

- Ambulance handover times remain challenged due to the level of crowding in Emergency Department (ED) and no criteria to reside (NCTR), 681 (44%) of ambulances were delayed in September. YAS have increased cohorting and a recovery plan has been revised.
- There were 650 x 12 hour trolley wait breaches in September. The national standard now is the time measured from point of arrival in the department.
- There is on average 233 NCTR and accounted for 3,913 lost beds days which is an increase by 200 from September, and is impeding the acute care provision, and equates to costing the Trust £8m. There has been some discussion with the Local Authority regarding addressing the issue and the Trust is awaiting a plan outlining delivery.
- At the end of September the Trust reported zero 104 week waits, the focus remains to maintaining zero 104 week waits and look at 90 week waits. The Trust will be moved from Tier 1 reporting to Tier 2.
- The Trust achieved 89% of elective activity which is still short of 110% of 19/20.
- The Trust's total waiting list volume (WLV) has reduced. At the end of September 2022, the position was 69,842 down 2,013 on last month.

Item: Financial Report & CRES Delivery 2022/23	Level of assurance gained: Limited

The Trust are reporting a deficit of £0.3m at month 6 which is £1.1m away from plan which is mainly driven by unidentified CRES and the additional resources to manage NCTR patients.

- There is a risk on the elective recovery income if NHSEI enact clawback for not achieving the 110% target on elective activity.
- CRES delivery is slow and there is a £1.4m shortfall, we are forecast to achieve 96% by the end of the year with £4.7m of identified CRES being non-recurrent.
- No further funding will be received towards the pay award which is a £1m cost pressure.
- The Salix grant income is not expected to happen until 2023/24. This does not affect the Trust reported performance position.
- There are shortfalls in income on Catering and Car Parking due to still being below pre-covid levels.
- There is an unidentified expenditure risk of £5.9m which is broken down into 6 areas.
- The trusts cash position remains healthy.

The following reports were shared for information:

- Procurement Strategy, the committee agreed the strategy was moving the correct direction and would like updates on progress.
- Board Assurance Framework, the committee agreed the recommendation and that there were no changes.
- Capital Resource Allocation Committee Minutes

The following contracts were approved;

- Contract recommendation paper for supply of insulin pumps
- Contract recommendation paper for the supply of CPAP machines and masks

Agenda Item		**Meeting**	**Trust Board**	**Meeting Date**	**8 November 2022**
Title	Tier One Elective Recovery – Board Self-Certification				
Lead Director	Ellen Ryabov – Chief Operating Officer				
Author	Julia Mizon – Deputy Chief Operating Officer (Elective Recovery & Cancer)				
Report previously considered by (date)	Not applicable				

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:

NHSE wrote to Tier One and Tier Two Trust Chairs and Chief Executives on 25 October 2022 setting out the immediate next steps to ensure that the delivery of zero 78+ week long wait patients is achieved, and that +62-day cancer waits achieve the agreed trajectory (130 for HUTH), by 31 March 2023.

A Board self-certification process was introduced in that letter, which must be signed by the Chair and Chief Executive and submitted to NHSE by 11 November 2022. A copy of the evidence to support the self-certification against the 12 dimensions is attached.

There are 8 dimensions where the Trust is rated Green and 4 dimensions rated Amber; there are identified actions to address gaps in evidence in relation to each of these

The Trust Board is asked to approve the attached self-certification for signature by the Chair and Chief Executive.

To: NHS Trust and Foundation Trust chief executives and chairs

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

25 October 2022

Dear colleague,

Next steps on elective care for Tier One and Tier Two providers

On 18 October, NHS England wrote to the NHS outlining further plans to boost capacity and resilience for services over the coming challenging winter period. This letter now sets out immediate next steps for tier one and tier two of the elective recovery programme to ensure that our phase two objectives around 78 week waiters and 62 day cancer waits are met.

The NHS has delivered a massive reduction in patients waiting two years and is also now steadily reducing the number of people waiting more than 18 months and 62 days respectively. Activity levels compared to pre-pandemic are increasing but we can still do more. There is no one silver bullet, but through a combination of getting the basics right and data-led management and innovation, particularly on outpatient and diagnostic activity, we firmly believe that we can continue to make genuine progress.

We realise that there are a lot of asks on providers and that each of you will know best your local circumstances and what works well. However, through each wave of Covid over the past two years, hospitals have got better and better at protecting elective and cancer care. There are significant learnings from individual organisations across the country that can make a huge difference if adopted collectively. That is why we are now asking all colleagues to step up efforts on all of the measures outlined below. With this in mind, we ask that you complete the Board self certification, (see appendix A) to allow us to support you where you are having the greatest challenges. The fundamentals that we have, collectively, proven to work are:

Excellence in the Fundamentals of Waiting List Management

Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance. All patients past 62 days for cancer and 78

weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.

