Trust Board in Public
Tuesday 14 March 2023
The Boardroom, Alderson House, HRI

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 14 February 2023** 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	09.30	Attached
	6.2 CQC Update Suzanne Rostron, Director of Quality Governance	Assurance		Attached
	6.3 Audit Committee Summary February 2022 Mike Robson, Non-Executive Director	Assurance		Attached
	6.4 Board Assurance Framework – Q3 Suzanne Rostron, Director of Quality Governance	Approval		Attached
	Strategy			
7	**7.1 - Operating Plan Update** Michelle Cady, Director of Strategy and Planning	Approval	09.50	Attached
	Quality			
8	**8.1 Quality Report** Jo Ledger, Acting Chief Nurse/Makani Purva, Chief Medical Officer/Suzanne Rostron, Director of Quality Governance	Assurance	10.05	Attached
	8.2 Maternity Update Lorraine Cooper, Head of Midwifery	Assurance		Attached

	8.3 Patient Safety Incident Response Plan Suzanne Rostron, Director of Quality Governance	Approval		Attached
	8.4 Summary from the Quality Committee Una Macleod, Non-Executive Director	Assurance		Attached
	Break		10.30	
	Workforce			
9	**9.1 Our People Report** Simon Nearney, Director of Workforce and OD	Assurance	10.40	Verbal
	9.2 Staff Survey 2022/23 Simon Nearney, Director of Workforce and OD	Assurance		Attached
	9.3 Gender Pay Gap Report Simon Nearney, Director of Workforce and OD	Approval		Attached
	9.4 Freedom to Speak Up Report Fran Moverley, Head of Freedom to Speak Up	Assurance		Attached
	9.5 Guardian of Safe Working Report Mahmoud Loubani, Guardian of Safe Working	Assurance		Attached
	Performance			
10	**Performance Report** Ellen Ryabov, Chief Operating Officer **10.1 Finance Report** Lee Bond, Chief Financial Officer **10.2 Charitable Funds Summary** Tony Curry, Chair Charitable Funds Committee	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
11	**Questions from the public relating to today's agenda** Sean Lyons, Chair		12.00	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 9 May 2023, 9am – 11am			

Attendance 2022/23

Name	10/5	16/06	12/07	03/08	13/09	11/10	08/11	14/2	14/03	Total
Sean Lyons	✓	✓	✓	✓	✓	✓	✓	✓		8/8
S Hall	✓	✓	✓	✓	✓	✓	✓	x		7/8
T Christmas	✓	✓	✓	x	x	✓	✓	✓		6/8
T Curry	✓	x	✓	✓	✓	✓	✓	✓		7/8
U MacLeod	x	✓	✓	✓	✓	✓	✓	✓		7/8
M Robson	✓	✓	✓	✓	✓	✓	✓	✓		8/8
L Jackson	x	x	x	✓	x	✓	✓	✓		4/8
A Pathak	x	✓	✓	✓	✓	x	✓	✓		6/8
D Hughes	✓	✓	x	✓	✓	✓	✓	✓		7/8
C Long	✓	✓	✓	✓	x	✓	✓	✓		7/8
L Bond	✓	✓	✓	✓	✓	x	✓	✓		7/8
M Purva	✓	x	✓	✓	✓	✓	✓	✓		7/8
J Ledger	✓	✓	✓	✓	x	✓	✓	✓		7/8
S Nearney	✓	✓	✓	✓	✓	✓	✓	x		7/8
E Ryabov	✓	✓	x	✓	✓	x	✓	✓		6/8
M Cady	✓	✓	✓	✓	✓	x	✓	✓		7/8
S Rostron	✓	✓	✓	✓	✓	✓	✓	✓		8/8
S McMahon	✓	x	✓	✓	✓	✓	✓	✓		7/8
R Thompson	✓	✓	✓	✓	✓	✓	✓	✓		8/8

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
Held on 14 February 2023

Present:	Mr S Lyons	Chairman
	Dr A Pathak	Associate Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Ms J Mizon	Deputy Chief Operating Officer
	Mr M Robson	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mrs M Cady	Director of Strategy and Planning
	Mrs S McMahon	Joint Chief Information Officer
	Mrs S Rostron	Director of Quality Governance
	Dr D Hughes	Non-Executive Director
	Mrs H Knowles	Head of HR
	Mrs J Ledger	Chief Nurse
	Prof M Purva	Chief Medical Officer
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
In Attendance:	Mrs Rudston	Assistant Chief Nurse
	Mrs G Johnson	Director of Infection Prevention and Control
	Ms J Haslam	Clinical Fellow
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies:** Apologies were received from Mr S Nearney, Director of Workforce and OD and Mr S Hall, Vice Chair	
2	**Chair's Opening Remarks** The Chairman welcomed everyone 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 meetings held on:** **8 November 2022** The minutes were approved as an accurate record of the meeting. **14 November 2022** The minutes were approved as an accurate record of the meeting. **25 January 2023** Mrs Ledger to be added to the attendance. Following this change the minutes were approved as an accurate record of the meeting.	

4.2 Board Work Programme
Mrs Thompson advised that the Board Work Programme would be updated for the next meeting to include some job title changes.

4.3 Board Development Framework
Mrs Thompson had updated the Board Development Framework and a further discussion regarding emerging issues would take place after the Joint Board meeting on 28 February 2023.

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

4.5 Action Tracker
Mrs Thompson advised that Under Graduate Education had been added to the Board Work Programme for September 2023 for an annual review.

5 Patient Story
Prof Purva presented two patient stories regarding ED waiting times and staffing issues. There were a number of issues raised by the patients including incorrect wearing of facemasks, long waits, being talked down to and poor communication.

Prof Purva advised that since the incidents had taken place a number of actions had been implements in ED. These included training on the correct way to wear a facemask, using the patient videos as training aids for staff, a tannoy system being installed and new chairs being ordered. There was also a RAT doctor at the front end with a escalation doctor and nurse in place.

Dr Patak advised that communicating with patients who were facing long waits was key to inform them why their pathway was delayed. Prof Purva agreed but added that when the system was overwhelmed it did not perform as effectively. Mr Robson agreed and added that no communication made patients more insecure and anxious.

Mr Bond asked if there had been any increase in costs due to the new RAT doctor and escalation staff and Mrs Ledger advised that it was all within budget and new ways of working had been introduced.

The Board discussed the pressure being the new normal and Mrs Rostron advised that as part of the Quality Strategy assurance visits would be programmed in. Mrs Ledger added that staff were so busy they were very task orientated to see as many patients as possible. Mr Curry asked if the staffing levels were correct and Prof Purva advised that it was not just the amount of staff in the department that was important but how they worked. Mr Long added that the Trust was limited as to how it used Junior Doctors after hours.

Mrs McMahon spoke about a service excellence programme in Canada where creating a positive experience for patients was the goal. She advised that this changed cultures and how staff treated patients. Mrs Rostron asked Mrs McMahon to share the details of the programme to see how it fitted with the Human Factors programme currently being ran within the Trust. **SMc/SR**

Prof Macloed was concerned that bad stories regarding the NHS were drowning out the good practice and how detrimental this was to staff.

Mr Lyons stated that there was a lot to do and the CQC action plan would inform some of the work. He added that it was important not to just manage actions plans but carry on with innovative changes also.

6.1 CEO Report/Covid Update
Mr Long advised that the Trust was successful in securing £3.6m and a new 60 bedded ward block was being built. This would be completed by April 2023. He added that a UTC type facility was in the plans to help the flow through the hospital.

Mr Bond advised that there was no confirmed capital allocation at this time but any allocations would need to be worked through with PLACE partners.

6.2 CQC Update
Mrs Rostron updated the Board regarding the factual accuracy checks that were being carried out following receipt of the draft CQC report. She advised that the full report would be shared with the Board when the final version was available.

Mrs Rostron reported that the Quality Committee would monitor the actions and there would be an owner for each area. Mrs Jackson suggested actions be shared between other assurance committees to stop the Quality Committee becoming overwhelmed.

Action: The Board to decide how progress against the action plans are presented and assurance received at the Board. **SL/SR**

6.3 Standing Orders
Mrs Thompson presented the report and highlighted the use of the Trust Seal and a change to the Standing Financial Instructions (SFI).

The change to SFIs was to allow the Director of Procurement to sign contracts up to £100k.

Resolved: The Board approved the use of the Trust Seal and the change to SFIs.

6.4 Audit Committee Summary
Mrs Christmas presented the Audit Committee summary and highlighted audits relating to the Data Security Toolkit and Safeguarding review. Both audits had actions in place.

The Committee also discussed the HFMA self-certification and the actions being monitored at the Committee to ensure all processes were robust. Mr Bond added that the culture of finance had changed since the pandemic and some grip had been lost so the self-assessment action plans would help for the future.

7 Collaborative of Acute Providers CIC TOR, HNY CAP Operating Model, HNY CAP Working Arrangements

Mr Long presented the report and advised that the documents represented the governance arrangements for the 4 trusts as part of the collaborative. A formal committees in common process had been agreed and the terms of reference presented. There was more work to do but the 4 Boards were being asked to approve the approach.

There was a discussion around the ICB Board and how the CIC would become a sub-committee of that Board. Mr Bond asked how the CAP and the PLACE would work together and Mr Long advised that PLACE would be primarily concentrating on primary care and mental health and the CAP would concentrate on the acute. Mrs Cady added that the Hull and ER PLACEs would be focussing on health inequalities, primary care, housing and other social issues.

Resolved: The Board approved the direction of travel.

8 8.1 Quality Report

Mrs Rostron presented the report and advised that the PSIRF planning was developing and required ICB approval. She added that the Human Factors Hub would be launched on 1 April 2023 which would be a good place for improvement actions for patients and staff.

Prof Purva informed the Board that there had been an issue with repeat wrong eye injections due to the checklist not being embedded. An action plan was in place and patients were now being marked appropriately.

Mrs Ledger advised that there was a robust action plan in place for patient falls as there had been an increase in falls as well as patients falling a number of times. A number of Falls Champions were in place and were being supported by the Quality Improvement leads.

Mrs Ledger also reported that there had been an increase in pressure ulcers in ED and surgical wards which was not common. A review of good performing wards was being undertaken to highlight good practice to share.

Prof Purva advised that the SHMI was continuing to reduce and that the Trust was no longer an outlier. The Mortality and Morbity Committee continues to monitor the SHMI. Prof Purva stated that the HSMR would hopefully start to mirror this trend. The Trust was still an outlier regarding sepsis but there had been a number of improvements including use of the sepsis online tool. Mr Bond congratulated Prof Purva on the hard work she and the teams had put in to reduce the SHMI.

There had been significant improvement in the complaints service to clear the backlogs and Mrs Rostron advised that once these were clear, themes would be identified for learning purposes.

Mrs Rostron advised that the next QSIR programme had commenced and was fully subscribed. A 2nd celebration event would show what we do well.

8.2 Infection Prevention and Control BAF
Mrs Johnson advised that a new nationally updated IPC BAF was out for consultation and would be published towards the end of March 2023. Mrs Johnson advised that the Trust would move onto the new template and present it to the Board for assurance.

8.3 Mental Health, Learning Difficulties and Autism Strategy
Ms Rudston joined the Board to provide assurance around the work ongoing with the Mental Health, Learning Difficulties and Autism Strategy and added that the work was in collaboration with Humber FT.

Ms Rudston advised that some good improvements had been made which included a training plan for restraint and interventions, business intelligence reports and consultant LD champion interest.

Work was also ongoing regarding suicide prevention linked to long term conditions, children and young people and eating disorders and strengthening governance structures and electronic systems.

Workforce development and training plans were being developed as were environmental considerations such as access and signage.

Dr Pathak asked about 7 day services and how resources were directed. Ms Rudston responded stating that all staff should be able to deliver high quality care to anyone with disabilities.

8.4 Quality Committee Summary
Dr Hughes presented the summary and advised that the SNAPP data status was being rated at B which was the second best category and that Stroke SHMI was coming down.

Dr Hughes also highlighted that a series of quality improvement initiatives had been implemented since the last Trust Board and the patient story relating to delays in death certification.

TARN had presented a risk relating to data uploads for the major trauma service. There has been a number of people off sick and this has caused significant commissioning implications.

9 **9.1 Our People Report**
Mrs Knowles advised that the Trust was monitoring the potential industrial action for Junior Doctors for a 72 hour walk out. Emergency planning was taking place so that emergency care would be provided during the strike.

Mrs Knowles advised that the Staff Survey had been received but many of the indicators were lower.

Specific TRIM training had been rolled out. TRIM trained staff could be called to a number of areas to give support to staff.

The Trust had offered 862 Apprenticeships since May 2013.

The LGBTQ+ network was launching the NHS rainbow badge as part of LGBTQ+ history month. Mrs Knowles advised that the LGBTQ+ and disability networks have asked to be involved in the planning stages of new builds on the hospital sites. This would ensure, for example, that appropriate access and toilet facilities were in place.

The Board discussed a discrepancy regarding the nursing figures in the Workforce report compared with the Chief Nurse staffing report. Mrs Ledger advised that this was a timing issue and the also included the 77 international nurses at Band 5 that were not yet registered.

Mrs Ledger advised that the actual figure was 4.7% which was positive.

Mr Bond asked if the flu vaccination uptake would b a CQUIN next year and Mrs Knowles advised that this was being reviewed.

Mr Bond also asked if there was a risk that the £2.6m for the Apprentice Levy would be lost if not used and Mrs Knowles agreed to provide Mr Bond with the information. **HK/LB**

Mr Bond asked if the OD programmes had effectiveness reviews and Mrs Knowles reported that their effectiveness was reviewed at the Workforce, Education and Culture Committee.

9.2 Summary from WECC

Prof Macleod advised that the meeting had been postponed due to quoracy.

At the last meeting updates were received from the Guardian of Safe Working, nurse staffing, LGBTQ+ network chair and information relating to national awards.

Mr Long highlighted an issue with Junior Doctor fines and inappropriate use of the funds. This matter had been dealt with and closed.

10 Performance Report

Mrs Mizon presented the report and advised that the Ambulance position was still deteriorating and lodged patients were hindering flow.

Cancer performance was improving slightly and 274 patients had waited over 63 days against a trajectory of 200. The trajectory reduces to 120 by March 2024.

There have been improvements for the 4 major tumour sites and the PTL was now 1200.

The Trust was off trajectory for 78 week waits, this was due to cancellations of elective and cancer plans.

Dr Pathak asked about Gynae cancer and Mrs Mizon advised that there was a huge amount of work being carried out relating to histopathology working closely with SYHPS. It was agreed that an

update would be received at the Performance and Finance Committee.

The Board discussed the national ED performance and asked why the Trust was not improving. Mrs Ryabov advised that the Trust only reports type 1 activity and other Trusts report all activity. The national figure for type 1 is 45%.

10.1 Finance Report
Mr Bond presented the Month 9 position and advised that the Trust would meet its financial target this year although the underlying deficit had increased to £56m from £43m.

Mr Lyons asked about the gap in productivity and Mr Bond advised that elective theatres were still facing challenges with productivity and the Trust was doing too many outpatient follow ups. Mrs Mizon added that theatre utilisation only incorporated elective lists and a piece of work was being carried out to address the issues.

10.1.1 Procurement Business Case
Mr Bond presented the Procurement Business Case and highlighted the sizeable investment required but also the good return. He added that the programme would be managed collaboratively within the ICS.

The Performance and Finance Committee and CAP Board had endorsed the business case previously. Mrs Christmas added that the Director of Procurement would be attending the Audit Committee in February to give an update on progress so far.

Resolved: The Board approved the Procurement Business Case.

10.2 Charitable Funds Summary
Mr Curry presented the summary from the Charitable Funds Committee. He advised that the Committee signed off the annual accounts and made some alterations to the Terms of Reference.

10.3 PAF Summary
Mr Robson presented the summary and advised that the Committee had received presentations from Emergency Care and Outpatients. He advised that the report was still showing limited assurance due to the performance issues and underlying financial position, although the Trust was still forecasting a break-even financial position by the end of March 2023.

11 Questions from the Public
There were no questions received.

12 Chairman's summary of the meeting

13 Any Other Business
Mr Lyons thanked Dr Hughes on behalf of the Board for the work that he had done for the Trust. It was Dr Hughes' last Board meeting and Mr Lyons was grateful for his wise advice and support.

Dr Hughes thanked the Board for making him feel welcome during his time at the Trust and stated that it had been an honour working with everyone.

14 Date and time of the next meeting:
Tuesday 14 March 2023, 9am – 11am

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	Director 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
Under Graduate Education	Director of Workforce and OD							✓		Annually	To provide assurance to the Board regarding the programme	Workforce, Education and Culture Committee	So that the Board have sight of Under Graduate Education and any new developments	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 2023

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
February 2023									Freedom to Speak Up
April 2023	Trust Strategy								Board Assurance Framework
June 2023				BAF 3.2: Patient Harm/Recovery	BAF 4: Risks to recovery plan				
August 2023		BAF 1: Board Leadership/ Leadership and culture						BAF 7: Financial sustainability	Staff Survey
October 2023			BAF 2: Staffing			BAF 5: ICS			
December 2023				BAF 3.1: High Quality Care			BAF 6: Research and Innovation		

Other topics for discussion:

- **Group Model**
- **CQC**
- **Winter Pressures**
- **Quality Improvements (Deep Dives)**
- **Performance issues**

Principles for the Board Development Framework

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

Overarching aim:

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

Area 1 – High Performing Board

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

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

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

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

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

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

Area 2 – Strategy Development
Strategy refresh commenced

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

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

Area 3 – Looking Outward/Board education

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

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

Area 4 – Deep Dive and exceptions

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

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

Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (March 2023)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
February 2023						
01/02	Patient Story	Mrs McMahon to share details of the service excellence programme used in Canada	SMc	March 2023		
02/02	CQC Update	CQC assurance reports to be received at the Board – format to be agreed	SR	March 2023		
03/02	Our People Report	Clarity regarding the £2.6m apprentice levy and whether it is lost if not used	HK/SN	March 2023		
COMPLETED						

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
December 2022	Patient Story	Death Certificate patient story – follow up report to the Quality Committee	MP	December 2023		Completed

Hull University Teaching Hospitals NHS Trust

Trust Board

14th March 2023

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:	Industrial action, safety champions, just culture, apprenticeships award	

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 14 March 2023

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 FEBRUARY 2023

COMPASSIONATE CARE

Industrial action
Clinical and non-clinical staff at all levels have been involved in helping us plan for the junior doctors' strike action in March.

Patient safety and the maintenance of essential services, such as emergency and critical care, will be of utmost importance throughout these periods, but we are also working to try and minimise the impact which industrial action has on our patients as far as planned care and elective procedures are concerned.

Due to the scale and extended nature of the action by junior doctors, we will be asking some staff such as consultants, AHPs, ACPs and specialist nurses to work differently in order to help us maintain safety and quality of care. This may mean working in a different area or department to help support patient flow, or using your skills in a different way.

To enable us to continue providing essential services such as emergency and intensive care, we have asked suitably skilled and experienced clinical staff such as advanced clinical practitioners and specialist nurses to support in key departments. Regrettably, in order to redeploy staff, this does mean we have rescheduled some routine outpatient appointments and non-urgent procedures which were due to take place. We will be in touch directly with anyone affected to provide further details and we will seek to rebook those appointments as soon as possible.

In addition, the Trust's Gold Command group has recommended that all non-essential meetings be cancelled from 13th March up to and including 16th March, as there is likely to be a focus on recovery work required immediately after the strike period has ended.

Patient safety champions
As part of the trust Quality Strategy to continually improve patient safety, the Trust is introducing a network of 'Patient Safety Champions'.

Anyone at the Trust who is interested in becoming a Patient Safety Champion is welcomed to ensure representation across the organisation.

Patient Safety Champions will:

- Act as a conduit to communicate key patient safety messages, promote sharing learning and good news stories and identify areas for improvement in their department/ward and within the wider organisation
- Hold safety huddles in your area to share learning
- Participate in after actions reviews, debriefs, swarm huddles in your area
- Develop strong relationships and promote a positive just culture to support the delivery of the safest care possible
- Promote incident reporting as a way to learn
- Be part of identifying and implementing patient safety improvements
- Be a point of contact for the Patient Safety Team
- Attend quarterly briefings and learning events

Each Patient Safety Champion will: complete Health Education England 'Patient Safety Syllabus' e-learning modules; be signposted to training packages on Human Factors *(coming soon)* and systems based approaches to patient safety; and access Quality, Service Improvement and Redesign (QSIR) Fundamentals training.