Validation

The validation and review of patients on a non-admitted waiting list is important for the appropriate use of outpatient capacity and to provide clean visible waiting lists to ensure timely and orderly access to care. There are three phases to validating waiting lists that providers are required to undertake routinely – technical, administration and clinical and, following on from guidance sent out on 16 August available here, we expect providers to meet this timeline:

a) By 23rd December 2022
   Any patient waiting over 52 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

b) By 24th February 2023
   Any patient waiting over 26 weeks on an RTT pathway (at 31 March 2023) who has not been validated* in the previous 12 weeks should be contacted

c) By 28th April 2023
   Any patient waiting over 12 weeks on an RTT pathway (at 20 April 2023) who has not been validated* in the previous 12 weeks should be contacted

Appropriate surgical and diagnostic prioritisation

We know that 85% of patients waiting longer than 62 days from their referral for urgent suspected cancer are waiting for a diagnostic test. For cancer in particular, the significant demand for additional diagnostic capacity means that Trusts need to adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway, but should at all times have a maximum backstop timeframe of 10 days from referral to report. Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.

Trusts should ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single PTLs across the system. Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved, and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity.

Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July, providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.

Cancer pathway re-design for Lower GI, Skin and Prostate

There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally.

Lower GI: Full Implementation of FIT in the 2ww pathway

As set out in the joint guidance on FIT issued by the British Society of Gastroenterology and Association of Coloproctology of Great Britain and Ireland (ACPGBI), and reinforced in this letter, most patients with suspected colorectal cancer symptoms but a FIT of fHb <10 µg Hb/g, a normal full blood count, and no ongoing clinical concerns should not be referred on a LGI urgent cancer pathway. Where referred, teams should not automatically offer endoscopic investigation but consider alternative, non two week wait, pathways as set out in the letter.

Full implementation of teledermatology in the suspected skin cancer pathway

All Trusts should work with their ICS to implement teledermatology and digital referral platforms to optimise suspected skin cancer pathways and reduce unnecessary hospital attendances to tackle the backlog and meet increasing demand. NHS England's guidance on the implementation of teledermatology pathways is endorsed by the British Association of Dermatologists and supports a Best Practice Timed Pathway for skin cancer which has been published this week.

Implementation will require provision for dermoscopic images to be taken for Urgent Suspected Cancer Skin cancers. This could be delivered by primary care, a separately contracted service delivered by primary care, in a community image taking hub setting, or by medical illustration departments in secondary care. Capacity must be in place for daily dermatologist triage of images, as either additional activity or as part of existing job plans. Following triage, the consultant or a member of their team should communicate with the patient (via telephone, video or face-to-face consultation) and be booked directly for surgery and receive appropriate preoperative advice and counselling if required.

Full implementation of the Best Practice Timed Pathway for prostate cancer
All provider Trusts should implement the national 28-day Best Practice Timed Pathway for prostate cancer, centred on the use of multiparametric MRI (mpMRI) before biopsy. Using pre-biopsy mpMRI means patients can be triaged towards a biopsy so at least 25% can avoid it, over 90% of significant cancers can be diagnosed on imaging and fewer insignificant cancers are diagnosed. Use of local anaesthetic transperineal biopsy where clinically indicated provides increased accuracy and reduced risk of infection, without the resource intensity of procedures done under general anaesthetic.

Implementation will require all patients to be booked in for both mpMRI and biopsy at the point of triage, with triage taking place no later than 3 days from the date the referral is received. Ring-fenced mpMRI slots should be in place – weekly demand analysis from radiology requesting systems should be used to inform the level at which this is set, with frequency of mpMRI slots sufficient to support delivery of timely biopsy. Maximum use of local anaesthetic transperineal prostate biopsy should also be ensured, with general anaesthetic biopsy used only where clinically indicated or for patient preference. Pre-biopsy mpMRI and biopsy procedures should take place no later than 9 days from the date the referral is received.

Outpatient transformation
Outpatients make up around 80% of the total waiting list and it is crucial that, over the winter period, providers continue to keep a strong operational focus on providing these services. Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.

a) As part of this, trusts are asked to continue the expansion of patient initiated follow up (PIFU) to all major outpatient specialties, especially increasing the volume of PIFU activity in specialties where it is now well established.
b) Continue to deliver at least 16 specialist advice requests per 100 first outpatient appointments. Providers are asked to focus efforts on pre-referral advice models.
c) Further initiatives to support outpatient follow-up (OPFU) reduction should also include improved and standardised discharge procedures and more effective administrative processes – including focusing on reducing DNAs in outpatient settings
d) In order to enable a personalised approach for outpatients and where it is clinically appropriate to do so, outpatient appointments should continue to be delivered via video and telephone, at a rate of 25% of all outpatient appointments. Remote consultation guidance and implementation materials can be found on NHS Futures here.