Staff engaged to help deliver a Just Culture
A Just Culture ensures the fair treatment of staff and promotes a culture of fairness, openness and learning by developing an environment where staff feel confident to speak up when things go wrong, rather than fearing being blamed.

Supporting staff to be open about when errors occur, allows for important lessons to be learnt which in turn will help prevent and reduce the same errors from being repeated.
A Just Culture creates an environment that facilitates both individuals and organisations to learn, heal, grow and thrive.

Staff feedback is vital to understand the current view of the organisation and what needs to improve to develop and support a Just Culture. We have asked all staff to complete a survey to establish a baseline of the current position. This will inform what improvements are needed in order to develop a Just Culture.

Apprenticeship employer of the year
The Trust won Apprenticeship Employer of the Year at the recent Hull College Apprenticeship awards.

The Award ceremony was for 'Future Stars – Apprenticeship Awards 2023' an awards ceremony held in conjunction with Apprenticeship week.

Huge congratulations to our apprenticeship team for all of their hard work, and well done to Emily Shepherdson for winning the Health Apprentice of the year.

ZERO30

Caddies on wards to reduce food waste
Wards and departments are to be issued with food caddies from this week to help us transform the amount of food waste we send to landfill.

Our waste department is transforming the trust's approach to food waste as part of our Zero Thirty campaign to reduce our impact on the environment around us.
Before the introduction of the food caddies, excess food was disposed of through the general waste stream and sent to landfill.

However, this meant it was impossible for us to calculate how much food were wasting, how much it was costing us to process the waste and the amount of harmful emissions the trust was producing caused by rotting food.

The Waste Department is now working with contractor Mitie and other suppliers to roll out the campaign to segregate food waste in wards and departments through the introduction of the caddies, similar to those used by many of us at home.

Now, food waste put into the caddies will be sent to anaerobic digestion sites to be converted into renewable energy, supplied to the National Grid. It will also be used to supply local farmers with crop fertilizer.

2. MEDIA/SOCIAL MEDIA ACTIVITY

In February 2023 there were 31 articles published about the Trust:

- 18 positive (58%)
- 8 neutral (26%)
- 5 negative (16%)

Most negative coverage related to A&E performance and CQC safety concerns regarding emergency care.

Social media

Facebook

Total “reach” for Facebook posts on all Trust pages in February – 223,558

- Hull Women and Children’s Hospital – 55,244
  Castle Hill Hospital – 55,373
- Hull Royal Infirmary – 98,653
- Hull University Teaching Hospitals NHS Trust – 14,288

Twitter @HullHospitals

- 52,200 impressions in February 2023
- 10,779 followers
- Tweets with highest number of impressions related to the use of virtual reality headsets in teaching, appropriate use of A&E, and the portering team being shortlisted for two national awards

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14 March 2023
Title	Care Quality Commission (CQC) Update Report				
Lead Director	Suzanne Rostron – Director of Quality Governance				
Author	Head of Quality Compliance and Patient Experience				
Report previously considered by (date)	Information within this report has also been presented at the Operational Risk and Compliance Subcommittee and the Quality Committee.				

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

Key Recommendations to be considered:

The Trust Board is recommended to:

- Decide whether sufficient assurance has been provided and if any further information is required
- Acknowledge the overdue action

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
CARE QUALITY COMMISSION (CQC) UPDATE REPORT
Prepared for the Trust Board, March 2023

1. PURPOSE

The purpose of this report is to provide the Trust Board with an update against the Trust's response to the letter of intent raising the urgent concerns relating to the Emergency Department from the CQC Inspection in November 2022. Information about the full inspection is also provided.

2. DRAFT REPORT

The draft report was received 02 February 2023 with factual accuracy check completed and submitted by 15 February 2023. The factual accuracy checks were submitted ahead of time with all the supporting evidence.

As reported to the February Board, the draft report highlighted breaches in the regulations that the Trust is required to address as 'must' and 'should' do actions. Some of these concerns were those highlighted in the initial letter of intent regarding the Emergency Department and as part of our initial feedback from this CQC. A number of key improvement work streams are required to address the areas for improvement as follows:

- Assurance mechanisms – need to challenge ourselves on the assurances we receive,
- Training & appraisals
- Theatre work-stream – culture, WHO checklist, controlled drugs/medicines management
- Continuation of ED support & monitoring
- Continuation of Patient Flow & elective recovery work
- Digital health records & information
- Nutrition
- Continuation of complaints improvements
- Consent – particularly for those without capacity
- Mental capacity act/DoLS/Safeguarding
- Governance arrangement in Surgery Health Group – significant support required
- IPC – bare below the elbow, mask wearing, handwashing in ED
- Environmental risk assessments
- Never events learning & prevention
- Local induction arrangements
- Patient experience & engagement, particularly for ED
- Nursing & medical staffing levels
- Continue policy & procedure work for out of date documents

The Safety Oversight Group and Quality Committee have approved the work-streams below to take this work forward.

SROs and Operational leads have been assigned to each work-stream.

Work-stream	Exec Portfolio	Reporting Mechanism
Theatres – culture, WHO checklist, controlled drugs/medicine management, NatSSIPS 2*	Makani Purva	Theatre Steering Group Safety Oversight Group Patient Safety and Clinical Effectiveness Sub-Committee
Emergency Department*	Ellen Ryabov	Safety Oversight Group
Patient Flow/Discharge	Ellen Ryabov	In Hospital Steering Group
Elective Recovery and Cancer	Ellen Ryabov	PANDA
Digital health record and information	Shauna McMahon	Safety Oversight Group
Nutrition	Jo Ledger	Nutrition Steering Group
Complaints/Patient Experience and Engagement	Suzanne Rostron	Complaints Working Group Patient Experience Sub-Committee

Work-stream	Exec Portfolio	Reporting Mechanism
Surgery Health Group Governance	Suzanne Rostron	Operational Risk and Compliance Sub-Committee
Infection Prevention and Control	Jo Ledger	Operational IPC Strategic IPC
Environmental Risk Assessments and COSHH	Suzanne Rostron	Health and Safety Committee Non-Clinical Quality Sub-Committee
Never Events learning and assurance	Suzanne Rostron	Patient Safety and Clinical Effectiveness Sub-Committee
Local induction, training and appraisals	Simon Nearney	Workforce Transformation
Nursing staffing levels	Jo Ledger	Executive Nursing and Midwifery Committee/Workforce, Education and Culture Committee
Medical staffing levels	Makani Purva	Medical Workforce
Policy and procedures	Suzanne Rostron	Operational Risk and Compliance Sub-Committee Health Group Governance

Sessions have also commenced within the Health Groups to share these themes so that they can be incorporated into improvement plans at the earliest opportunity.

The approach will be very much aligned with the Trust Quality Strategy, PSIRF, NatSSIPS 2 using human factors and the established model of improvement for sustainable improvement as opposed to action plan tracking alone. Measures of success will be agreed for each work-stream and each regulatory action.

3. ED ACTION PLAN

Following the unannounced inspection in November 2022, the CQC issues a letter of intent and highlighted urgent concerns against the Emergency Department; the identification and management of deteriorating patients, the inability to demonstrate that fundamental standards of care are being met, management of patients waiting within the department and assessment rooms within the department (ECA) were potentially unsafe for patients with mental health needs.
In response to this, the Trust put an immediate action plan in place, which was shared with the CQC. The CQC confirmed they were satisfied with the Trust's actions to address the urgent concerns.

The ED action plan includes 43 actions and is reviewed at the Weekly Safety Oversight Group and was last updated at the meeting held 13 February 2023. A brief breakdown against the progress of the actions so far is provided in the table below.

Actions completed with evidence of completion provided	37
Implemented with ongoing monitoring	4
Open with further updates required	1
Overdue	1

The overdue action, ED 3.11, is in relation to the implementation of the ground floor model. The intention was to implement this at the end of January. A plan has now been drafted however, the implementation has not yet commenced.

The open action is ED 4.3 and is on track for its completion date of April 2023. This is the dedicated mental health assessment area that will be run by Humber NHS Foundation Trust to provide an improved service for those attending ED requiring mental health assessment as opposed to physical health.

The four actions that have been implemented but require further monitoring prior to being signed off as completed are:

ED1.2: Sepsis training and competencies. Implementation commenced as planned in November 2022. However, sufficient training compliance has not yet been achieved. The competency sign off and training started from a 0% position.

ED3.2: This action was not completed as stated but was implemented on H130. This is remaining under review as part of the gold command meetings

ED4.2: The implementation of the majority of actions commenced immediately, as planned, in November 2022. There have been some delays with suppliers in terms of anti-ligature equipment to enable all actions to be completed in full, however the work has now commenced.

ED5.4: The task and finish group was up and running from December as per the action. It was decided to keep this action under review due to the vast amount of work being undertaken. The reports are received at the Safety Oversight Group.

The full action plan has been previously received, the table below provides the Board with key highlights to note from the delivery of ED action plan since November 2022.

Overview	Actions completed in November 2022	Actions completed in December 2022 and January 2023	Actions completed in February 2023	Variations to plan	Outcomes achieved	Further actions required
ED1: The identification and management of deteriorating patients						
15 out of 16 actions have been completed with evidence of completion provided. The focus for these actions will now be on sustainability and the impact on the outcomes. Should the outcomes not be achieved, practice will be reviewed. The 1 remaining open action will continue to be monitored via the Safety Oversight Group.	• ED Sepsis task and finish group established. • Safety nurse role established • Additional nursing establishment created – registered and non-registered • Review of all cases identified in CQC letter of intent • RAT doctor in ECA commenced • Two hourly ward rounds commenced • NEWS scores visible on screens in department for all patients • Twice weekly bronze meetings including consultant review of improvement plan and exceptions	• Sepsis training and competency sign off is underway for Emergency Department staff • Digital sepsis bundle trialled and implemented • Patients on ambulances of a NEWS score higher than 5 to be moved into the department or have a plan within 30 minutes • SOP updated for escalation of NEWS score 5 or above or 3 in 1 parameter and communicated to the team • Clarification of B8a matron roles in the department and in the site team provided and evidence provided • Daily handover sheets analyses for feedback of where improvements are	• Confirm outstanding competency check requirements for ED staff – 39 staff have received Sepsis training before and after the inspection = 38% compliance. The competency assessment was not in place before the inspection; however, this has been introduced using the RCN competencies, currently at 13.7% compliance with competency checks from a baseline of 0%. The Sepsis Team are now also supporting the ED team to assess the competency quicker	• Established reviews every 2 hours are not always a full Board Rounds depending on patient flow. However, assurance has been obtained that a review of patients is undertaken by the senior nurse and consultant / registrar as a minimum. The full Board rounds are of most use when there is good patient flow and the patients change whereas the patient safety conversations are of most benefit when patients remain in the department for a longer period of time. • The term 'Escalation	• Reduction in SIs and incidents causing harm • Reduction in complaints and PALS – more compliments received than complaints during 2022 • Flow improved from mid-January with reduction in NCTR patients, improved ambulance handover and OPEL 3 level • Starting to see improvements in 12 hours in department	• Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved. • Audit reports from digital sepsis tool for screening in addition to compliance with sepsis bundle once sepsis is identified.

		working well and where further work could be required	• Risk 3439 was reviewed by the ED department who are going to separate into 2 risks after escalation to EMC. The crowding element is still a high risks whilst improvements have been seen on the impact of quality and safety for patients.	doctor/nurse' was changed to 'Safety doctor/nurse' early on in the implementation of the action plan. • The safety nurse is not always available if there is short notice sickness absence. However, the safety checks in place do now mitigate for this.		
ED2: The inability to demonstrate that fundamental standards of care are being met						
All 7 actions have been completed with evidence of completion provided. The focus for these actions will now be on sustainability and the impact on the outcomes. Should the outcomes not be achieved, practice will be reviewed.	• Met with all Band 6 and Band Senior Nurses and Band 5 Nurses to undertake briefing sessions around the expectations of fundamental standards of care • Released the Clinical Matrons from patient flow escalation to focus on training, assurance checks against the fundamental	• ED Tissue Viability task and finish group established • Matron handbook reviewed to be ED specific and links in with the documentation on Nerve Centre e.g. completed assessments as part of the quality and safety checks – this was done in conjunction with the ED Senior Matron	• ED Tissue Viability task and finish group continued to meet • Continued interim support arrangements from the Deputy Chief Nurse	• Weekly quality and safety checks commenced as planned; however, these have been undertaken by the ED Senior Matron in the absence of the ED Nurse Director and shared with the Interim Chief Nurse	• Improved completion and the quality and safety checks • Improved compliance with the completed assessments and intervention of fundamental standards of care • Reduction in SIs and incidents causing harm	• Continue with the close monitoring of the delivery of the fundamentals of care in a timely response • Tissue Viability Nurses to review the impact of any delayed skin assessments on patient outcomes • Continue with the interim support arrangements from the Deputy Chief Nurse

	standards of care and escalation • Weekly review commenced against the quality and safety checks • Pressure relieving mattresses were ring-fenced for ED use only; no concerns accessing these beds to date	• Interim arrangements were implemented via the Deputy Chief Nurse to support the department during the absence of the ED Nurse Director				• Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved
ED3: Management of patients waiting within the department						
9 out of 11 actions have been completed with evidence of completion provided. The focus for these actions will now be on sustainability and the impact on the outcomes. Should the outcomes not be achieved, practice will be reviewed. The 2 remaining open actions will continue to be monitored via the Safety Oversight Group.	• 2.5 WTE increase Registered and 2.5 WTE Non-registered Nurses to support in Emergency Care • The weekend Roaming Team continued as planned • Implementation of the Bristol Model following a trail in October 2022 • Safety brief at shift handover (8am, 4pm, midnight) – introduced as planned and well embedded into practice	• Implementation of dedicated treatment area for ambulatory patients to have ongoing care in Emergency Care • Non-registered staff identified and in place to support the discharge lounge to ensure patients are safe whilst waiting for transport during out of hours • Complete the 12 days of Christmas as planned and use learning from the scheme to inform an improved command and control framework	• Continually review the impact of the HOB opened on the 13th floor and agree the requirements for a HOB on the Acute Assessment Unit • Discussions are underway with the services regarding the most appropriate way to undertake this transition	• Development of a high observation acute assessment unit and an operational plan to release capacity in Resus – a hob has been implemented on the 13th floor following the relocation of the Children Wards. • Following discussions regarding introducing an additional daily Gold Command meeting at 3.00pm with the Executive Team it was felt a an assigned Director of	• Starting to see a reduction in the number of patients lodged in ECA • Starting to see improvements in 12 hours in department • Flow improved from mid-January with reduction in NCTR patients, improved ambulance handover and OPEL 3 level	• Continually review the impact of the HOB opened on the 13th floor and agree the requirements for a HOB on the Acute Assessment Unit • Recruitment to the 1WTE additional to support the discharge lounge • Continue with the plans to introduce the 90 day plan of the ground floor model • Continue assurance visits and Safety Oversight Group for February,

		• Clarification of B8a matron roles in the department and in the site team provided and evidence provided • Introduced an assigned Director of the Day • The Executive Team agreed for the 90 day plan of the ground floor model to commence in January 2023		the day would have a better impact. Therefore, this was introduced in replace of an additional Gold Command		considering any changes required for ensuring actions are sustained and outcomes achieved
ED4: Assessment rooms within the department (ECA) were potentially unsafe for patients with mental health needs						
2 out of 4 actions have been completed with evidence of completion provided. The focus for these actions will now be on sustainability and the impact on the outcomes. Should the outcomes not be achieved, practice will be reviewed. The 2 remaining open actions will continue to be monitored via the Safety Oversight Group. One of these	• Health and Safety undertook the ligature risk assessments in ED; Rooms 4 and 5 in Majors and dedicated room ECA and identified the areas for improvement. These were also shared with Estate and Facilities to support their plans and building works • The Director of Estates, Facilities and Development undertook a walk	• Work continued to take place with Humber Foundation Trust to develop a designated mental health assessment area adjacent to ED with a deadline of April 2023 agreed • Work continues with Humber Foundation Trust to support the development of the required SOPs and governance arrangements for the dedicated mental health assessment area	• The tenders for the new designated mental health assessment unit are back, building work is ongoing		• Small numbers of staff are starting to receive the MCA training • Increased staff awareness of mental health in the department and starting to see an improvement in the appropriate triage and assessment of patients with mental health needs via the	• Continue to raise awareness of and deliver the MCA training • Work to continue with the development of the designated mental health assessment area adjacent to ED • Completion of the actions in response the ligature risks • Continue assurance visits and Safety Oversight Group for February,

actions is not due for completion until April 23.	round with the ED Nurse Director to identify any further actions regarding potential ligature risks • Any immediate ligature risks were removed and patients with mental health needs placed in the dedicated rooms were assessed and the rooms were cleared if required • Work continued to take place with Humber Foundation Trust to develop a designated mental health assessment area adjacent to ED	• Introduction of an mental health triage and assessment form for ED on Nerve Centre • Implementation of a MCA training module offered to all staff delivered by the MCA Lead Nurse and are offered twice per week until the end of March 2023			Nerve Centre Triage Form	considering any changes required for ensuring actions are sustained and outcomes achieved
ED5: Other actions						
4 out of 5 actions have been completed with evidence of completion provided. The focus for these actions will now be on sustainability and the impact on the outcomes. Should the outcomes not be	• Implementation of the Weekly Safety Oversight Group and reporting / escalation to the Quality Committee • The first System Meeting took place with partners to accelerate and add	• Continuation of the Weekly Safety Oversight Group and reporting / escalation to the Quality Committee and the CQC • ED Digital task and finish group established – continue to meet	• To include performance data against the outcome measures from January 2023	• The System Meeting have been cancelled on a number of occasions • The YAS and HUTH risk assessment was reviewed as planned. It was agreed at Gold Command that cohorting will	• CQC update reports to the Quality Committee with progress against the ED action plan, feedback from the assurance reviews and escalation of	• Test staff feedback following the full completion of the ED digital work • 'Frosting' will be applied to glass to improve privacy and dignity. • Continue assurance visits and Safety

achieved, practice will be reviewed. The 1 remaining open action will continue to be monitored via the Safety Oversight Group.	to existing system wide plans	weekly. The majority of ED documentation has now been reviewed and updated on the digital records, tested and uploaded to LIVE. The latest form to be uploaded was the mental health triage and assessment form. There are another 2/3 forms to be completed. • A review of the cohorting arrangements were undertaken jointly by HUTH and YAS. A risk assessment was completed and a joint SOP was developed and agreed. The Trust also developed On-call guidance for YAS cohorting. • The YAS and HUTH risk assessment was reviewed as planned.		continue in the Atrium and 'frosting' will be applied to glass to improve privacy and dignity.	potential risks – demonstrating good progress against the delivery of the plan • Implementation of the improved ED digital documentation	Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved

4. OUTCOME MEASURES

From the end of January 2023 the Weekly Safety Oversight Group received and scrutinised the performance against the outcome measures highlighted on the ED action plan, which is shared at Quality Committee and with the CQC.

A summary of the performance outcome measures between November 2022 and February 2023 is as follows:

- 39 ED staff trained in Sepsis before and after the inspection in November 2022 = 38% compliance with training. 39 ED staff trained in Sepsis before and after the inspection in November 2022 = 38% compliance with training
- Emergency Department 30.7% overall compliance against the Sepsis Audit between 31 October 2022 and 31 January 2023
- The department has completed 3178 Sepsis assessments since the digital bundle was implemented
- The Emergency Department continues to demonstrate a good incident reporting culture
- The Emergency Department have seen a reduction in the number of SIs declared in the last 12 months and have declared 0 Never Events.
- The department has declared 5 sub-optimal care of a deteriorating patient SIs resulting in the death of the patient in the last 12 months (1 in May 2022 and 4 in October 2022) with none declared since then - demonstrating an improvement against the management of deteriorating patients and a reduction in harm
- The Emergency Department receives a low level of complaints compared with other Health Groups. The majority are in Majors and relate to treatment. The department respond well to complaints with the majority of complaints investigated and closed within 40 days
- A complaint received recently regarding long waits in ECA and the impact of this, occurring around the time of the inspection, was presented to the Trust Board. The patient and his wife have kindly agreed to be recorded to assist with training and learning. The video has since been shared with the Emergency Department team and they were very empowered by their feedback. The staff are now recording an apology video.
- Ambulance handovers under 30 minutes is starting to show signs of improvement.
- Between December 2022 and January 2023 the department has completed 3481 mental health assessments; 0 of which were overdue. This is an increase from 1,231
- Improvements in overall performance data is yet to be seen.

5. ASSURANCE REVIEWS

The assurance reviews have in time consistently demonstrated the safety elements in the department are being addressed and have improved with revised ways of working continually being embedded into practice. Staff have fed back the difference they have noticed and the positive impact the changes have had in the department.

The Quality Committee in February agreed the weekly assurance visits could be undertaken on a monthly basis with a multidisciplinary team and an external panel member to focus on key areas and still provide oversight that the actions have been sustained.

6. SAFETY OVERSIGHT GROUP

The Safety Oversight Group has been established since the 14 November 2022, led by the Director of Quality Governance and continues to meet weekly. The group receives weekly updates on the ED action plan and the assurance reports on compliance with the agreed actions and improvements. The Quality Committee receives a monthly assurance report from the Safety Oversight Group.

Following receipt of the draft CQC report and the implementation of the majority of the urgent actions, the terms of reference and work-plan have been reviewed. This reduces the frequency of the meeting to fortnightly from weekly and broadens the scope to other key work-streams and core services.

7. NEXT STEPS

The CQC report is likely to be published in March 2023. The Trust will be required to provide a full action plan in response to this. As detailed in Section 2 this work has commenced.
The standard arrangements of core service assurance visits will recommence in Quarter 2 enabling services across the trust to focus on improvement actions. This will clearly not be limited to those that were inspected by the CQC on this occasion as it is vital that all services learn from each other.
The Safety Oversight Group will continue until sufficient assurance has been received that actions are having the required impact and evidence has been received for the new 'must do' actions. There will be an aim of returning to the business as usual approach of Health Group Governance committee management with escalation to the Operational Risk and Compliance Subcommittee by the end of Quarter 2. This will depend on the evidence and outcomes seen at that time.

8. RECOMMENDATIONS

The Trust Board is recommended to:

- Decide whether sufficient assurance has been provided and if any further information is required
- Acknowledge the overdue action

Report to the Board in Public
Audit Committee February 2023

Item: Internal Audit – Financial Sustainability Review	Level of assurance gained: Reasonable
The financial review had highlighted 27 areas of improvement. The Finance Team took on the self-assessment and had been conservative in their views. RSM have challenged the evidence and reviewed the scores presented.	
Item: Internal Audit – Performance Management Report	Level of assurance gained: Reasonable
The Audit had been undertaken relating to the framework of holding the Health Groups to account regarding performance and reasonable assurance was given. Actions had been agreed and would be followed up with the Chief Operating Officer.	
Item: Quality and Safety Review	Level of assurance gained: Good
The Quality and Safety Review was undertaken and substantial assurance given. There was one medium action to implement an oversight structure.	
Item: Freedom to Speak Up Report	Level of assurance gained: Good
Substantial assurance was given to this audit. An action to add a board self-assessment tool was raised by the FTSU Guardian. This had been implemented.	
Item: Counter Fraud	Level of assurance gained: Good
The Committee discussed the ongoing fraud cases and received details relating to overtime claims and timesheets. RSM advised that the results were not alarming in any way.	
Item: External Auditors Report	Level of assurance gained: Good
There had been a change to the External Audit engagement lead and the Audit plan for the year was discussed.	
Item: Review of credit card spending	Level of assurance gained: Good
The committee discussed IT purchases and why they are purchased on the credit card. This had been set up initially for urgent orders so a review of the purchasing process would be undertaken. There were no other issues raised.	
Item: Review of Debts of >£50k and 3 months old	Level of assurance gained: Good
The top 3 debts were being processed and would be paid. The majority of the debts were with NHS organisations.	
Item: Accounting Policies	Level of assurance gained: Good
The Accounting policies were presented to the Committee and any updates highlighted. There were no issues raised with any of the changes.	
Item: Effectiveness of the Audit Committee	Level of assurance gained: Good
The HFMA committee self-assessment checklist was presented for the first time. There was one area of non-compliance regarding a policy to govern non-audit work carried out by the external auditors, which was discussed by the Committee and an action was put in place to address it.	
Item: Gifts and Hospitality Report	Level of assurance gained: Good
The report was presented to the Committee which included the registers of gifts and declarations.	
Item: Procurement Update	Level of assurance gained: Good
The Director of Procurement attended the Committee to give an update regarding the joint working and procurement improvements set out in the business case for joint working with the ICS.	

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14/03/23
Title	Board Assurance Framework 2022/23 Q3				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	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 approve the risk scores set out in the report and the following changes to risk ratings : · BAF Risk 3.1 - increase the current risk to 4 x 4 = 16 (section 4) · BAF Risk 3.1 - increase the target risk to 3 x 4 = 12 (section 4) · BAF Risk 3.2 - increase the target risk to 3 x 4 = 12 (section 4)

Hull University Teaching Hospitals NHS Trust
Board Assurance Framework (BAF)2022/23 – Q3

1. Purpose of the report

The purpose of the report is to present the 2022/23 Q3 Board Assurance Framework to the Trust Board.

2. Background

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

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

3. Risks

The strategic Risks are shown at table 1:

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 Trust Services following the residual impact of Covid	5x5=25	4x5=20	4x4=16	Low
5 - Partnerships That the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System due to recovery, primary care and social care constraints	3x4=12	3x4=12	2x3=6	Moderate
6 – Research and Innovation	4x4=16	3x4=12	2x4=8	Moderate

Risk	Inherent Risk (L x I)	Current Risk (L x I)	Target Risk (L x I)	Risk Appetite
There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment				
7.1 – Finance There is a risk that the Trust does not achieve its financial plan for 2022/23	5x4=20	5x4=20	3x4=12	Moderate
7.2 – Underlying Financial Position There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year	4x5=20	4x5=20	3x5=15	Low
7.3 – Capital Programme There is a risk over the next 3 years of failure ofcritical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability	4x5=20	3x5=15	2x5=10	Moderate

The risk appetite matrix is included for information in table 2:

Table 2

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

4. BAF 1 Culture

There has been great work carried out in 2022, but due to the Staff Survey results (December 2022) the Board is asked to consider leaving the risk at its high level as there is more work to do.

The Trust is above average in the following themes

- Morale

The Trust is below average in the following themes:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy

- We work flexibly
- We are a team
- Staff Engagement

The Be Remarkable leadership development programme will continue in Q4, supporting leadership capabilities, providing coaching and explore the attributes of an inclusive compassionate leader. Other leadership courses include: Great Leaders Bitesize, Rise and Shine, Realising your remarkable and Stretch Thinking.

The Golden Hearts Awards have launched for 2023 and new categories include: Zero30, Research Development and Innovation, Patient Safety as well as Rising Star and Lifetime Achievement awards.

The Board is also asked to consider the Q4 target as it is unlikely that this will be met.

BAF 2 Workforce

Although vacancy rates are in a good position, pressures in the hospital are causing capacity issues and staff sickness. Therefore the Q3 risk position is still high.

The Medical Staffing Team are continually advertising and recruiting directly to the Remarkable Medical Bank and since April 2022 new doctors have covered 660 shifts which would have previously remained unfilled.

117 newly qualified adult RNs have been appointed and started their substantive roles with just 7 awaiting their PINs and 8 paediatric RNs with 3 awaiting PINs. There are also 17 Registered Midwives have been appointed, all of which have already received their PINs.

The Board is also asked to review the Q4 target as again it is unlikely that this will be met.

BAF 3.1 High Quality Care

The draft CQC report has been received and highlights a number of concerns in relation to quality and patient safety. Immediately following the inspection the Trust received a 'letter of intent' from the CQC. Action plans wereput in place to respond to the urgent concerns. The Quality Committee and Board have received assurance on progress to date. This has also been provided to the CQC in December, January and February. No enforcement action has been taken at this stage. The draft report provides more information on some of the initial findings, such as Never Events learning and practice in theatres. A separate report has been provided on these findings, work-streams across the Trust and plans for core service improvement plans. The Quality Committee will continue to receive progress reports on a monthly basis.

Areas requiring improvement are:

- Assurance mechanisms – need to challenge ourselves on the assurances we receive,
- Training & appraisals
- Theatre work-stream – culture, WHO checklist, controlled drugs/medicines management
- Continuation of ED support & monitoring
- Continuation of Patient Flow & elective recovery work
- Digital health records & information
- Nutrition
- Continuation of complaints improvements
- Consent – particularly for those without capacity
- Mental capacity act/DoLS/Safeguarding

• Governance arrangement in Surgery Health Group – significant support required
• IPC – bare below the elbow, mask wearing, handwashing in ED
• Environmental risk assessments
• Never events learning & prevention
• Local induction arrangements
• Patient experience & engagement, particularly for ED
• Nursing & medical staffing levels
• Continue policy & procedure work for out of date documents

The Quality Strategy overview was received at the Quality Committee in December 2022. The process for quality and safety improvement, including a review of the development of the Quality Strategy was also undertaken in Quarter 3. This provided an opinion of 'substantial assurance'.

The Trust held its first celebration event in November 2022 and October saw the start of the QSIR virtual cohort. There is an increasing number of accredited QSIR Associates in the faculty. Since becoming a faculty, 147 staff have been trained in QSIR Fundamentals or Practitioner with a further 140 places allocated for 2023/24.

The ThinkTank programme has received a high number of Quality Improvement ideas.

Support is being given to each Health Group regarding the backlog of open complaints. This is starting to have an impact. Work is planned for Q4 on taking forward the model complaints standards, published by the PHSO in December 22.

Transition to PSIRF is planned from April 2023. PSIRF training has commenced as has the Human Factors training.

Development of a Falls Champions network is ongoing. This will be established to share lessons learned and best practice following quality improvement initiatives.

The Board is asked to consider the changes suggested by the Quality Committee to increase the current risk to 4 x 4 = 16 and increase the year-end target position to 3 x 4 = 12. This is in light of the CQC's findings particularly in ED and theatres. Whilst actions are on track, the impact of these was not seen fully at the time of the CQC inspection.

BAF 3.2 Harm Free Care
The HUTH flow model has been implemented and a RAT doctor and escalation staff are now in place in ED.

There have been no Regulation 28s reported in Q3 attributable to the Trust. However, there was one Regulation 28 report to NHSE around mental health training for doctors following a case at the Trust.

There have been no Never Events reported in Q3 but there have been 6 Never Events so far in the financial year. The open Serious Incidents have been reduced to manageable levels and the trajectory of 35 hit in November.

The 104 week wait patients have been reduced to zero. Work is now underway to review the 78 week waits. The 4 hour performance at November 2022 was 60.5% and there have been 538 over 60 minute ambulance handovers. The HUTH Bristol flow model was reducing the number of 12 hour trolley waits.

The Trust still had 200 patients with no criteria to reside in the hospital in January 2023 which was creating bottlenecks in the system. The CEO was discussing alternative community plans with the wider health system. A 60 bedded ward is being built on site to accommodate some of these patients to help with flow through the hospital. Additional wards have been opened in Q3 to manage patients and keep them safe.

Although there have been good improvements made it is recommended that this risk remain the same due to the ongoing operational pressures. The Board is also asked to review the year-end target as this is unlikely to be achieved. The Quality Committee recommended increasing the target risk to 3 x 4 = 12 and the Board is asked to approve this change.

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.

A number of performance issues remain:

- Ambulance handover position remains challenged
- 4 hour performance has deteriorated 55.6% for all types
- 3 out of 9 cancer waiting times' national standards were achieved, cancer performance remains comparable with previous months
- Elective activity was 81% of plan which is a deterioration due to NCTR, ICU bed capacity, ward bed capacity and infection outbreaks (VRE).
- NCTR patients remains on average at 200+ per day
- CQC Action Plan is now in place and being implemented and reported weekly

Improvements seen:

- The Trust was stepped down from a Tier 1 organisation to a Tier 2 due to the reduction in the 104 waits
- Trust's waiting list volume has reduced marginally
- The HUTH 'Bristol Model' has been implemented
- RAT Doctor, escalation Doctor and escalation Nurse now in place

It is recommended that the risk rating remains the same due to the pressure in the hospital and the wider health system. The Board is also asked to consider the Q4 target risk rating as this is unlikely to be met.

BAF 5 Partnerships
The Trust has engaged as part of the Humber Acute Services Review with the ICB and the consultation date for the hospitals capital business case will be June 2023. Two potential models have been highlighted and developed. Close working with the ICB to finalise the scope of a third Clinical Senate Review is ongoing.

Oversight of any temporary operational service changes are being taken into account during the winter.

The Board is asked to consider that this risk be reduced in Q3 and whether it has achieved its target position as the Trust has contributed to the development and implementation of the ICS despite the operational pressures being faced.

BAF 6 Research and Innovation
The inevitable reduction of support services capacity (i.e. imaging, labs, pharmacy) dealing with clinical service delivery backlogs 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.

The Board is asked to review the Q3 risk rating and year-end target and consider if it should remain, due to operational pressures limiting staff's ability to deliver future research without protected time and investment.

BAF 7.1 Finance
Reported break-even position at month 9, £0.5m away from plan chiefly driven by additional wards to support NCTR patients.

Risk on elective recovery income if NHSEI enact clawback in the second half of the year. Clawback is no longer anticipated.

Uncovered risk of £1.8m in the year-end forecast and the actions needed if the Trust is to deliver its plan.

Due to the year-end forecast of achieving the financial plan, it is proposed that the risk rating remain for Q3 but would achieve its target in Q4.

BAF 7.2 Underlying Financial Position
Need to increase in-house productivity and to continue to identify CRES opportunities to reduce the unidentified balance.

The underlying deficit remains at £50m - £56m.

It is proposed that the risk rating remains the same at Q3. The Board is also asked to consider if the target risk rating has been achieved.

BAF 7.3 Capital
December 2022 saw the front entrance build almost completed with a new Costa Coffee, Nourish restaurant and WH Smith included.

The reported capital position at month 9 shows gross capital expenditure of £14.9m against a plan of £22.8m. 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 (£6m) which has now slipped to 2023/23.

The planned capital spend is £0.7m above the Trust CDEL limit. This is to support slippage across the ICS.

It is recommended that this risk rating remain the same at Q3. The Board is also asked to agree the achievement of the year-end target risk rating.

5. Corporate Risk Register
Attached after the BAF and assurance ratings is the Corporate Risk Register to allow the Board to have sight of the high level risks in the organisation. Each of the Corporate Risks are linked to the BAF and you will note that ED, delays in discharge and flow are included.

Having sight of the Corporate Risk register will assure the Board of the movement, actions and mitigations of the risks on a monthly basis.