Surgical and theatre productivity

It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter. As such we expect providers to:

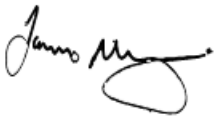
a) Review the senior responsible officer(s) (SROs) and oversight arrangements in relation to theatre productivity and strengthen these if necessary. Ideally, it should consist of a senior manager working ‘shoulder-to-shoulder’ with a senior clinician – to succeed we need both groups working together.
b) Drive up theatre utilisation to 85%, underpinned by the cases per list standards set out within the GIRFT high volume low complexity (HVLC) programme.
c) Make elective surgery daycase by default, delivering daycase rates across all surgery of 85%, and helping to free up valuable inpatient beds for complex work.
d) Maximise Right procedure right place, taking simple surgical procedures out of theatre into procedure rooms, eg hand surgery, cyctoscopy, hysteroscopy
e) Adopt best practice pre & peri-operative medicine pathways to reduce issues of under booking of lists, on the day cancellations, and pro-longed length of stay, as well as providing better care for patients.
f) Optimise the booking & scheduling processes, ensuring that patients are ready for surgery prior to being offered a surgery date, with an embedded data driven, clinically led approach.
g) Not performing those interventions identified as ‘must not do’ on EBI lists 1 and 2 and following the stated process for those List 1 and 2 interventions that should only be performed after applying the specific criteria.

Board Self-certification

As part of the above priorities, we are asking each provider to undertake a Board self certification process and have it signed off by Trust Chairs and CEOs by November 11, 2022. If you are unable to complete the self certification process then please could you discuss next steps with your Regional team. The details of this self certification can be found at Appendix A.

Thank you for all of your continued hard work in addressing what are two critical priorities for the NHS over the winter period. Please share this letter with your Board, key clinical and operational teams and relevant committees, and do email england.electiveopsanddelivery@nhs.net should you have any questions.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Elective Recovery Self certification **Appendix A**

The Chair and CEO are asked to confirm that the Board:

a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.

b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.

c) Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.

d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.

e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.

f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.

g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.

h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.

i) Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.

j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.

k) Confirm your SROs for theatre productivity.

l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.

Signed by CEO Date:

Signed by Chair Date:

Tier 1 and Tier 2 Elective Recovery Programme
Board Self-certification

02/11/2022

The Chair and CEO are asked to confirm that the Board:

Indicator	Action	Assurance	Operational Lead	SRO	Assurance RAG
a)	Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.	Ellen Ryabov, Chief Operating Officer is the Executive Director supported by Julia Mizon, Deputy Chief Operating Officer (Elective Recovery and Cancer)	Deputy COO	Chief Operating Officer	**Green**
b)	That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.	Monthly Performance and Finance Report Trust Board Performance Report Integrated Performance Report - Making Data Count SpC Additionally, the NEDs receive a weekly Flash Report related to key operational delivery metrics	Deputy COO	Chief Operating Officer	**Green**
c)	Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.	Internal milestones to reduce RTT 80w waits by end of December 2022 and reduce 70w by end of March 2023 to achieve zero +78 week waits by 31 March 2023. Monthly trajectory to recover 62 day Cancer to a maximum of 130 by end of March 2023. Mutual aid programme in place with providers within and outwith the HNY ICS. Outsourcing to Independent Sector providers. Insourcing in place to create additional capacity Information/assurance provided to NHSE National and Regional Leads at Tier One meetings every 2/52	Deputy COO	Chief Operating Officer	**Green**

Indicator	Action	Assurance	Operational Lead	SRO	Assurance RAG
d)	Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.	The monthly report to the Performance and Finance Committee outlines the monthly Cancer Waiting Times (CWT) performance; the report will be amended to specifically highlight the performance of Lower GI, Skin and Prostrate cancer pathways (November 2022). Additionally, CWT performance is considered through 2/52 Performance and Activity meetings. The Trust has available: a) BI FiT dashboard which provides the proportion of patients who are FiT negative or no FiT, who have an endoscopic investigation; b) MRI demand and capacity analysis for prostate pathway is planned in the Trust's Cancer Transformation Programme (improvement 1/2 day scheduled 10 November 2022) and c) the Trust does not have a mechanism in place to determine the proportion of urgent skin referrals avoided by the use of dermoscopic quality images. Dermatoscopes were provided to all GP practices across Hull and East Riding through a partnership with CCGs, however, not all practices have chosen to use them. The Trust will continue to work with the Cancer Alliance to improve use in primary care; we have a service/structure established to receive, triage and respond to images provided as part of an 2WW referral.	Trust Lead Cancer Manager	Deputy COO	**Amber**
e)	Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.	Through the Trust Outpatient Transformation Forum which reports to Trust Elective Recovery Group - a work plan has been established to achieve the expected goals of the Operational Plan. The Performance Delivery structure within the Trust oversees the progress at speciality and Health Group level. Presentation to the Performance and Finance Committee (May 2022) and the Performance and Efficiency Board. The Trust has taken part in the NHS Outpatient Benchmarking and the final report will be presented at the Elective Recovery Group (November 2022). NHS Futures and the National Outpatient networks, GIRFT and Model Hospital all provide useful tools by which to measure and guide improvement/transformation. Key clinicians have joined Northern and Yorkshire Clinical PIFU events e.g. Rheumatology, Urology, Endocrinology and Gynaecology	Head of Outpatient Services	Deputy COO	**Green**