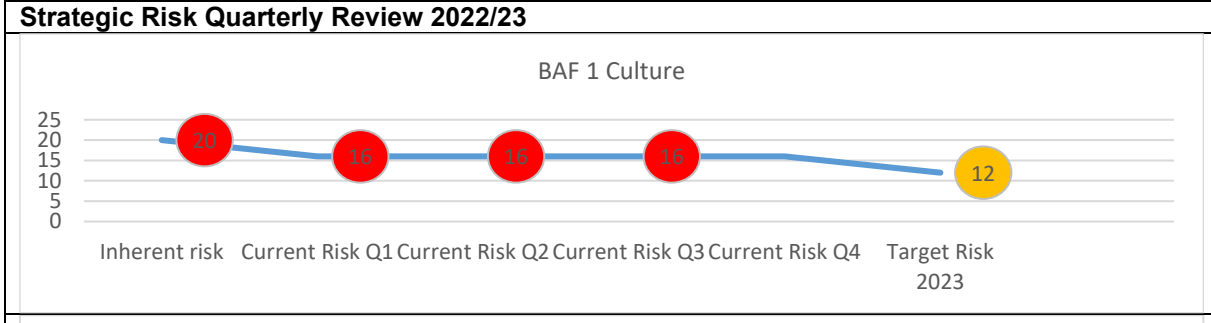
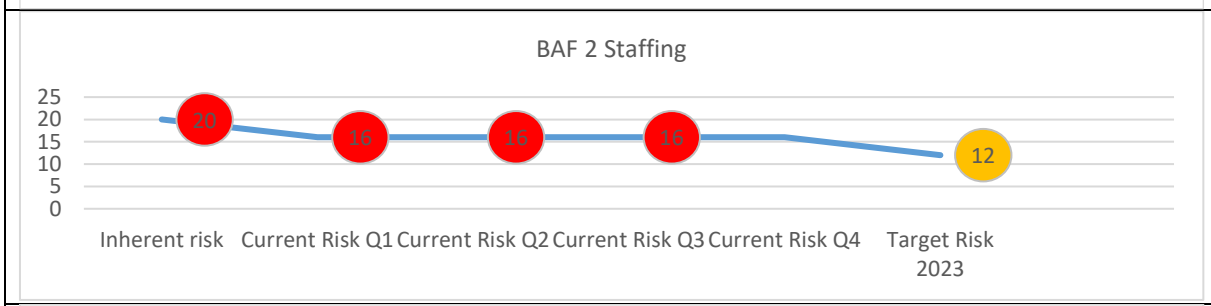
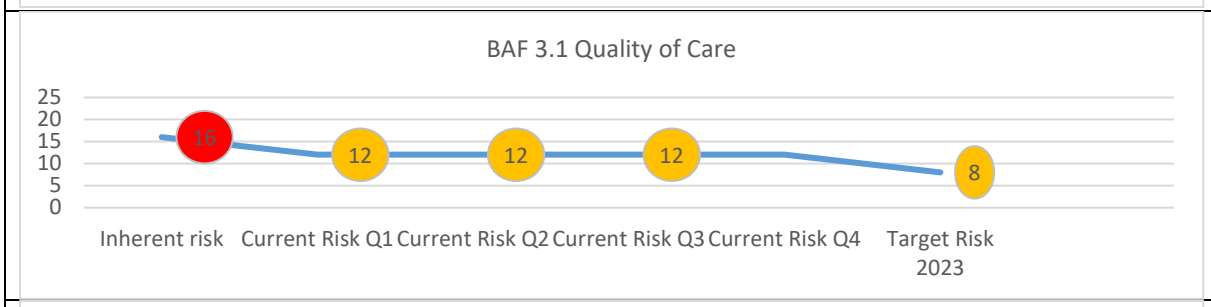
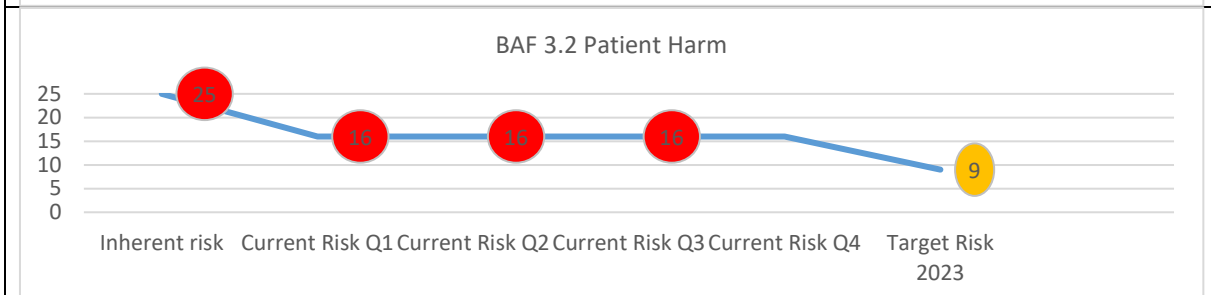
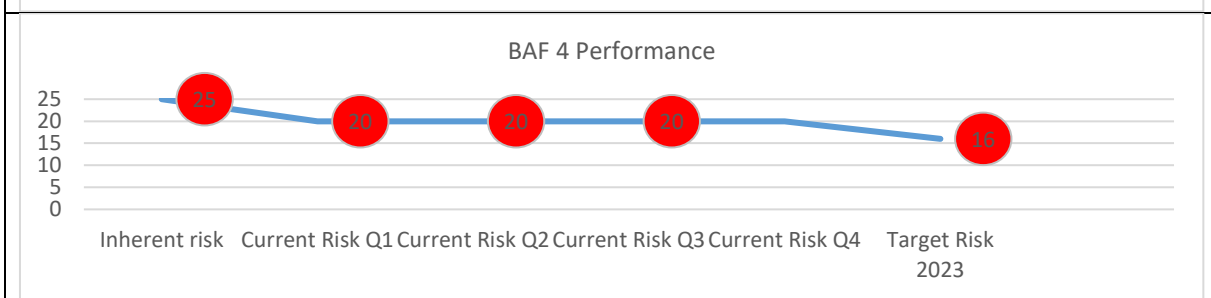
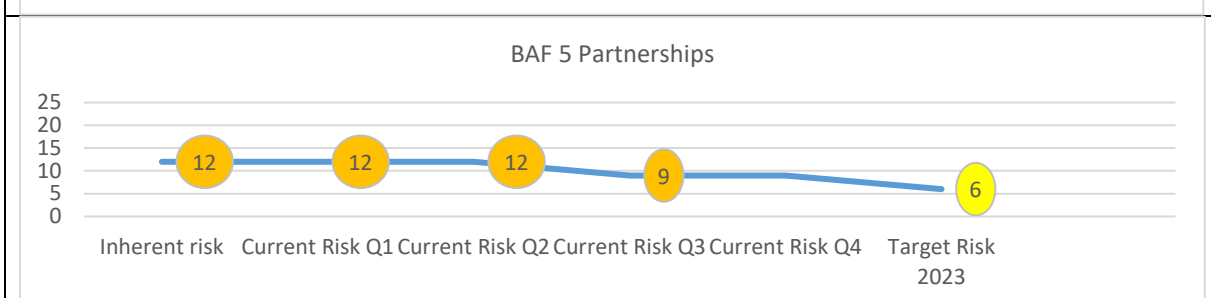
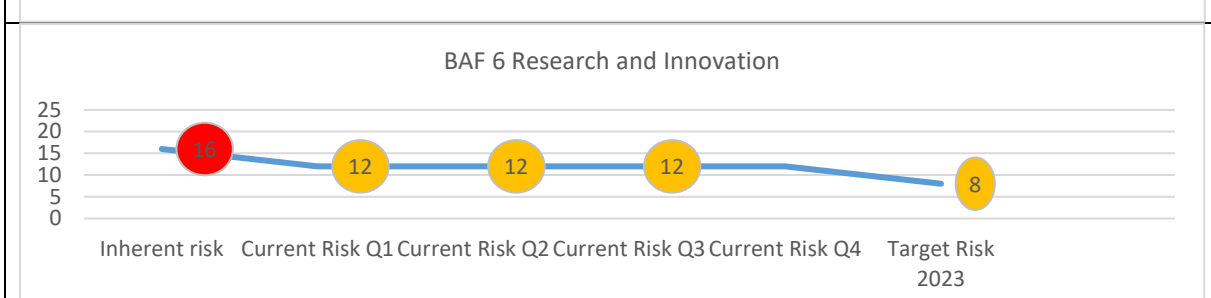
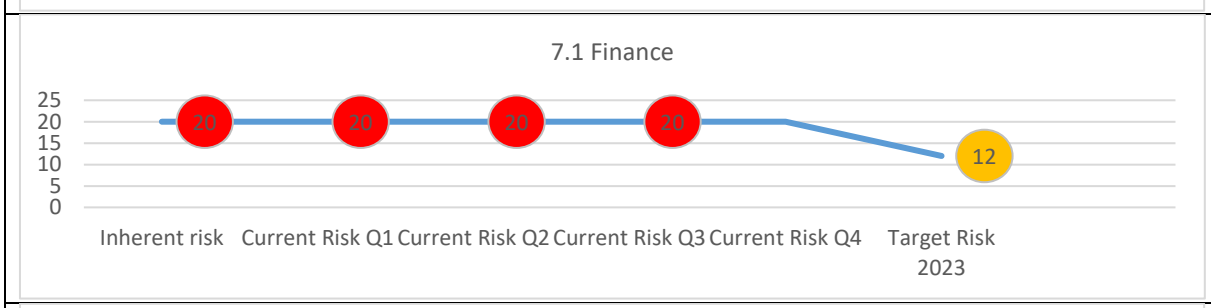
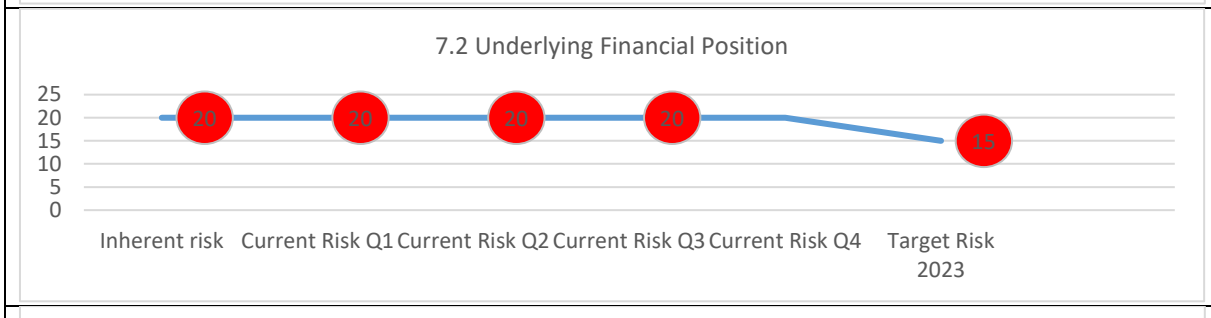
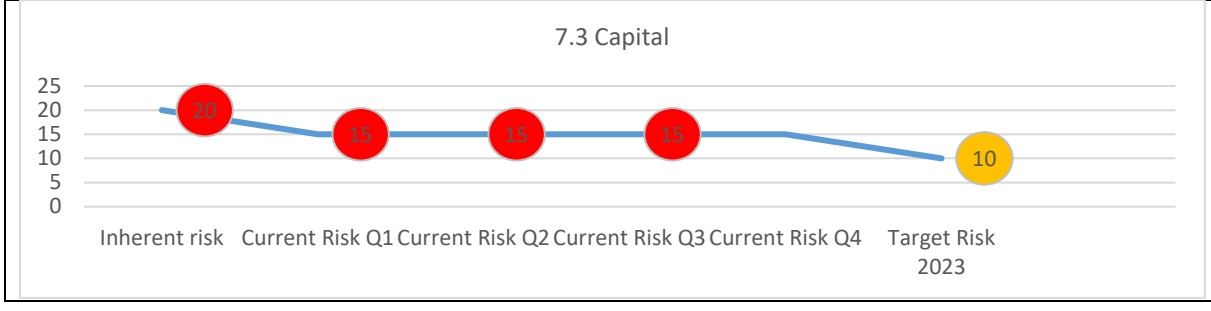
6. Timetable for reporting
Each BAF risk is reviewed monthly after each Committee meeting by the Head of Corporate Affairs and Q3 updates will be presented to the Board in March 2023. Q4 updates will be presented to the April Committees and the Board in May 2023.

7. Recommendation

The Board is asked to review and approve the risk scores set out in the report and the following changes to risk ratings :

- BAF Risk 3.1 - increase the current risk to 4 x 4 = 16 (section 4)
- BAF Risk 3.1 - increase the target risk to 3 x 4 = 12 (section 4)
- BAF Risk 3.2 - increase the target risk to 3 x 4 = 12 (section 4)

Head of Corporate Affairs
March 2023

Strategic Risk Quarterly Review 2022/23	Risk Appetite	Owner	Committee
	Low	Director of Workforce and OD	Workforce, Education and Culture
	Low	Director of Workforce and OD	Workforce, Education and Culture
	Moderate	CMO/CN/Director of Quality Governance	Quality
	Low	CMO/CN	Quality
	Low	COO	Performance and Finance
	Moderate	Director of Strategy and Planning	Trust Board
	Moderate	CMO	Quality
	Moderate	CFO	Performance and Finance
	Low	CFO	Performance and Finance
	Moderate	CFO	Performance and Finance

Strategic Theme: Culture
Appetite: Low
Risk: 1

Strategic objective: Honest, caring and accountable culture
Assurance Committee: Workforce Education and Culture Committee
Executive Lead: CEO
CQC Domain: Well-Led
Enabling Strategies/Plans: People Strategy

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: 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	Workforce, Education and Culture Committee Workforce Transformation Committee Rise and Shine programme – emerging leaders to commence 2021/22 Disability Network established	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 Individual HG work ongoing re retention/cultural work e.g. task & finish group led by Chief Nurse & Director of Midwifery with comprehensive actions & work re cultural transformation; cultural & advanced comms workshops in Critical Care Great Leaders Bitesize 90-Day Challenge Rise and Shine – aspirational leaders – cohort 5 Realising your remarkable – self study 4 hour webinars	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. Q3 Rainbow Badge – The Trust has been accepted on the NHSE national Phase 2 assessment for the Rainbow Badge accreditation. ESR Bridging the Gap Measure – Create an inclusive environment within the Trust that enables people to feel confident to be open about their sexual orientation and/or gender identity. Launch a Zero Tolerance to LGBTQ+ Discrimination Framework Q3 2023. Conference – Organise a conference for the 2nd Quarter of 2023 to raise the visibility and accessibility of the LGBTQ+ network. Pride Recruitment Event – At 2023 Pride in Hull event

						Stretch thinking – online course introduced A bespoke cultural programme “The Inclusion Academy” is in development. The aim is to develop and deliver meaningful content to bring our values to life and make HUTH an innovative and inclusive employer. Facilitation of the Mary Seacole NHS Leadership Programme will be completed in Q4. 2023/24 will mean 5 places on the programme for HUTH staff members. Optometry compassionate and collective leadership model being implemented	organise for a recruitment and careers stall to be present on behalf of the Trust making people aware of both career opportunities in the NHS as well as showcasing live current vacancies at the time, and signing people up to Trac Jobs profiles.
	Risks from Risk Register: There are no direct risks on the Corporate 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:** National Staff Survey results 56.4% staff engagement Staff experiencing harassment – below average for white staff, equal to national average for BAME staff Equal opportunities – below average for white staff, above average for BAME staff		

Inherent Risk			Risk position as at 31.12.22 (Q3)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	4	4	16	3	4	12

Strategic Theme: Workforce
Appetite: Low
Risk: 2

Strategic objective: Valued, skilled and sufficient staff
Assurance Committee: Workforce Education and Culture
Executive Lead: Director of Workforce and OD
CQC Domain: Safe, effective, well-led
Enabling Strategies/Plans: People Strategy

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **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 **Risks from Risk Register:** 2789 – Capacity in the intra-vitreal injection service 3439 – ED staff recruitment 3990 - Shortage of staff is a serious issue in the department of cardiothoracic surgery 3044 – Consultant Pathologist shortages (Breast Pathology) 4110 – Pharmacy Aseptic staffing issues	People plan in place which sets out the changing workforce requirements Remarkable People, Extraordinary Place brand – targeted recruitment Golden Hearts, Moments of Magic rewards 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.	Monitoring of Workforce assurances through the Workforce Transformation Committee and Workforce Education and Culture Committee Vacancy position reported in every Board meeting	Certain medical specialities struggle to recruit due to national/international shortages Managers thinking innovatively about new roles to new ways of working (ACP/PA) 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	People Plan People Strategy Refresh Lets get Started` Induction programmes for RN`s & 'Where Care Begins' for the Nursing Assistants. Keep in touch days for all newly qualified/International Nurses throughout the year Robust PDM/ CNE /PLF infrastructure Matron late shift (till 10pm Mon – Fri) to visit wards and deliver pastoral care/support to staff Non Registered Development Programme/Induction and Preceptorship Programme Tea Trolley – OD team provide staff support confidentially The Trust has expanded its TRiM investment with a number of TRiM practitioners taking the next steps to become TRiM managers. Clinical Lead Physiotherapy – Integration of Critical Care and Surgery Therapy Services to create joint services and a shared vision. Work is ongoing to expand the project across the services.	Q1 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) 5.Exec-led manager briefing/feedback sessions (May/June) BAME networking event (June) Zero tolerance policy launch 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

				Metrics: Staff Survey People Performance Report **Independent / semi-independent:** CQC NHS England/Improvement Internal Audits	**Outcomes:** Q1 Trust adjusted vacancy rate = 2.4% Turnover 12.1% against a target of 9.3% Less than 1 year leavers = 20.8% Consultant job plans = 64% Sickness 3.96% Appraisals Medical = 90% Appraisals AFC staff = 85% Q2 Trust adjusted vacancy rate = 4.1% Turnover 12.1% against a target of 9.3% Less than 1 year leavers = 17.1% Consultant job plans = 64.6% Sickness 3.99% Appraisals Medical = 90% Appraisals AFC staff = 69.5% Q3 Trust adjusted vacancy rate = 3.6% Turnover 12.4% against a target of 9.3% Less than 1 year leavers = 18.7% Consultant job plans = 90% Sickness 1.7% Appraisals Medical = 90.2% Appraisals AFC staff = 65.6%		Q2 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. Q3 Health and Wellbeing Committee – Commences December 2022 and Chaired by the Deputy Chief Nurse. Mental and Emotional Wellbeing Multidisciplinary Team Meeting – Commenced October 2022 and Chair by our Organisational Development Manager. Phase 1 Health Roster is practically complete with 95.35% of Nursing staff on the e-roster system Almost 2000 staff were added to the HealthRoster system between August 2021 and August 2022 and now benefit from the functionality it provides

							Explore electronic solutions for the processing of Pool and Pilot bank overtime to remove the need for paper timesheets.

Inherent Risk			Risk position as at 31.12.22 (Q3)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	4	16	3	4	12

Strategic Theme: High Quality Care
Appetite: Moderate
Risk: 3.1

Strategic objective: We will achieve a rating of 'Outstanding' in the next 5 years (2019-2024)
Assurance Committee: Quality Committee
Executive Lead: CMO/CN/DQG
CQC Domain: All/Well-led
Enabling Strategies/Plans: Quality, Patient Safety, Improvement

Risk 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:** The Trust does not develop its patient safety culture and become a learning organisation Insufficient focus, resource and capacity for continuous quality improvement for quality and safety matters Poor governance arrangements 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 Strategy/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 Safety Oversight Group	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 Increase in Falls in December – Falls Committee reviewing whether this is due to patients having multiple falls and increased length of stays PALS increased activity continues, the main themes are delays, waiting times and cancellations	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 CQC Inspection Internal Audit Reports	Gaps: Quality Risk Profile – Patient flow and the Trust's waiting list UTI mortality increasing – Mortality and Morbidity Task and Finish Group to review December 2022 Category 2 pressure ulcers have increased above the upper control limit Assurance: Structured framework for the assessment of Dementia patients in relation to falls is now in place Stroke improvement plan in place/all stroke deaths reviewed at the Stroke Mortality and Morbidity Committee Falls Champions Network being developed – aim to have 1 registered and 2 non-registered champions on each ward Falls improvement programme to be implemented in line with the Quality Strategy The overall Trust SHMI has reduced further and is now within the 'expected levels of deaths' with a SHMI of 1.11 The Trust is no longer highlighted at one of the top 12 Trusts with an outlier status by NHS Digital Pneumonia SHMI has reduced further and is now within the 'expected levels of deaths' with a SHMI of 1.03 in August 2022 compared with a SMHI of	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 Second Celebration Event planned for February 2023 Complaints Weekly challenge meetings to be embedded into BAU Promote Early Resolution cases (closed within 10 working days)	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. Q3 Upcoming QI Celebration Event to be held virtually 28/11/22. 31/10/22 Start of HUTHs first QSIR Virtual cohort commenced ThinkTank programme has now received 165 submissions, ongoing work to progress staff ideas Trajectories given to each HG to support backlog of open complaints. Targeted work with Surgical HGs with Exec led weekly backlog meetings to clear complaints. This will

					1.19 at its highest point in 2020. Stroke SHMI has also improved further with a SHMI of 1.10 in August 2022 compared with a SHMI of 1.46 at its highest point in 2020. Letter of intent received from CQC November 2022 Internal audit for quality & safety improvement – 'substantial assurance'	Deliver patient experience plan that was presented to the Patient Experience Sub-Committee (Jan 23) CQC ED Action plan in place Digital Safety Huddle is now live Escalation Dr is embedded in the department. Rapid assessment and triage/streaming doctor at front door to Emergency Care Area 4 hour board rounds are in place and happening Weekly safety checks are being completed by Chief Nurse and Deputy Chief Nurse Trust-wide implementation of updated full capacity protocol in place	commence in Medicine HG from December. An investigation has been completed and presented to the November 2022 Mortality and Morbidity Committee. The investigation did not identify any unavoidable deaths; however, it did identify some minor coding issues with pneumonia. A further review into the 10 malignancy deaths in August 2022 is to be completed. Transition to PSIRF planned from April 2023. PSIRF training has started. Development of Falls Champions network to share lessons learned, best practice and quality improvement initiatives
	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 Q3 Regulation 28 =0		

					Never Events reported in Q3 = 0 Open Serious Incidents = 38 (October) hit trajectory of 35 (November) Rolling HSMR showing a consistent mortality rate SHMI is now 1.12 above the national average of 1 and the reduction of excess death 380 to 325 Complaints closed within 40 days is not achieving the 80% target Increasing faculty of accredited QSIR associates There were 51 patient safety incidents per 1000 bed days recorded in October 2022		

Inherent Risk			Risk position as at 31.12.22 (Q3)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Strategic Theme: High Quality Care/Great Clinical Services
Appetite: Low
Risk: 3.2

Strategic objective: We will increase harm free care
Assurance Committee: Quality Committee
Executive Lead: CMO/CN
CQC Domain: Safe
Enabling Strategies/Plans: Recovery Plan and work-streams, Patient Safety

Risk 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 Complaints backlog 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 Cancer 2ww referrals have increased by 6.6%	**Management assurance:** Reports to Quality Committee Clinical harm data and reports Performance Reports to the Performance and Finance Committee CQC Reports	Diagnostic waiting times GP Capacity and increased referrals The RTT trajectory **CQC Report actions** HUTH Flow Model (Bristol Model) implemented. RAT and Epic role fully embedded in department and positive feedback from staff. Board rounds are completed every 4 hours, There is an awareness of who is in ambulances and the escalation and board are working well. Management of mental health patients continues to improve with increased awareness of the tool and risks. Additional work identified to ensure no loss of oversight of medical in-reach patients 60 bedded area for patients with no criteria to reside being built on the old helicopter site – due to be finished April 2023 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). Capacity alerts in x6 pressured specialities are live – with monitoring arrangements to consider the effectiveness and	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 Continued focus and achievement of zero 104-week breaches.	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 Q3 RAT Model for Emergency care commenced EMHG to explore potential of 7 day service Short term plan to use Storey Street whilst a co-located UTC is being progressed SDEC to function from 8am to assist with patient flow National streaming tool directing patients to a UTC to be trialled in December 2022 HUTH Flow model being trialled – November 2022 Cohorting ambulances with YAS enables a single crew to monitor patients Board to ward rounds in Medicine are being rolled out to non-frailty wards – Audit has shown the peak discharges brought forward by 1 hour compared to October 2021 System leaders have agreed no more than 100 NCTR

					impact (2x specialities – referrals have increased) 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	Additional internal milestones have been set: Zero +52 week non-admitted waits at 31 March 2023. This initiative will progress reductions on the Total WLV Mutual aid from other providers is supporting the total WLV reduction overall. Continuing with patient transfers (outsourcing) to Independent Sector Providers and insourcing from a range of providers. Additional support for Gynaecology is a priority. The risk for the on-going theatre timetable is anaesthetic and theatre staffing due to vacancies and absence. Text validation will be delivered as a business as usual validation process for the remainder of 2022/23 & into baseline from 2023/24. RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management has commenced through Learn RTT e-learning. Digital Mutual Aid System being used to find alternative providers in colorectal surgery, vascular surgery and Gynaecology. 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.	patients by end of December 2022 Additional 30 community beds by the end of December 2022 Focussed review of OPFU rates and comparison to regional and national performance is continues with the development of OP Transformation Plans at Health Group speciality level. Many procedures are counted/coded in the HUTH follow-ups – work is underway to understand if this activity should be excluded from the reduction in follow up rates