Indicator	Action	Assurance	Operational Lead	SRO	Assurance RAG
f)	Have received a report on Super September and have reviewed the impact of this initiative for their Organisation.	The Trust adopted Outstanding October to focus on outpatient transformation . A final report will be presented via Elective Recovery Group and will report to the Performance and Finance Committee (December 2022).	Head of Outpatient Services	Deputy COO	**Green**
g)	Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.	Source Group (commissioned February 2022 & complete June 2022) a full validation of the RTT PTL. 6.5% removal rate - second lowest PTL removal rate that Source Group had experienced. IST Visit (May 2022) - exemplary systems and processes; no actions required. Text message validation to patients commenced in July 2022. As at October 2022, 27,000 patients contacted with a 6.7% removal rate. Validation Opportunity BI report in place with weekly management of any potential data quality errors. These are reported through to the Performance and Finance Committee and the Trust Board in regular reports.	Assistant Director of Operations	Deputy COO	**Green**
h)	Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.	All patients on the Trust's elective waiting list have a Prioritisation code. Weekly scrutiny of P2 performance to achieve 70% treated within 4 weeks, diagnostic wait times reports to the Performance and Finance Committee, through to the Trust Board. NHSE Regional Medical Director review of P2 prioritisation (May 2022) - assurance provided. Diagnostic turnaround times are discussed in multiple forums including an executive led performance meeting relating to both elective and cancer recovery. In addition to this, there is a specific performance meeting to discuss CT as a speciality in it's own right and diagnostic imaging turnaround times are reviewed. Each of these meetings have an action tracker which is reviewed regularly.	Deputy COO	Chief Operating Officer	**Green**

Indicator	Action	Assurance	Operational Lead	SRO	Assurance RAG
i)	Discuss theatre productivity at every trust board; we suggest with the support of a non-executive director to act as a sponsor.	The Integrated Performance Report - Making Data Count SpC which is presented to the Trust Board includes metrics related to theatre productivity. Theatre productivity metrics will be added to the monthly Performance and Finance Committee and weekly NEDs Flash Report (November 2022). Mike Robson, NED/Chair of Performance and Finance will be the nominated sponsor.	Deputy COO	Chief Operating Officer	**Amber**
j)	Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.	The Integrated Performance Report - Making Data Count SpC which is presented to the Trust Board includes metrics related to theatre productivity. Theatre productivity metrics will be added to the monthly Performance and Finance Committee and weekly NEDs Flash Report (November 2022). Theatre utilisation and Model Health productivity data reviewed at fortnightly (Top 12) Specialty Recovery Meeting. Actions in place to improve to a minimum of 85% in-session theatre utilisation	Operations Director - Surgery HG	Deputy COO	**Green**
k)	Confirm your SROs for theatre productivity.	Julia Mizon, Deputy Chief Operating Officer (Elective Recovery & Cancer) and Kartikae Grover, Associate Chief Medical Officer, Lead for GIRFT (Clinical Lead Breast Surgery/Consultant Breast Surgeon)	Operations Director - Surgery HG	Deputy COO & Associate Chief Medical Officer	**Green**
l)	Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.	The Integrated Performance Report - Making Data Count SpC which is presented to the Trust Board includes metrics related to diagnostic service delivery. Trajectories and action plans in place for 7 key diagnostic modalities and shared across the ICS for all 4 providers. Aim to achieve 5% standard by March 2025 in 6 of the 7 modalities (CT to reduce to 10%). Staffing concerns are the rate limiting factor in terms of imaging diagnostics, despite these challenges we seek solutions including mutual aid support, outsourcing opportunities and exploration of international recruitment. There is also a commitment to utilise mobile vans to work towards achieving at least the minimum optimal utilisation standards.	Operations Director - Clinical Support HG	Deputy COO	**Amber**

Signed by CEO		Date	11th November 2022

Indicator	Action	Assurance	Operational Lead	SRO	Assurance RAG
	Signed by Chair		Date	11th November 2022	