						ED – Intentional rounding, EPIC reviewing ambulance handovers, safety briefings 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 Ambulance handover showing signs of improvement in January 2023 – December 2022 YAS reported a 30% increase in Category 1 calls Data from Model Health for 2022/23 (up to 4.12.22) shows capped theatre utilisation at 74% and in Quartile 2 nationally, this is an improvement on the last reported position of 66%, in the lowest quartile nationally	
	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 lists, recovery included in schedule Positive feedback from ECIST visit May 2022	**Outcomes:** 4 hour performance 60.5% Waiting list 65,853 104 week wait = zero 3 out of 9 cancer standards achieved 538 over 60 minute ambulance handovers HUTH Flow model has reduced the number of 12 hour trolley waits Audit of Frailty wards show the peak of discharges has been brought forward by 1 hour compared to October 2021. 10 FNOF beds/capacity from 2 December 2022 234 patients per day with no criteria to reside Recovery of elective activity in December 2022 against the operational plan delivered:		

					New Activity 86% Follow up Activity 96% Day Case Activity 100% Ordinary Elective Activity 81% The indicative activity requirement of 110% of 19/20 baseline was not delivered in any POD. Overall financial position delivered 87% of the plan and 95% of baseline in December 2022, which is the highest during this financial year		

Inherent Risk			Risk position as at 31.12.22 (Q3)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	4	4	16	3	3	9

Strategic Theme: Performance
Appetite: Low
Risk: 4

Strategic objective: Great Clinical Services
Assurance Committee: Performance and Finance
Executive Lead: COO
CQC Domain: Effective
Enabling Strategies/Plans: Operating Plan

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: 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	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.	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	Revised Trust trajectory agreed with NHSE on 19th May 2022 104 week wait performance improving 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	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	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 SDEC 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 Q3 - Increasing the number of support workers using overseas recruitment pool to provide care for lodged patients in ED HUTH Flow Model reduces the number of lodged patients in ED by 10:30am daily, thereby creating space in

						completed by the end of May 2022; this will run over in to June 2022. The next phase will be to implement/deliver revised RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management A process of text validation on 31,000 pathways will commence 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 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 +52 week non-admitted waits at 31 March 2023. All of these initiatives will progress reductions on the Total WLV	majors to handover ambulances and reduce queuing in the morning. This has also reduced the number of Trolley waits. System leaders have agreed to achieve no more than 100 NCTR patients by the end of December 2022, with a further trajectory to 50 to be agreed. 10 Fracture Neck of Femur beds/capacity in the community to come on-line from 2nd December 2022 Additional home care capacity from 12th December 2022 Additional 30 community beds by end of December 2022 RAT Model ED commenced EMHG to explore potential of 7 day services SDEC to function from 8am to assist with patient flow

	Risks from Risk Register: 3439 - There is an issue that patient care is compromised due to the emergency department being crowded 3960 - Risks associated with Mental Health patients managed in the Emergency Department 3994 - There is a risk to quality of care and patient safety as a result of delayed discharges and poor patient flow 3995 - Significant waiting list issues including access to screening and follow-up programmes – risk of patient harm 3997 - Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E 3998 - Quality issues identified due to handover delays 3999 - > 52 week wait 4000 - HGB - Maximum 62-day wait for first treatment from an urgent GP referral for suspected cancer. NHS cancer screening referral 4031 - Patient transmitting hospital acquired infections due to inadequate bed spacing 4110 - There is a risk to patient safety as a result of the Pharmacy aseptic unit being unable to meet the required service demands			**Metrics:** Health Group recovery plan trajectories **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit	**Outcomes:** Waiting list increasing 71855 (August 2022), 65,853 (December 2022) 104 week wait expected performance no worse than 127 (June 2022) 20 (July 2022), 16 (August 2022), zero (December 2022) Patients with no criteria to reside = 169 July 2022, 179 August 2022, 234 December 2022 1out of 9 cancer waiting times national standards were achieved in July 2022 and August 2022, 1 of 9 cancer waiting times' national standards achieved October 2022 1 out of 9 cancer standards were achieved in November 2022, 3 out of 9 cancer standards in December 2022 Long wait reduction as of end of October 1 x 104 week wait - Trust stepped down as a Tier 1 Organisation November 2022 Ambulance handover position remains challenged 4 hour performance has deteriorated 55.6% for all types 3 out of 9 cancer waiting times' national standards were achieved, cancer performance remains comparable with previous months Elective activity was 81% of plan which is a deterioration due to NCTR, ICU bed capacity, ward bed capacity and infection outbreaks (VRE). NCTR patients remains on average at 200+ per day CQC Action Plan is now in		

					place and being implemented and reported weekly		

Inherent Risk			Risk position as at 31.12.22 (Q3)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	4	5	20	4	4	16

Strategic Theme: Strategy
Appetite: Moderate
Risk: 5

Strategic objective: Partnerships and Integrated Services
Assurance Committee: Trust Board
Executive Lead: Director of Strategy and Planning
CQC Domain: Well-led, Effective, Safe
Enabling Strategies/Plans: Trust Strategy

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **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	Bi-monthly reports detailing progress to the Committees in Common Joint Board meeting in July 2022 Joint Board meeting in February 2023	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 Q3 Integrated Impact assessment exploration with clinical staff CAP Planned Care Strategy to be established
Risks from Risk Register: There are no direct risks on the Corporate Risk Register			**Metrics:** Recovery rate Outcomes of Service Reviews **Independent / semi-independent:** NHS E/I CQC ICS HASR Acute Collaborative	**Outcomes:** Q1 PCBC finalised end of June Clinical Senate Report received 1 June Q2 Joint Board HUTH/NLAG 5 July Market testing of consultation and engagement - June/July NHS E/I Gateway 2 review – July Commenced reviews of maternity/paediatrics/neonatal and Ockenden out of hospital alignment – August Q3 ICP Programme – 59% completion Q3		

					Dermatology service successfully joined PTLs Post implementation reviews have taken place for Neurology, Oncology and Haematology.		

Inherent Risk			Risk position as at 31.12.22 (Q3)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
3	4	12	3	3	9	2	3	6

Strategic Theme: Research and Innovation
Appetite: Moderate
Risk: 6

Strategic objective: Research and Innovation
Assurance Committee: Quality Committee
Executive Lead: CMO
CQC Domain: Safe
Enabling Strategies/Plans: Research and Innovation Strategy

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: There is a risk that R&I support service is not delivered operationally to its full potential due to lack of investment **Cause:** Funding is unavailable **Consequence:** Impact on R&I Investment Impact on R&I capacity	Strengthened partnership with the University of Hull Infection Research Group ICS Research Strategy	Reduction in support services due to activity delivery Loss of commercial research income as well as other income as non-Covid activity was paused Additional research due to Covid without additional investment in staff The inevitable reduction of support services capacity (i.e. imaging, labs, pharmacy) dealing with clinical service delivery backlogs which may limit the ability to take on some new research activity as well as slowing down existing activities. This is being addressed on a national level by DHSC and NIHR but local strategies are needed. Legacy of COVID activity and follow-ups – the success of our COVID research activity means we will have the burden of additional workload into early 2022-23. Without additional investment in delivery staff, this will impact upon research specialties in the delivery of their existing and planned activities. 2021-22 has shown our staff have worked incredibly hard to ensure our recovery from a 'COVID legacy' is ahead of trajectory.	Successful portfolio of Covid studies managed in 2020/21 2316 patients involved in clinical research as at August 2021 Continuing working with HYMS and the ICS	Scale of ambition vs deliverability Current research capacity hampered due to the recovery plan Funding availability Reconfigurations and the implementation of social distancing have led to several research areas experiencing accommodation issues. Capital developments will need to ensure research and innovation activities can be accommodated and staff appropriately housed. 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	A Research Aware Organisation Positive, Proactive Partnerships Reputation through Research HUTH will continue to provide equitable access for patients and staff to both Urgent Public Health Research and non-COVID-19 research where it is possible and safe to do so. Build Research and Innovation capacity into consultants protected time. Fund dedicated research time into job roles, especially difficult to recruit areas. Additional investment is a priority for 2022/23 Increasing research capacity in our workforce – 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 ultilised by the end of March 2023. Areas supported include; Surgery, Imaging, Pathology, Pharmacy Paediatrics and Reproductive Health. Research Workforce Strategy – the 4 RDI funded Clinical Research Fellows continue to work on the delivery of research programmes (including endometriosis, wound management and cardiothoracic rehabilitation). 5 nursing staff have had successful	Q1/Q2 – 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. Q3 The inevitable reduction of support services capacity (i.e.

					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. Demand for IT and Digital innovation is increasing. This brings an inevitable increase in the demand for the associated skills in the workforce and from our dedicated H-Digital Teams.	applications to PG Cert Research Courses that commenced in September. The UoH/HYMS HUTH PhD Scholarship programme currently supports 4 applicants with projects commencing in the areas of ultrasound services, plastic surgery/infection and wound management, physiotherapy and liver disease. Research communications and engagement strategy – a monthly meeting of the RDI and Communication Teams has been established to ensure our website and newsletter content is regularly reviewed and to share successes and achievements. The RDI newsletter will be launched from the first week of November.	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. Service pressures resulting in issues with the recruitment and retention of staff. Opportunities for staff to join research teams via secondments ad other shared models is becoming increasingly difficult, creating challenges for the deployment of suitable staff across research vacancies. Reconfigurations and the implementation of social distancing have led to several research areas experiencing accommodation issues. Capital developments will need to ensure research and innovation activities can be accommodated and staff appropriately housed.
	Risks from Risk Register: No risks highlighted			**Metrics:** Recovery Activity R&I Capacity **Independent / semi-independent:** NHS E/I HASR CQC ICS	**Outcomes:** HUTH is currently supporting BABi study Funding secured for the development of a Surgical Research Cluster for Upper GI, Colorectal, Neurosurgery and Orthopaedics Health Innovation Manager appointed to identify innovation projects and clinical synergies of our partnerships		

Inherent Risk			Risk position as at 31.12.22 (Q3)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Strategic Theme: Financial
Appetite: Moerate
Risk: 7.1

Strategic objective: Financial Sustainability
Assurance Committee: Performance and Finance
Executive Lead: CFO
CQC Domain: Effective
Enabling Strategies/Plans: Financial Plan 2022/23

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **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 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 November 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	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 expenditure plans. ERF target of 104% activity value is delivered or funding is not clawed back in second half of the year.	Performance Committee and Boards Finance Performance Reviews with Health Groups	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 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. Q3 No clawback of Elective Recovery funding is required for the first 6 months, removing the £6m risk
Risks from Risk Register: No direct risks on the Corporate Risk Register			**Metrics:** Run rate I&E position CRES position Activity performance against plan Cash flow **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:** 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 Q3 Expenditure risk = £2.9m I&E position = £0.4m above plan CRES position = shortfall £0.6m		

					Activity performance against plan = total shortfall £0.9m		

Inherent Risk			Risk position as at 31.12.22 (Q3)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	5	4	20	3	4	12

Strategic Theme: Finance
Appetite: Low
Risk: 7.2

Strategic objective: Financial Sustainability
Assurance Committee: Performance and Finance
Executive Lead: CFO
CQC Domain: Effective
Enabling Strategies/Plans: Financial Plan 2022/23

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **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	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	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 Surgery Health Group has the biggest pressure excluding CRES delivery with a further £1.2m overspend (£0.1m reduction in month). The main areas are the pressures on Junior Doctors (£0.7m unchanged in month) which remains under review, Anaesthetic Consultant sessions to support theatre lists (£0.6m, down £0.1m in month) and loss of private patient income (£0.2m). There is also pressure on non-pay costs (£0.3m) but this reduced in month. There are staffing vacancies (£0.7m) 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 increased by £0.2m in month mainly due to non-pay pressures. The two NCTR wards, totalling 45 beds are now funded for the remainder of the year and overspend should not increase. Clinical Support Health Group position deteriorated by £0.1m in month 7 due to increased cost of outsourcing imaging reporting. Family and Women's Health Group is £0.6m over-spent, excluding CRES. This is unchanged in month 7. Main driver is the high level of Wet AMD cases (£0.8m) but there	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 Q3 The overall forecast for CRES delivery has improved and the Trust is reporting that it will achieve 99% delivery by year-end. £4.8m of this is non-recurrent so recurrent delivery is 72%. Health Groups are reviewing plans and looking to identify additional schemes to close the recurrent gap. CRES position improving in Clinical Support, Medicine and EF&D

						are also pressures on junior doctors and paediatric devices. These are being offset by the high level of vacancies, especially in nursing staff.	
	Risks from Risk Register: No direct risks on the Corporate Risk Register			**Metrics:** Run rate I&E position CRES position Activity performance against plan Cash flow **Independent/semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:** Risk on elective recovery income Deficit of £0.4m at month 2 mainly driven by unidentified CRES Unidentified CRES £0.6m at month 7		

Inherent Risk			**Risk position as at 31.12.22 (Q3)**			**Planned target risk position by 31/03/2023**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	**5**	**20**	**4**	**5**	**20**	**3**	**5**	**15**

Strategic Theme: Financial
Appetite: Moderate
Risk: 7.3

Strategic objective: Financial Sustainability
Assurance Committee: Performance and Finance
Executive Lead: CFO
CQC Domain: Effective
Enabling Strategies/Plans: Capital Plan 2022-2025

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **Condition:** There is a risk over the next 3 years of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability **Cause:** Lack of sufficient capital and revenue for funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment. Partially dependent on HASR Capital EOI funding No additional capital allocation outside of ICS CDEL 2022/23 assumes 'do minimum' position **Consequence:** Lack of capital funding impacting on services Lack of investment impacting on patient and staff safety	Capital programme in place and risk assessed Comprehensive maintenance programme in place Capital Resource Allocation Committee in place to allocate funds Service level business continuity plans in place	Supplier price increases and delays to building works to be managed Energy and Decarbonisation funding not yet secured Schemes that sit outside of the capital programme - IRT4, the Vascular Hybrid Theatre; addressing ward isolation facilities, car parking and risks associated with aged equipment and potential additional IT hardware requirements associated with some of the planned capital developments.	Monthly updates to the Performance and Finance Committee Regular updates to the Board	Building works impacting on patients and staff Delays in Day Surgery Unit Impact of IFRS 16 – expected CDEL cover totalling £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 August 2022 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). November 2022 The planned capital expenditure for 2022/23 (incl PFI/IFRIC12 impact) is £27.6m; this has reduced from plan due to the removal of the Salix Grant scheme (£10m). The revised total also now includes confirmed PDC schemes relating to Lung Health check (£1.135m); Endoscopy (£0.6m); Mental Health ED (£0.8m) and MRI Upgrades (£0.1m). It does not yet include other PDC bids the Trust has submitted in relation to Community Diagnostics; EPR digital, Gamma Camera; NICU	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. Q3 Capital position at month 7 shows gross capital expenditure of £9.6m against a plan of £15.8m

						and Phase 2 of the Day Surgery scheme (TIF2). These are all awaiting approval.	
	Risks from Risk Register: 4078 - In year achievement of the Capital plan 1747 - Backlog maintenance issues impacting on Clinical Service Delivery			**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 December 2022 Front entrance build to be completed, Costa Coffee, new restaurant and WHSmith shops open Capital performance and expenditure against the plan = £9.6m against plan of £15.8m		

Inherent Risk			**Risk position as at 31.12.22 (Q3)**			**Planned target risk position by 31/03/2023**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	**5**	**20**	**3**	**5**	**15**	**2**	**5**	**10**

Actions taken, planned and draft assurance rating (AR)

BAF Risk 1		**Culture** The Trust does not make progress towards further improving a positive working culture this year.						
		Inherent Risk Rating		**Current Risk Rating**		**Target Risk Rating**		
		5 x 4 = 20		**4 x 4 = 16**		**2 x 3 = 6**		
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**
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		Zero Tolerance Policy Launched Management Briefing sessions continued 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. 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.		ESR Bridging the Gap Measure – Create an inclusive environment within the Trust that enables people to feel confident to be open about their sexual orientation and/or gender identity. Launch a Zero Tolerance to LGBTQ+ Discrimination Framework Q3 2023. Review Staff Survey results (Dec 2022)		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 Individual HG work ongoing re retention/cultural work e.g. task & finish group led by Chief Nurse & Director of Midwifery with comprehensive actions & work re cultural transformation; cultural & advanced comms workshops in Critical Care Great Leaders Bitesize 90-Day Challenge Rise and Shine – aspirational leaders – cohort 5 Realising your remarkable – self study 4 hour webinars Stretch thinking – online course introduced A bespoke cultural programme "The Inclusion Academy" is in development. The aim is to develop and deliver meaningful content to bring our values to life and make HUTH an innovative and inclusive employer. Facilitation of the Mary Seacole NHS Leadership Programme will be completed in Q4. 2023/24 will mean 5 places on the programme for HUTH staff members. Optometry compassionate and collective leadership model being implemented		

Red	Target risk unlikely to be met – insufficient or ineffective 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.

BAF Risk 2		Workforce The Trust does not effectively manage its risks around staffing levels in both quality and quantity of staff across Trust						
		Inherent Risk Rating		Current Risk Rating		Target Risk Rating		
		4 x 5 = 20		4 x 4 = 16		3 x 4 = 12		
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**
There are currently 43 Trainee Nursing Associates (TNA), with 19 due to finish the programme in May July 2022, and a further 3 who will finish in September 2022. The Trust has recently appointed a RNA Nurse Educator who is providing pastoral support and gaining an understanding of what is working well and where improvements need to be made for this group of Staff. Work has commenced in developing a mechanism to triangulate the actual and required CHPPD, (which is determined through identification of the patient acuity and dependency levels using the SNCT), for all inpatient areas and ED in conjunction with the harm rates, red flags, staff training and engagement for all areas where the required CHPPD is greater than the actual. It is envisaged that this information will support the Nurse Directors to proactively identify `High Risks` areas and required action. This information will be presented in future reports in conjunction with the following factors/mitigation implemented to mitigate the identified risk		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.		Health and Wellbeing Committee – Commences December 2022 and Chaired by the Deputy Chief Nurse. Mental and Emotional Wellbeing Multidisciplinary Team Meeting – Commenced October 2022 and Chair by our Organisational Development Manager. Phase 1 Health Roster is practically complete with 95.35% of Nursing staff on the e-roster system Almost 2000 staff were added to the HealthRoster system between August 2021 and August 2022 and now benefit from the functionality it provides Explore electronic solutions for the processing of Pool and Pilot bank overtime to remove the need for paper timesheets.		Lets get Started` Induction programmes for RN`s & 'Where Care Begins' for the Nursing Assistants. Keep in touch days for all newly qualified/International Nurses throughout the year Robust PDM/ CNE /PLF infrastructure Matron late shift (till 10pm Mon – Fri) to visit wards and deliver pastoral care/support to staff Non Registered Development Programme/Induction and Preceptorship Programme Tea Trolley – OD team provide staff support confidentially The Trust has expanded its TRiM investment with a number of TRiM practitioners taking the next steps to become TRiM managers. Clinical Lead Physiotherapy – Integration of Critical Care and Surgery Therapy Services to create joint services and a shared vision. Work is ongoing to expand the project across the services.		

Red	Target risk unlikely to be met – insufficient or ineffective 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.

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 'outstanding' rating						
		Inherent Risk Rating		Current Risk Rating		Target Risk Rating		
		4 x 4 = 16		3 x 4 = 12		2 x 4 = 8		
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**
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 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		Falls task and finish group established 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		Upcoming QI Celebration Event to be held virtually 28/11/22. 31/10/22 Start of HUTHs first QSIR Virtual cohort commenced ThinkTank programme has now received 165 submissions, ongoing work to progress staff ideas Trajectories given to each HG to support backlog of open complaints. Targeted work with Surgical HGs with Exec led weekly backlog meetings to clear complaints. This will commence in Medicine HG from December. An investigation has been completed and presented to the November 2022 Mortality and Morbidity Committee. The investigation did not identify any unavoidable deaths; however, it did identify some minor coding issues with pneumonia. A further review into the 10 malignancy deaths in August 2022 is to be completed. Development of Falls Champions network to share lessons learned, best practice and quality improvement initiatives		Transition to PSIRF planned from April 2023. PSIRF training has started. Targeted work with HGs regarding complaints is ongoing. Band 6 Patient Experience and Engagement Manager recruitment underway Implementation of new PHSO complaints framework underway 2nd Celebration event planned for February 2023 Development of a CQI public facing website commenced Development of Human Factors Hub to commence and launched in April 2023 Tissue viability – eLFH modules 1 and 2 have been added to HEY 24/7 and a draft template has been developed for each directorate to report to the Safer Skin Committee to identify actions to reduce pressure damage incidents		

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

BAF Risk 3.2		Harm Free 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 Rating			Current Risk Rating			Target Risk Rating	
		5 x 5 = 25			4 x 4 = 16			3 x 3 = 9	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
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 ECIST Visit – positive feedback Progressing mutual aid with partners		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 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		RAT Model for Emergency care commenced EMHG to explore potential of 7 day service Short term plan to use Storey Street whilst a co-located UTC is being progressed SDEC to function from 8am to assist with patient flow National streaming tool directing patients to a UTC to be trialled in December 2022 HUTH Flow model being trialled – November 2022 Cohorting ambulances with YAS enables a single crew to monitor patients Board to ward rounds in Medicine are being rolled out to non-frailty wards – Audit has shown the peak discharges brought forward by 1 hour compared to October 2021 System leaders have agreed no more than 100 NCTR patients by end of December 2022 Additional 30 community beds by the end of December 2022		Transition to PSIRF from April 2023 will transform the approach to patient safety investigations Confirm outstanding competency check requirements for ED staff Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved. Continue with the close monitoring of the delivery of the fundamentals of care in a timely response Tissue Viability Nurses to review the impact of any delayed skin assessments on patient outcomes Continue with the interim support arrangements from the Deputy Chief Nurse Continually review the impact of the HOB opened on the 13th floor and agree the requirements for a HOB on the Acute Assessment Unit Recruitment to the 1WTE additional to support the discharge lounge Continue with the plans to introduce the 90 day plan of the ground floor model Continue to raise awareness of and deliver the MCA training Work to continue with the development of the designated mental health assessment area adjacent to ED Test staff feedback following the full completion of the ED digital work 'Frosting' will be applied to glass to improve privacy and dignity.			

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

BAF Risk 4		**Great Clinical Services** There is a risk to access to Trust Services							
		Inherent Risk Rating			**Current Risk Rating**			**Target Risk Rating**	
		5 x 5 = 25			**4 x 5 = 20**			**4 x 4 = 16**	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
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		RAT Model for Emergency care commenced EMHG to explore potential of 7 day service Short term plan to use Storey Street whilst a co-located UTC is being progressed SDEC to function from 8am to assist with patient flow National streaming tool directing patients to a UTC to be trialled in December 2022 HUTH Flow model being trialled – November 2022 Cohorting ambulances with YAS enables a single crew to monitor patients Board to ward rounds in Medicine are being rolled out to non-frailty wards – Audit has shown the peak discharges brought forward by 1 hour compared to October 2021 System leaders have agreed no more than 100 NCTR patients by end of December 2022 Additional 30 community beds by the end of December 2022		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. Internal milestone set to achieve zero x 80 week waits at 31 December 2022, however due to capacity constraints this was not achieved in challenged specialties (mainly Colorectal and Gynaecology). 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 Improvement in the Lower GI triage processes will shorten the pathway and lead to performance improvement – non-recurrent funding in place; will need recurrent support from the 23/24 & 24/25 growth for cancer Increasing numbers of 2WW referrals received with a FIT test result will enable more patients to be effectively triaged; locally at +60% which continues to be monitored and on-going		

						discussions with primary care planned to further improve uptake by GPs Gynae-oncology – service improvement meeting (13.01.23) identified a programme of work that will support improvement in cancer pathways for patients and performance against Cancer Waiting Times Urology action plan developed and agreed with the service and already gaining traction, although improvement will not be realised until into the new year Hull University Teaching Hospitals NHS Trust 19 | Page Upper GI – newly introduced steps at the beginning of the pathway that allows patients to have a CT scan on the same day as endoscopy if the results of the endoscopy indicates a likely cancer. This will speed up the pathway, reduce the number of times patients are discussed at MDT meeting and improve compliance with the 62 day standard Head and Neck – service improvement session being planned to share pathway analysis and recommendations for improvement These action plans form part of the overall Cancer Transformation programme of work		

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Blue	Target risk rating achieved.

BAF Risk 5		Partnerships There is a risk to the development of the ICS and HASR due to recovery constraints							
		Inherent Risk Rating 3 x 4 = 12			Current Risk Rating 3 x 3 = 9			Target Risk Rating 2 x 3 = 6	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**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)		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		Consultation process for HASR postponed until April 2023 due to political situation and local elections Integrated Impact assessment exploration with clinical staff CAP Planned Care Strategy to be established		**Cardiology** Cardiac CT working group established and work plan under development NLAG validation to prevent duplicate/repeat echo requests now embedded Agreement to progress with Heart Failure workstream with project team support **Dermatology** Service Strategy approved at FWHG and Medicine Divisional Board Activity profile and baseline metrics for 2022/23 received **ENT** Development of specialty level Delivery Group and Operational Groups to mobilise planned activities Time out to be arranged for HUTH and NLAG clinical, nursing and operational teams. **Gastroenterology** Scoping meetings held with NLAG and HUTH clinicians QIP to review current processes for suspected cancer pathways Time out for teams in Feb 2023 Operational lead recruited Jan 2023			

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Blue	Target risk rating achieved.

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 Rating 4 x 4 = 16			Current Risk Rating 3 x 4 = 12			Target Risk Rating 2 x 4 = 8	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
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		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.		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. Service pressures resulting in issues with the recruitment and retention of staff. Opportunities for staff to join research teams via secondments ad other shared models is becoming increasingly difficult, creating challenges for the deployment of suitable staff across research vacancies. Reconfigurations and the implementation of social distancing have led to several research areas experiencing accommodation issues. Capital developments will need to ensure research and innovation activities can be accommodated and staff appropriately housed. Demand for IT and Digital innovation is increasing. This brings an inevitable increase in the demand for the associated skills in the workforce and from our dedicated H-Digital Teams.		Joint RDI working between HUTH and NLAG Joint strategy to be agreed			

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Blue	Target risk rating achieved.

AF Risk 7.1		Financial Expenditure incurred exceeds income by greater than agreed control total							
		Inherent Risk Rating 5 x 4 = 20		Current Risk Rating 5 x 4 = 20				Target Risk Rating 3 x 4 = 12	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**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.		No clawback of Elective Recovery funding is required for the first 6 months, removing the £6m risk				

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

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 Rating			Current Risk Rating			Target Risk Rating	
		4 x 5 = 20			4 x 5 = 20			3 x 5 = 15	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**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.		The overall forecast for CRES delivery has improved and the Trust is reporting that it will achieve 99% delivery by year-end. £4.8m of this is non-recurrent so recurrent delivery is 72%. Health Groups are reviewing plans and looking to identify additional schemes to close the recurrent gap. CRES position improving in Clinical Support, Medicine and EF&D					

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Blue	Target risk rating achieved.

BAF Risk 7.3		Financial Sustainability Failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability							
		Inherent Risk Rating		Current Risk Rating				Target Risk Rating	
		4 x 5 = 20		3 x 5 = 15				2 x 5 = 10	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
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		Capital position at month 7 shows gross capital expenditure of £9.6m against a plan of £15.8m The planned capital expenditure for 2022/23 (incl PFI/IFRIC12 impact) is £27.6m; this has reduced from plan due to the removal of the Salix Grant scheme (£10m). The revised total also now includes confirmed PDC schemes relating to Lung Health check (£1.135m); Endoscopy (£0.6m); Mental Health ED (£0.8m) and MRI Upgrades (£0.1m). It does not yet include other PDC bids the Trust has submitted in relation to Community Diagnostics; EPR digital, Gamma Camera; NICU and Phase 2 of the Day Surgery scheme (TIF2). These are all awaiting approval.					

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

Agenda Item		Meeting	Operational Risk and Compliance Sub-Committee	Meeting Date	22 February 2023
Title	Corporate Risk Register				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Chris Richards, Risk Manager				
Report previously considered by (date)	The report is considered at The Executive Management Committee bi-monthly				

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2022/23	
Trust Board Approval		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 Operational Risk and Compliance Sub-Committee is asked to:

- Receive the Corporate Risk Register and offer any challenge to the movement, risk ratings or mitigating actions.
- Advise if any more information or scrutiny is required.
- Review High Operational risks for possible escalation onto the Corporate Risk Register.
- To approve closure of risks; 3995, 3999, 4000 to be replaced with 4178, 4179, 4180 and for them to remain on the Corporate Risk Register at Moderate 12 for Board level oversight.
- *4031 – Patient transmitting hospital acquired infections due to inadequate bed spacing*. Acknowledge rise in risk rating to 20 and agree tolerance level for this risk.
- *3988 – Lack of Therapeutic Radiographer Staffing.* Consider if inclusion onto the Corporate Risk Register is required.
- *4049 – There is a risk to the safety and wellbeing of children and young people with mental health requirements who require admission* - Acknowledge removal from the Corporate Risk Register and approve closure.
- *3317 - There is a risk of Legionella proliferation within the HRI Tower Block piped water systems* – Acknowledge removal from Corporate Risk Register back to the Operational Risk Register.

Hull University Teaching Hospitals NHS Trust

Corporate Risk Report – February 2023

1. Open Risks on the Corporate Risk Register

There are currently 11 open risks on the Corporate Risk Register. Full details can be found in Appendix 1.

Open risks on the Corporate Risk Register by Health Group:

	Sept	Oct	Nov	Dec	Jan	Feb
Corporate Functions	4	3	2	0	0	-
Clinical Support - Health Group	2	2	2	2	1	1
Emergency Medicine - Health Group	2	2	2	2	2	2
Family and Women's Health - Health Group	3	2	2	2	2	2
Medicine - Health Group	1	0	0	0	0	-
Trustwide	5	5	5	5	6	3
Total	17	14	13	11	11	8

Current Open risks on the Corporate Risk Register by Risk Subtype:

	Infection Prevention & Control	Patient Safety & Quality of Care	Regulatory inc. Health and Safety	Total
Clinical Support - Health Group	0	1	0	1
Emergency Medicine - Health Group	0	1	1	2
Family and Women's Health - Health Group	0	2	0	2
Trustwide	1	2	0	3
Total	1	6	1	8

2. Closed Risks (Appendix 2)

<u>February 2023</u>

Following review by the Deputy Chief Operating Officer (Elective Recovery and Cancer) all of the risks below have been closed as deemed out of date. These have been replaced with new risks that better reflect the current position.

3995 - Significant waiting list issues including access to screening and follow-up programmes
(Replaced with 4179 - Delivering on the Operational Plan requirement to reduce the backlog of long-waiting patients)

3999 - > 52 week wait
(Replaced with 4178 - Delivering the improvement trajectories for screening programmes delivered by the Trust)

4000 - HGB - Maximum 62-day wait for first treatment from an urgent GP referral for suspected cancer. NHS cancer screening referral
(Replaced with 4180 - Patient safety risk for patients who have waited 63+ days for a 1st definitive cancer treatment)

3. Changes to Risks and Risk Ratings

4031 - Patient transmitting hospital acquired infections due to inadequate bed spacing. This risk was raised from 15 to 20 due to increase in infections. Strategic Infection Prevention Committee agreed that they are unable to mitigate this risk further or achieve target. Decision requested as to the tolerance level for this risk.

4. Operational Risks Escalated for Inclusion on the Corporate Risk Register (Appendix 3)

December
3320 - Paediatric Theatre Capacity risk
November Operational Risk and Compliance Sub-Committee approved for escalation to the Corporate Risk Register but the Clinical Director and the Operations Director did not feel this should be a high risk. Risk taken back to the Health Group for further discussion.

January
3988 – Lack of Therapeutic Radiographer Staffing
This has not been escalated for inclusion on the Corporate Risk Register by the Health Group but the Executive Management Committee is asked if inclusion is needed due to the ongoing work and discussions surrounding this at Board level.

February
These risks replace 3995, 3999 and 4000.

New risk - 4178 - Delivering the improvement trajectories for screening programmes delivered by the Trust (Moderate 12)

New risk - 4179 - Delivering on the Operational Plan requirement to reduce the backlog of long-waiting patients (Moderate 12)

New risk - 4180 - Patient safety risk for patients who have waited 63+ days for a 1st definitive cancer treatment (Moderate 12).

5. De-escalated from Corporate Risk Register Back to the Operational Risk Register (Appendix 2)

November
4049 - There is a risk to the safety and wellbeing of children and young people with mental health requirements who require admission.
Due to the significant amount of work carried out in this areas this risk has been reduced to a current risk rating of 8 which is lower than the target of 12. Recommendation is that this risk be closed was taken to the Mental Health Steering Group 09 November 2022.

3960 - Risks associated with Mental Health patients managed in the Emergency Department Risk downgraded to 12 Moderate. Transferred back to be managed via the operational risk register.

December
3317 - There is a risk of Legionella proliferation within the HRI Tower Block piped water systems
Regular testing and monitoring have all come back with negative or very low results. Downgraded to 10 Moderate.

6. Risks on the Corporate Risk Register Over Two Years Old

Risk Type	ID	Opened	Title	Rating (current)
Clinical	2789	16/12/2014	Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service	16
Clinical	3044	18/01/2017	Shortage of Breast Pathologist	16
Clinical	3439	04/09/2019	Crowding in the Emergency Department	25

Actions taken:
Challenges are being given to risk owners and services to encourage discussions around if the risk reflects the present day or if a new risk should be opened.

7. Operational High Risks - for information only

There are currently 48 High risks on the Operational Risk Register that have not been escalated for inclusion onto the Corporate Risk Register (Appendix 4).

8. Risk Management – Areas of Ongoing Improvement

1. Action plans are not always utilised to maximise focus and movement of the risks.
2. Although improvements are being seen, risks are not always reviewed within timescales.
3. Risk owners/handlers are not always updated when staff leave or responsibilities change and those who do replace old handlers don't always have an understanding of the issues or the risk management process in general.

The risk team are working with health groups and risk owners to support in all the areas of ongoing improvement. It is hoped that the new training which is to be delivered in the New Year will also help.

9. Recommendations

The Operational Risk and Compliance Sub-Committee is asked to:

- Receive the Corporate Risk Register and offer any challenge to the movement, risk ratings or mitigating actions.
- Advise if any more information or scrutiny is required.
- Review High Operational risks for possible escalation onto the Corporate Risk Register.
- To approve closure of risks; 3995, 3999, 4000 to be replaced with 4178, 4179, 4180 and for them to remain on the Corporate Risk Register at Moderate 12 for Board level oversight.
- *4031 – Patient transmitting hospital acquired infections due to inadequate bed spacing*. Acknowledge rise in risk rating to 20 and agree tolerance level for this risk.
- *3988 – Lack of Therapeutic Radiographer Staffing*. Consider if inclusion onto the Corporate Risk Register is required.
- *4049 – There is a risk to the safety and wellbeing of children and young people with mental health requirements who require admission* - Acknowledge removal from the Corporate Risk Register and approve closure.

- *3317 - There is a risk of Legionella proliferation within the HRI Tower Block piped water systems* – Acknowledge removal from Corporate Risk Register back to the Operational Risk Register.

Rebecca Thompson
Head of Corporate Affairs
February 2023

Chris Richards
Risk Manager
February 2023

Appendix 1 – Corporate Risk Register Open Risks

Risk ID	Risk Description	Risk Owner	Date Identified	Inherent Risk Score (SxL)	Current Risk Score (SxL)	Target Risk Score (SxL)	Commentary & Action Updates
2789 - Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service (F&W)							
Condition: Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service Within the Ophthalmology Department the capacity for intra-vitreal injections has been limited for a number of years. The target for a new patient is to be seen and treated within 2 weeks of the date of referral and the follow up injection must be performed in a timely manner or there is a risk of disease reactivation /progression with resulting sight loss. **Cause:** Additional causes to this risk are: 1. The significant expansion in the numbers of retinal	Downey, Ms Louise	16/12/2014	20 4 x 5	**16** **4 x 4**	8 4 x2	**Links** Strategic Goal 2 – Valued, skilled and sufficient workforce BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm Linked Risks - 2665, 1817 **Updates** 08 November 2022 Discussed at Specialty Governance. New Nurse Injector has been trained which should help increase capacity. One further nurse to commence training 09/11/22. December 2022 Nursing practitioner capacity improved but patient number have also increased. Large backlog on virtual reviews remains. Risk to remain the same. January 2023 Reviewed at Ophthalmology governance meeting. No change - awaiting submission and approval of staffing business case

diseases that can be treated with this therapy. 2. Difficulties with recruitment and retention of Consultant staff. 3. Issues with Nursing capacity to support this service **Consequence:** The consequence of this risk is that there is a delay in patients receiving their treatment which could adversely affect their vision.						
3044 – Shortage of Breast Pathologists (F&W)						
Condition: The Trust has 2 Consultant Pathologists who do Breast pathology. The crisis has been precipitated by one Consultant going off with a long term illness. **Cause:** The service is dependent on one Consultant, if she were to go off for any reason, not only will the symptomatic breast service collapse the breast screening service would also.	Brendan Wooler	18/01/2017	16 4 x 4	**16** **4 x 4**	8 4 x 2	**Links** Strategic Goal 2 – Valued, skilled and sufficient workforce BAF Risk 2 – The Trust does not effectively manage its risks around staffing levels **Updates** November 2022 Risk reviewed at governance and still remains a high risk and issue is still a real issue with the service. January 2023

Consequence: There is likely to be a delay in turnaround time for biopsies and resection specimens that can potentially lead to cancer breaches and delay in treatment.						Specialty meeting took place on 09/12/2022, the service needs another pathologist however there is recruitment issues and a national shortage. Still remains an issue and to remain on the RR. <u>January 2023</u> Confirmation received that this risk will be raised on the SHYPS governance escalation report asking them to provide more up to date data on turn-around times and service provision etc. Breast service to be asked for any data to support the current high risk rating that can be shared with SHYPS
3439 – Crowding in the Emergency Department (EM)						
Condition: There is an issue that patient care is compromised due to the emergency department being crowded. **Cause:** 1. Mismatch between demand and capacity 2. Flow through the department 3. Exit block **Consequence:** 1.Increased Mortality 2. Increased length of stay 3. Reduced quality of care	Rayner, Dr Ben	04/09/2019	25 4 X 5	**25** **5 x 5**	6 3 x 2	**<u>Links</u>** Strategic Goal 2 – Valued, skilled and sufficient workforce Strategic Goal 3 – High Quality Care Strategic Goal 4 – Great Clinical Services BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm BAF Risk 4 - There is a risk to access to Trust services due to the impact of Covid-19 Linked Risks – 4056, C3044, 3295, 3296, 3646, 3991, 4008, 3607, 2906, 4002, 2960, 4010, 2898, **<u>Updates</u>** <u>November 2022</u>

4. Poor Patient experience 5. Staff Burnout 6. Difficulty in recruiting and retaining staff						ED monthly Risk review - the Bristol model in place, ECA flow and the use of decision makers in the department to reduce crowding and waiting times for patients. Department has seen improvement however the programme is in its infancy. 1. ECA flow and decision maker is helping the crowding situation and flow. Decision makers are redirecting patients to urgent treatment centres. 2. The Trust in implementing the Bristol Model Concerns raised about turning patients away being sat at the front streaming can lose oversight of the rest of the department. Decision maker can be a Consultant or senior Registrar. The streaming role still needs refining about the expected outcomes. <u>December 2022</u> ED continue amending work practices. Bronze and many other meetings/workstreams feed into the management of this risk including the urgent CQC action plan. <u>January 2023</u> ED Monthly risk meeting - discussion of adding a new risk versus adding an additional element to this risk regarding patient safety measures V's. Flow in the ED, Flow for emergency and acute patients is compromised across the Trust. Due to the nature of the risk and mitigation's in place the decision to create a new risk. The number of patients attending the department has decreased but the time spent in the department has increased.

						The department is still experiencing crowding, the risk is discussed daily at the GOLD command meeting and daily mitigation put in place to ease pressures.
3994 - Discharges and Patient Flow with impact on quality and safety (Trustwide)						
Condition: There is a risk to quality of care and patient safety as a result of delayed discharges and poor patient flow **Cause:** Delay in discharge impacts on patient flow which contributes to delays in access to treatment **Consequence:** Deterioration in the health of patients and their Risk and poorer clinical outcomes. Poor patient experience and possible regulatory action	Paul Walker	09/09/2021	20 4 x 5	**16** **4 x 4**	6 3 x 2	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services BAF Risk 3.2 - There is a risk that patients suffer unintended or avoidable harm **Updates** December 2022 The number of patients in November 2022 with No Criteria to Reside continues to be the single largest factor affecting performance with a daily average of 257 (+23 on last month) patients per day remaining within the hospital who have no medical need for acute services. Risk rating to remain the same. January Update 2023 At 31 December 2022, there were on average 231 patients per day with NCTR, increased from last month. This is 22% of the total general & acute beds, and 34% of the beds at HRI (total G&A beds 680 HRI/347 CHH) occupied by NCTR patients who should be receiving appropriate care elsewhere with the support of other partner organisations or settings. • The Interim Deputy Chief Nurse leads a regular review of patients 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. - Next discharge initiative 27 February 2023, for 1 week, focusing on smaller number of initiatives with system partners.
3997 - Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E (EM)						
Condition: There is a risk that patients may come to unintended harm **Cause:** Prolonged waiting times within the ED in excess of the 4-hour target **Consequence:** Deterioration of Risks, poorer clinical outcomes, delays in access to specialist treatment and possible regulatory action	Ramsay, Carla	09/09/2021	25 5 x 5	**20** **5 x 4**	10 5 x 2	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 3.2 - There is a risk that patients suffer unintended or avoidable harm Linked Risks – 4056, 3683, 3687 **Updates** November 2022 ED monthly Risk review - the Bristol model in place, ECA flow and the use of decision makers in the department to reduce crowding and waiting times for patients. Department has seen improvement however the programme is in its infancy. 1. ECA flow and decision maker is helping the crowding situation and flow. Decision makers are redirecting patients to urgent treatment centres. 2. The Trust in implementing the Bristol Model Concerns raised about turning patients away being sat at the front streaming can lose oversight of the rest of the department. Decision maker can be a Consultant or

						senior Registrar. The streaming role still needs refining about the expected outcomes. <u>December 2022</u> Trial has been ongoing which is having a positive impact lower waiting times when a clinician is on the front door. Data analysis to be done. Actions from crowding risk link to this risk. Discussion taken and all agreed to leave rating until data is compiled. Data from the streaming clinician and re-attendances is being collected. Discussion held around the 4 hour target rating, with the suggested of increasing the rating. <u>January 2023</u> Still unable to see patients within the 4 hour target, due to current pressures. Trying to make improvements to targeted areas such as ECA. Data maybe inconsistent due to the documentation of safety checks and triage of patients, additional training for clinical body to ensure consistency across the department. Discussion held on the best way to see patients ensuring the sickest patients are seen first whilst trying to ensure the least sick patients are not left waiting for substantive amounts of time.
3998 - Quality issues identified due to handover delays (Trustswide)						
Risk: Quality issues identified due to handover delays causing unintentional harm to patients	Paul Walker	09/09/2021	25 5 x 5	20 5 x 4	9 3 x 3	**<u>Links</u>** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services

Cause: Number of ambulances waiting at A&E due to lack of Community Care, GPs and Urgent Care Treatment Centres. **Consequence:** Unintentional patient harm						BAF Risk 3.2 - Quality issues identified due to handover delays **<u>Updates</u>** <u>December 2022</u> Ambulance handover position remains highly challenged due to the number of lodged patients within ED. YAS reporting a 30% increase in Category 1 calls (immediate response) • YAS and HUTH continue to work on improving ambulance handover times to enable the release of ambulance crews to support the community, albeit there continues to be significant challenges in this area. The use of cohorting has increased, there have been discussions and a risk assessment completed for using the Fracture Clinic for cohorting and this area is not being used whilst identified risk are addressed. Risk rating to remain the same <u>January 2023</u> There were 911 (+413 on previous month) over 60 minute ambulance handover delays in December 2022 that equated to 35.5%. Patient flow model in place in ED but performance is varied due to multiple factors. Cohorting of ambulances also in place. Flow remains challenged - NCR occupying over 30% of medical bed base.
4031 - Patient transmitting hospital acquired infections due to inadequate bed spacing (Trustwide)						

Condition: the risk of patients transmitting hospital acquired infections due to inadequate bed spacing in surgical and medical wards **Cause**: beds are too close together **Consequence:** patients harm due to spread of infection	Greta Johnson	17/12/2021	20 5 x 4	**20** **5 x 4**	10 5 x 2	**Links** Strategic Goal 3 – High quality care BAF Risk 3.2 - There is a risk that patients suffer unintended or avoidable harm **Updates** December 2022 Risk updated at OIRC meeting. Increase of infection seen. Risk rating increased from 15 to 20 updated to reflect this. # Some wards have now have the floor to ceiling partitions installed. # Infection control incidents are being supported by IPC, this will result in an increase of reporting to demonstrate incidents and provide support for risks # A back to basics - staff infection control awareness program is being rolled out across the trust to remind staff of simple infection control necessities such as hand washing procedures. February 2023 Risk discussed at Operational and Strategic IPC committee. GJ agreed some SOPs are to be developed regarding management of various infection strains but unable to mitigate risk further without reducing overall bed base and will not achieve target. To escalate to Board / BAF as to tolerance level for this risk.

4110 - There is a risk to patient safety as a result of the Pharmacy aseptic unit being unable to meet the required service demands (CS)						
Condition: There is a risk that the aseptic unit is on the verge of collapse, partial or totally. **Cause**: As a highly regulated area, the pharmacy aseptic unit needs to meet strict criteria to ensure low risk of harm to the patients. This is assessed by the EL(97)52 audit regularly undertaken by the QA regional team. Our unit has always enjoyed as low risk status and the "issues found" have mostly been able to be resolved easily. Our quality and safety has always been paramount. Unfortunately there are many contributing factors that are putting the aseptic unit at risk: The list comprise: -Increased number of patients	Antonio Ramirez	21/09/2022	**20** 4 x 5	**16** 4 x 4	**4** 2 x 2	**Links** Strategic Goal 3 – Valued, skilled and sufficient workforce Strategic Goal 4 – Great clinical services BAF Risk 3.1 – There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long term aim of an 'outstanding' rating. BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm. **Updates** <u>02 November 2022</u> Staffing issues • The service are strengthening HR and staff support processes. Discussions have been held with the finance department to strengthen business plan. • Two further members have staff are leaving. Recruitment for replacements is underway. Isolators • The replacement program has been brought forward and the service have been allowed to order 2 isolators. Unfortunately, the lead-time for delivery is within 46 weeks. Air Handling Unit • It is worth noting that the sites (NLAG and York) which the service can move to, as per their contingency plans, have only approximately a quarter of the capacity of HUTH complicating our business continuity issues. There are two key potential solutions to this:

-External compounders unable to meet market demand -Insufficient staff levels -Poor performance and quality of the isolators -Poor performance of the unit's air handling unit (AHU) and need for replacement, including unit's closure -Radiopharmacy pressures **Consequence:** If the service continues as it is, there is a possibility that during the next audit visit (scheduled for October 2022) our quality systems prove insufficient and the risk rating could increase from low to moderate or high. . If that happens, we would need to invest more staff resources to achieve low risk again, reducing our manufacturing capacity furthermore. There is also the possibility of total or partial closure of the unit for some time, the reduction of the expiry dates for our products (making preplanning near to						a) HUTH have contingency plans with a larger unit or contemporary unit to our own (e.g. Leeds, Sheffield) either direct to a single Trust or as part of the hub-and-spoke model with WYAAT+Harrogate b) HUTH invests in a second aseptic facility to split the Trust's requirements. Therefore, if one needs a programmed shutdown or fails the other can accommodate it without the need to decamp to another Trust. <u>December 2022</u> Risk discussed at HG governance meeting. The situation is deteriorating as two staff will be leaving in December and one going on maternity in January. A new starter will be in training. Active recruitment is ongoing. Higher grades are being employed to cover lower grade roles and keep service running. Risk to be reviewed as part of Triumvirate scrutiny meeting in January. <u>December 2022</u> Reviewed in Pharmacy Governance. Date for closure has been set as for 15th May 2023 and should take a couple of weeks. GFM has ordered parts needed. Pharmacy team will need to clean aseptic unit after the work has been completed and revalidate all areas. Plan for NLAG to complete Aseptic work and all non aseptic work to be completed at HUTH. Staffing is being reviewed in all pharmacy areas to identify what support can be given in the interim, however this will leave other areas short. <u>January 2023</u>

impossible) or the reduction of number of items we can prepare.						Reviewed at Pharmacy governance. Interviews for additional staff being held and discussions are ongoing with suppliers. No change to risk rating at this moment.

Appendix 2 – Risks Removed from the Corporate Risk Register

***Closed* 4049 - There is a risk to the safety and wellbeing of children and young people with mental health requirements who require admission (CF)**						
Condition - There is a risk to the safety and wellbeing of children and young people with mental health requirements who require admission to the Trust within both the paediatric and adult bed base. **Cause** - Mental health issues have become more prevalent over the last two years within the adolescent age group. Staff within the paediatric team at HUTH are not trained in physical restraint as standard training. The Trust has seen a significant increase in children and young people with eating disorders **Consequence** - Patients and staff have the potential to come to physical harm.	Kate Rudston	16/03/22	4 x 5 20	**4 x 2 8**	4 x 2 8	**Links** Strategic Goal 2 – Valued, skilled and sufficient workforce Strategic Goals 3 – High quality care Strategic Goal 5 – Partnership and integrated services BAF Risk 3.2 - There is a risk that patients suffer unintended or avoidable harm **Updates** November 2022 Update Update from risk owner - Bullet points are the updates as of November 2022 – evidence can be provided for all of the below points if required. The risk can be lowered to unlikely but moderate if so – 8. • The SG children's team continue to visit paediatric areas each working day. Children and young people with MH and SG concerns are reviewed regularly and appropriate input provided with internal escalation to the Assistant Chief Nurse when required. The Named Nurse for SG Children attends strategy meetings and escalates any issues related to patient safety, risk, resources, and provider challenges. • A weekly report is submitted for children and young people in the Trust with MH problems so that the

						executive team are aware of this and any problems with delays in transfer of care to MH inpatient beds. • One to One Supervision. With paediatric services, the care plan and MH risk assessment has been updated and this is more robust in assessing the risk of self-harm and provision of one to one supervision. The Enhanced Care Team Matron has full oversight of all patients on one to one supervision in the Trust and provides support and advice on legal frameworks as well as visibility in areas where high-risk patients are being supervised and detained. • Training for therapeutic holding has been developed in collaboration with Humber FT and is compliant with Restraint Reduction Network regulations (2019). The training commenced end of March 2022 with over half of the nursing staff on the inpatient ward attended with further training booked between January and March 2023 which will include identified staff in the Emergency Department. The training is over 2 days and covers all aspects of mental health and holding techniques such as required for treatment and care. This is particularly important for patients with eating disorders who are detained under the MHA and to preserve life. • The Trust hosts an advanced clinical MH practitioner from HFT from July 2022 and is works on the paediatric wards with the clinical teams and the patients and their families. Specifically assists with training, risk assessments, cognitive therapy, staff supervision, learning from case review, development of processes and transfer of care. The post holder works

						closely with the MCA Matron and the enhanced care team. • Establishment of a senior leads monthly meeting between Humber FT and HUTH to discuss cases, progress, workforce, 'in reach', capacity, good practice and escalation. This was set up between the Deputy COO for Humber FT and the Assistant Chief Nurse at HUTH with meetings to commence in March and specific to paediatrics and CAMHS. Minutes of the meeting will be provided to the MH, LD and Autism Committee. Two task and finish groups will focus on eating disorders and one to one supervision. • A Business Intelligence report has been developed in July 2022 to have a real time view of all under 18's in adult inpatient beds. This report is reviewed daily by the SG children's team and contact with the ward is made to check capacity, consent, SG or any other issues such as MH detainments. The SG children's team will visit the ward if there are any positive disclosures to their questions or the staff need support with a patient on an adult ward. • The Trust has established a working group in ED to review the MH QIP and includes review triage documentation of children and young people with MH problems. The first meeting was held on 3rd November and chaired by a senior consultant in ED – terms of reference set and key priorities. • The Assistant Chief is a member of the regional collaborative working groups on MH and works closely with the Trust Commissioners as part of this issue.

						Risk to be reviewed at the Mental Health Steering Group 09 November to approve closure.
***De-escalated to ORR* 3960 - Risks associated with Mental Health patients managed in the Emergency Department (CF)**						
Condition: Risks associated with Mental Health patients managed in the Emergency Department **Cause:** Delay/availability of decision makers and beds for mental health patients (Outside the control of HUTH) **Consequence:** Highly vulnerable and high risk Patients are kept in the ED department for long periods without specialist staffing or suitable environment to manage the risks associated with their needs.	Kate Rudston	26/05/2021	20 4x5	**12** **4x3**	3 3x1	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated cervices BAF Risk 3.2 - There is a risk that patients suffer unintended or avoidable harm **Updates** 14 October 2022 Update received from Nurse Director (HH) The risk remains the same, there has not been anything implemented in terms of improving outcomes etc. November 2022 Risk reviewed by KR – downgraded to 12 Moderate. Removed from CRR to be manage via the ORR.
***De-escalated to ORR* 3317 - There is a risk of Legionella proliferation within the HRI Tower Block piped water systems (CF)**						
Condition: There is a risk of Legionella proliferation within the HRI	Greta Johnson, Director of	06/02/2019	25 5x5	**10** **5x2**	5 5x1	**Links** Strategic Goal 3 – High quality care

Tower Blockpiped water systems **Cause**: bacteria within the water system **Consequence:** Risk of patients becoming infected and suffering harm	IPC and Neil Kaye, Head of Estates					BAF Risk 7.3 – There is a risk of failure of critical infrastructure **<u>Updates</u>** <u>25 October 2022</u> Risk discussed with risk owner. Tests are ongoing and it has been more than 12 months since a significant positive result. This risk is to be presented at the next Water Committee on December 9th to recommend reduction in risk rating. Action plan to be reviewed what additional actions are required to achieve target risk rating. <u>December 2022</u> This risk was not discussed at the December Water Committee however the Committee Chair (Dean Jackson) confirmed outside the meeting that this was no longer a high risk due to regular monitoring and sampling returning negative results. Advised risk could be downgraded to moderate and removed from the Corporate Risk Register and managed via the Operational Risk Register.
***Closed* 3995 - Significant waiting list issues including access to screening and follow-up programmes (Trust wide)**						
Condition: There is a risk of unintended or avoidable harm to patients **Cause:** Prolonged amount of time of waiting lists which includes access to screening	Julia Mizon	09/09/2021	25 5 x 5	**15** **5 x 3**	9 3 x 3	**<u>Links</u>** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 3.2 - There is a risk that patients suffer unintended or avoidable harm

programmes and follow-up appointments **Consequence:** Deterioration in patient which impacts on quality of life, loss of vision and increased mortality and morbidity						**Updates** November 2022 At the end of November 2022, the Trust reported Zero 104 week waits and it was confirmed that the Trust had been stepped down as a Tier 1 organisation (national oversight and assurance) to Tier 2 (regional oversight/assurance) for long 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. February 2023 Risk reviewed by COO. Risk to be closed as now out of date. To be replaced with new risk which better reflects the current position.
***Closed* 3999 - > 52 week wait (Trustwide)**						
Condtion: There has been a deterioration in the Trust's performance on a number of key standards as a result of the organisation responding to Covid-19. Uncertainty around pace of recovery plan **Cause:** Delayed access to clinical services i.e.	Julia Harrison - Mizon	09/09/2021	25 5 x 5	**15** **5 x 3**	8 4 x 2	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 4 - There is a risk to access to Trust services due to the impact of Covid-19 Linked Risks – 4008, 2668, 2960, 3128, 4011, 4013 **Updates**

outpatient follow-ups, diagnostic testing and screening programmes **Consequence:** Deterioration in the health of patients						December 2022 5,451 patients have waited more than one year for their appointment/procedure, this is below the trajectory of 5,484; validation is on going until the upload deadline of 19th December 2022. The 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. At the end of October 2022, the initial cohort of 31k patients have all been contacted; for the non-admitted pathways, the removal rate was 8.6%. Due to the success of this validation work it has been agreed to continue the text validation as business as usual. February 2023 Risk reviewed by COO. Risk to be closed as now out of date. To be replaced with new risk which better reflects the current position.
***Closed* 4000 - HGB - Maximum 62-day wait for first treatment from an urgent GP referral for suspected cancer. NHS cancer screening referral (Trust wide)**						
Condition: Deterioration in the Trust's performance against the maximum 62-day wait for first treatment from urgent GP referral for cancer patients **Cause:** Delayed access to services underpinned by the Covid-19 pandemic	Julia Mizon / Margaret Parrot	09/09/2021	25 5 x 5	**20** **5 x 4**	5 5 x 1	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great Clinical Services BAF Risk 3.2 - There is a risk that patients suffer unintended or avoidable harm Linked Risks - C3996, 2898, 4010, 2960, 4002, 2906, 3607, C3044, 3295, 3296, 3646, 3991, 3205, 4008

Consequence: Deterioration in patient Risks, delayed treatment, increased mortality and morbidity						December 2022 The number of patients on the 62-day from referral to treatment Cancer PTL has stabilised at between 1,500 – 1,600 (from the highest peak of 1,800), with the latest PTL number (07/12/22) 1,573; this continues to require focussed support to maintain performance improvement, which is starting to deliver. • HUTH remains a Tier 1 provider for cancer performance and is the focus of the 2/52 NHSE assurance and recovery meetings – with particular emphasis on those patients +62 and +104 days, and the recovery trajectory to 31 March 2023 January 2023 Risk changed from Clinical Support to Trust Wide risk. February 2023 Risk reviewed by COO. Risk to be closed as now out of date. To be replaced with new risk which better reflects the current position.

Appendix 3 – New Risks for Approval

***NEW* 4178 - Delivering the improvement trajectories for screening programmes delivered by the Trust (Trust wide)**						
Condition: There is a risk of unintended or avoidable harm to patients if the timeframe for the delivery of screening to patients is delayed/outside of the screening round length. **Cause:** Extended screening round length as a result of the organisation responding to Covid-19 when screening programmes were paused/delayed. **Consequence:** Potential deterioration in patient conditions which impacts on quality of life, i.e. loss of vision, undetected cancer, leading to increased mortality and morbidity	Julia Mizon	Date opened 13/02/2023	20 4 Major x 5 Almost Certain	**12** **4 Major x Possible 3**	6 3 Moderate x 2 Unlikely	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 3.1 – There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating. BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm BAF Risk 4 - There is a risk to access Trust services following the pandemic and during the recovery of elective services Linked Risks – 3999, 4008, 2668, 2960, 3128, 4011, 4013
***NEW* 4179 - Delivering on the Operational Plan requirement to reduce the backlog of long-waiting patients (Trust wide)**						
Condition:	Julia Mizon		20	**12**	6	**Links** Strategic Goal 3 – High quality care

There has been increase in the number of patients on the Trust's waiting list, which has impacted on the number of long-waiting patients who are at risk of breaching the operational plan target, as a result of the organisation responding to Covid-19, the demand for acute, P2 & cancer cases, and the number of patients with no criteria to reside in the bed base at HRI & CHH. **Cause:** Delayed access to clinical services i.e. ICU beds, base ward beds, outpatient 1st and follow-ups and diagnostic testing. **Consequence:** Increased numbers of patients waiting >78 weeks (by March 2023) and >65 weeks (by March 2024) waiting for treatment with the potential for clinical harm.		Date opened 13/02/2023	4 Major x 5 Almost Certain	**4 Major x Possible 3**	3 Moderate x 2 Unlikely	Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 3.1 – There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating. BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm **<u>Update</u>** New risk to replace 3995 - Significant waiting list issues including access to screening and follow-up programmes
***NEW* 4180 – Risk of avoidable harm for patients who have waited 63+ days for a 1st definitive cancer treatment (Trust wide)**						

Condition: The number of patients who have waited 63+ days for a 1st definitive treatment for cancer is higher than the trajectory agreed in the Operating Plan. **Cause:** Delayed access to clinical services partly as a result of the organisation responding to Covid-19, i.e. ICU beds, base ward beds, outpatient 1st and follow-ups and diagnostic testing, and increased 2WW referrals. **Consequence:** Deterioration in patient conditions/delayed treatment with potential for clinical harm.	Julia Mizon	Date opened 13/02/2023	20 4 Major x 5 Almost Certain	**12** **4 Major x Possible 3**	6 3 Moderate x 2 Unlikely	**<u>Links</u>** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 3.1 – There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating. BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm BAF Risk 4 - There is a risk to access Trust services following the pandemic and during the recovery of elective services Linked Risks – 4000, C3996, 2898, 4010, 2960, 4002, 2906, 3607, C3044, 3295, 3296, 3646, 3991, 3205, 4008 **<u>Updates</u>** New risk to replace risk 4000 as now out of date.

Appendix 4 – Operational High Risks not escalated for inclusion onto the Corporate Risk Register

ID	Specialty	Title	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)
2982	Paediatric Surgery	Lack of Anaesthetic cover for Under 2's out of hours	20	High	10	Moderate
3646	Clinical Haematology (Ward)	Haematology Medical Staffing locally and regionally	20	High	8	Moderate
3975	Radiology	Patient care is being compromised due to delays in MRI reporting turnaround times	20	High	5	Low
3983	Radiotherapy	Insufficient Radiotherapy Physics staffing to support the Department's required and mandated activities	20	High	8	Moderate
4032	Radiotherapy	Potential non compliance with the IR(ME)R legislation for incident investigation and mandatory reporting	20	High	5	Low
4038		HGB – There is a risk to patient safety within the Health Group due to shortages of key consultant staff	20	High	6	Low
4068	Orthopaedics (Elective)	Risk to patient safety due to reduction in ability to treat elective Orthopaedic & Neurosurgery (Spinal) patients @ CHH	20	High	10	Moderate
4071	Occupational Therapy	There is a risk that patients assessment and therapy requirements within OT are not identified due to capacity and demand issues	20	High	6	Low
4076	Radiotherapy	The risk is patient harm and/or impact on long-term outcomes due to the timeliness of receiving radiotherapy from DTT	20	High	4	Low
4122	Theatres	Risk to patient safety due to the urgent replacement of Air/Oxygen gas blenders for the heart lung machines.	20	High	4	Low

4163	A and E	Patient safety measures vs. flow in the Emergency Department	20	High	8	Moderate
4170	Major Trauma	Risk of increased morbidity and mortality for elderly MTC patients due to inadequate DME support for Major Trauma Centre	20	High	10	Moderate
3125		Multiple junior doctor vacancies - risk to patient safety and care	16	High	8	Moderate
3918	Acute Medicine	Lack of Adequate Substantive Consultant Workforce in Acute Medicine	16	High	4	Low
3919		E-Radiology Results System: Results not being Actioned Appropriately	16	High	4	Low
3945	Infection Control	There is a risk that patients develop a preventable Healthcare Associated Infection during an inpatient/outpatient episode	16	High	4	Low
3946	Nuclear Medicine	There is a risk to patient safety due to the inability to meet the current demand for mps imaging	16	High	2	Very Low
3988	Radiotherapy	Lack of Therapeutic Radiographer Staffing	16	High	3	Very Low
4002	Gynaecology Oncology	Delayed gynaecology cancer pathways	16	High	4	Low
4030	Nuclear Medicine	There is a risk to service continuity within Nuclear Medicine due to a lack of technical staffing	16	High	1	Very Low
4037	Cardiology	Lack of Suitably Trained Staff to Perform Cardiac Stress Testing	16	High	1	Very Low
4041	Orthopaedics (Trauma)	Risk to patient outcomes from delays due to bed capacity for Priority 1b trauma patients	16	High	4	Low
4056	A and E	Reduced medical staffing numbers (doctors, ACP's etc) leading to increased waiting time for patients and workload on existing cl	16	High	12	Moderate
4075	Radiotherapy	There is a staffing risk with RT Medical Physics (MP Expert) which may affect the delivery of clinical services	16	High	2	Very Low

4090	Clinical Oncology	There is a risk that the patients on the Queen's Centre wards and those who use the triage service may not receive the treatment	16	High	8	Moderate
4120	Systems and Applications	Inability for HUTH to meet the NHSx mandate of one EPR for the ICS by March 2025	16	High	1	Very Low
4134	Systems and Applications	Weak passwords (Domain Users)	16	High	4	Low
4141	Systems and Applications	Network shares (passwords in clear text, sensitive patient data, backups, logs, world writable shares, etc)	16	High	4	Low
4148	Diabetes and Endocrinology	Risk to Patient Safety and Staff Wellbeing Due to Staffing Shortfalls in Diabetes	16	High	8	Moderate
4169	Cardiology	Risk to Continuity of TAVI service due to staffing shortfalls	16	High	4	Low
3252	Ophthalmology	Patients with Diabetic Eye Disease are experiencing delays in assessment and treatment resulting in potential loss of sight	15	High	6	Low
3291	Radiotherapy	Failure to update the Dosimetry Check Patient Transit Dose System	15	High	2	Very Low
3416	A and E	Staff working in the Emergency Care Area feel vulnerable when there are violent and aggressive patients in the department	15	High	3	Very Low
3475	Gynaecology	Concerns surrounding RCOG Trainee Curriculum - Obstetrics and Gynaecology	15	High	5	Low
3962	Radiology	Cardiac CT demand outstripping capacity	15	High	6	Low
3964	Radiology	Patient care is being compromised due to a shortfall in CT Reporting capacity	15	High	5	Low
3979	Radiology	Patient care is being compromised within General Radiology because of staff shortages	15	High	3	Very Low
4004		Risk that patient care may be compromised due to a lack of nursing staff	15	High	10	Moderate

4011	Ophthalmology	Clinical risk to patients requiring sub-specialist Medical Retina outpatient follow-up due to lack of capacity	15	High	6	Low
4012	Ophthalmology	Clinical risk to patients referred as new patients into the new wet macular degeneration pathway	15	High	6	Low
4013	Ophthalmology	Clinical risk to patients referred as new patients into new Medical Retina patient assessment clinic due to lack of capacity iss	15	High	6	Low
4033	Radiotherapy	Potential inability to deliver Colorectal Contact Radiotherapy due to equipment related issues	15	High	5	Low
4067	Orthopaedics (Elective)	Risk to Patient safety and outcomes due to lack of dedicated operating lists for ortho-plastic cases & impact on trauma capacity	15	High	10	Moderate
4115	Ear Nose and Throat (use this one)	ENT Laser replacement	15	High	3	Very Low
4132	Systems and Applications	Cyber Security vulnerabilities	15	High	5	Low
4137	Business Intelligence and Information	Accuracy of Data of Business Decision Making	15	High	5	Low
4138	Systems and Applications	Annual Penetration Testing Delayed	15	High	5	Low
4160	Cardiology	Absence of 8A Matron support within Cardiology at HUTH	15	High	6	Low

Appendix 5

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

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

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

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14.03.23
Title	**Operational Planning Process 2023/24**				
Lead Directors	Michelle Cady, Director of Strategy and Planning				
Authors	Jackie Railton, Deputy Director, Strategy and Planning				
Report previously considered by (date)	Financial aspects of this report were considered at the Performance and Finance Committee on 27 February 2023				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2022-25**	
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 note the contents of this report and the progress made to date in developing initial draft activity, finance and workforce submissions to contribute to the development of the ICB Plan. The Trust Board is asked to agree to an additional meeting towards the end of March to sign off the final plan once the financial and contracting elements have been agreed with the ICB.

Hull University Teaching Hospitals NHS Trust

Trust Board

Operational Planning Process 2023/24

1. Purpose

The purpose of this document is to update the Trust Board on the NHS operational planning process for 2023-24 and to advise on work to date to produce a Trust level operational plan which will be used to inform the Humber and North Yorkshire Integrated Care Board's operational plan.

2. Background

The NHS 2023/24 Priorities and Operational Planning Guidance[1] was published on 23rd December 2022. It set out three tasks over the coming year:

- recover core services and productivity;
- make progress in delivering the key ambitions in the Long Term Plan (LTP), and;
- continue transforming the NHS for the future.

Integrated Care Boards and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other Integrated Care System partners. System plans should be triangulated across activity, workforce and finance, and signed off by ICB and partner trust and foundation trust boards before the end of March 2023.

National NHS Objectives for 2023/24 impacting on HUTH include the following:

Area	Objective
Urgent and Emergency Care	Improve A&E waiting times so that no less than 75% of patients are seen within 4 hours by March 2024, with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement to pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Elective care	Eliminate waits of over 65 weeks by March 2024
	Deliver the system-specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
Diagnostics	Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition

[1] https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/

Area	Objective
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Use of resources	Deliver a balanced net system financial position for 2023/24
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise.
Prevention and Health Inequalities	Continue to address health inequalities and delivery on the CORE20PLUS5 approach

Integrated Care Systems are expected to agree specific local objectives that complement the national NHS objectives.

Elective Recovery Fund Technical Guidance[2] was issued on 27th January 2023, together with Guidance on Revenue, Finance and Contracts[3], and Capital[4].

NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. At a national level, total ICB allocations (including COVID-19 and Elective Recovery Funding (ERF)) are flat in real terms with additional funding available to expand capacity.

The contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay unit prices for activity delivered. System and provider activity targets will be agreed through planning as part of allocating ERF on a fair shares basis to systems. NHS England will cover additional costs where systems exceed agreed activity levels.

Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. Capital allocations will be topped-up by £300 million nationally, with this funding prioritised for systems that deliver agreed budgets in 2022/23.

3. Development of the Draft Trust Level Operational Plan

Under the national Operational Planning guidance, NHS Trusts are not required to produce an operational plan, however they are required to contribute to the ICB level plan via the submission of a series of templates relating to activity, finance and workforce.

3.1 Activity/Performance Assumptions

An initial draft submission was made to the ICB on 16th February 2023 based on the demand and capacity modelling undertaken by the Health Groups. In the absence of an agreed funding allocation for 2023/24, the Health Groups were asked to base their demand and capacity plans based on 2022/23 funding levels. Work is continuing to develop the Trust's draft activity plan and confirm and challenge meetings are being held with each Health Group.

[2] https://www.england.nhs.uk/publication/elective-recovery-fund-technical-guidance/

[3] https://www.england.nhs.uk/publication/2023-24-revenue-finance-and-contracting-guidance/

[4] https://www.england.nhs.uk/publication/capital-guidance-for-2023-24/

The table below provides an overview of the activity and performance assumptions to date based on the Health Group's initial submissions.

Domain: Outpatients	Baseline 2019/20	Plan 2023/24	As % of 2019/20 baseline		Comment
All attendances	807455	818808	101%		Counting changes since 2019/20 include:
All new attends	257130	243160	95%		SDEC
All follow ups	525884	575648	109%		Radiotherapy
Patient initiated follow ups		11926			Neurology NLAG PTL to HUTH
1st outpt spec acute	227418	191355	84%		Dermatology NLAG PTL to HUTH
1st outpt with procedures	38309	31901	83%		250 Haematology NLAG to HUTH
Follow up spec acute	426894	442477	104%		
Follow up spec acute with procedures	74395	107954	145%		
Domain	**Baseline 2019/20**	**Plan 2023/24**	**As % of 2019/20 baseline**		**Comment**
Elective Spells	90058	95023	106%		Counting changes since 2019/20 include:
day cases (adults)	74420	80967	109%		Ophthalmology inpatients to day cases
ordinary spells	15638	14056	90%		Gynaecology ward attenders to NEL
day cases (under 18 years)	2774	2773	100%		
ordinary spells (under 18 years)	655	548	84%		
A&E attendances	137450	123672	90%		
Treated and discharged in less than 4 hrs		84403			Building trajectory to 76% by March 2024
Non-Elective Spells	57144	56383	99%		
LOS of zero days	12491	21228	170%		SDEC/Radiotherapy counting OP to NEL
LOS of 1 day or more	44653	35155	79%		
Domain	**Baseline 2019/20**	**Plan 2023/24**	**As % of 2019/20 baseline**		**Comment**
RTT					
52 weeks and over		5101			as at end of March 2024
65 weeks and over		0			at March 2024
Number of incomplete pathways		65820			at March 2024
Completed Admitted Pathways	44536	42942	96%		
Completed Non Admitted	170290	199079	117%		
Number of new RTT pathways	211509	213980	101%		
Diagnostics					
MRI	26577	28901	109%		
CT	54050	61899	115%		
Non obstetric ultrasound	58636	54605	93%		
Colonoscopy	3931	4418	112%		
Flexi sigmoidoscopy	2051	2318	113%		
Gastroscopy	5784	6554	113%		
Echocardiography	5276	6079	115%		

Initial indications are that current plans deliver 103% towards the 106% target, but this would require additional funds for independent sector service provision, the new Day Surgery Unit, new Endoscopy Unit and variable costs.

3.2 Financial Planning Assumptions

Financial planning assumptions are that the Trust will achieve a break even position in 2022/23. National guidance assumes delivery of 2.2% efficiency savings.

Table 1 shows the high-level income and expenditure account, mapping the move from 2022/23 to 2023/24. This gives a deficit of £73.2m compared to 2022/23 forecast out-turn.

	22/23 Forecast Outturn £m	23/24 Draft Plan £m	Change £m
Total Clinical Income	717.5	703.3	-14.3
Total Other Income	70.0	57.2	-12.8
Donations Income	0.7	2.5	1.7
Employee Expenses	-438.0	-465.6	-27.6
Other Operating Expenses	-337.6	-354.4	-16.8
Finance Costs	-13.3	-15.1	-1.8
Excluded Items	0.6	-1.1	-1.7
Surplus / (Deficit)	**0.0**	**-73.2**	**-73.2**

Table 1: Draft High Level Income and Expenditure 2023/24

Table 2 summarises the movements from the 2022/23 balanced outturn to the current 2023/24 draft plan deficit.

	Draft Submission £m
22/23 Forecast Outturn	**0.0**
22/23 Non Recurrent Income	-47.3
22/23 Non Recurrent Expenditure	16.0
22/23 Non Recurrent Efficiency Savings	-13.1
22/23 Other Non Recurrent Savings	-9.2
22/23 Full Year Effects	-1.4
22/23 Underlying Deficit	**-55.0**
23/24 Tariff Inflation Uplift (2.9%)	17.0
23/24 Tariff Inflation Deflator (1.1%)	-6.4
23/24 Convergence Efficiency Deflator	-4.2
23/24 Inflation Expenditure Estimate	-18.5
23/24 CNST Increase above tariff funding	-2.7
23/24 Cost of Capital & PDC	-2.4
23/24 Savings Efficiency Target (2.2%)	17.9
22/23 Underlying Deficit post Inflation	**-54.3**
23/24 Additional Elective Capacity Funding (Figure to be finalised)	20.4
23/24 Additional Elective Capacity Reserve	-20.4
23/24 Activity Growth Funding (Figure to be finalised)	4.4
23/24 Activity Growth Expenditure (1.9%)	-11.3
23/24 Capacity Funding (Figure to be Finalised)	3.8
23/24 Capacity Expenditure Schemes	-12.7
23/24 Virtual Ward	-0.8
23/24 New Investment Programme	-2.3
23/24 Draft Surplus / (Deficit)	**-73.2**

Table 2: Draft Income and Expenditure Plan 2023/24

Investments totalling £2.3m are included in the plan. These include additional Obstetrics/ Gynaecology Consultants (£0.4m), Carbapenemase Producing Enterobacteriaceae (CPE) testing (£0.3m), C29 Oncology Ward (£1.7m), funding transfer from NLaG for oncology ward (-£1.1m), Cancer Assessment Unit/Day Case Unit (£0.6m), and Transcatheter Aortic Valve Implantation (TAVI) (£0.4m).

3.3 Draft Workforce Plan

The Trust's draft Workforce Plan shows an increase in staff in post of 281.7 wte by March 2024. The growth is predominantly in Registered Nursing and Health Care Assistant support staff. This is to support the proposed 60-bedded discharge/step down facility. The Trust will be using its successful recruitment campaigns, including international recruitment.

	Baseline		Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	Staff in post outturn Year End (31-Mar-23)	Establishment Year End (31-Mar-23)	As at the end of Apr-23	As at the end of May-23	As at the end of Jun-23	As at the end of Jul-23	As at the end of Aug-23	As at the end of Sep-23	As at the end of Oct-23	As at the end of Nov-23	As at the end of Dec-23	As at the end of Jan-24	As at the end of Feb-24	As at the end of Mar-24
Workforce (WTE)	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE
Total Workforce (WTE)	8432.30	8603.98	7164.10	7166.08	7172.74	7180.32	7207.94	7317.72	7412.21	7452.02	7447.89	7431.71	7423.80	8714.00
Total Substantive	8277.66	8603.98	7009.46	7011.44	7018.10	7025.68	7053.30	7163.08	7257.57	7297.38	7293.25	7277.07	7269.16	8559.36
Total Bank	111.01	0.00	111.01	111.01	111.01	111.01	111.01	111.01	111.01	111.01	111.01	111.01	111.01	111.01
Total Agency	43.63	0.00	43.63	43.63	43.63	43.63	43.63	43.63	43.63	43.63	43.63	43.63	43.63	43.63

Table 3: Draft Workforce Plan 2023/24

In addition to actions to recruit new staff, the Trust is working in collaboration with NHS England to ensure the retention of nurses and midwives. Work has started to prioritise five high impact areas of retention with a focus on early careers, experience at work and late careers. The Trust is in the process of developing a retention marketing plan, similar to its recruitment marketing strategy.

4. Next Steps

The Trust will continue to develop and refine its activity, finance and workforce plans in conjunction with the Health Groups and utilising feedback from its own confirm and challenge meetings with ICB colleagues.

The Trust is required to submit a further iteration of its draft plans by 16th March 2023 to inform the ICB level plan. However, as the funding allocations remain unknown at this time, it is proposed to timetable an additional Trust Board meeting towards the end of March to enable sign off of the Trust plan.

4. Recommendation

The Trust Board is asked to note the contents of this report and the progress made to date in developing initial draft activity, finance and workforce submissions to contribute to the development of the ICB Plan.

The Trust Board is asked to agree to an additional meeting towards the end of March to sign off the final plan once the financial and contracting elements have been agreed with the ICB.

Michelle Cady
Director of Strategy and Planning

March 2023

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14 March 2023
Title	Quality Report				
Lead Director	Suzanne Rostron, Director of Quality Governance, Jo Ledger, Chief Nurse and Prof Makani Purva, Chief Medical Officer				
Author	Associate Director of Quality, Head of Patient Safety and Improvement, Head of Quality Compliance and Patient Experience, Head of Continuous Quality Improvement				
Report previously considered by (date)	This report has previously been considered a the Quality Committee February 2023				

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 Board is asked to consider the Quality Summary report. The Report is also considered at the Quality Committee with supporting in-depth papers.

Quality Report

January 2023 Performance Data

Produced for the February 2023 Quality Committee

TABLE OF CONTENTS

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 January 2023.

	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 again been an increase in the incidents that are being reported. Incidents causing moderate harm or above have increased slightly, remaining 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. A Quality Improvement project is currently underway to further increase incident reporting across the organisation.
	Serious Incidents	The trajectory to be in a sustainable position of ~35 SI open at any time has been met and is still demonstrating a downward trend.	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	All open SI investigations are reviewed weekly and additional focus and support is given to the oldest open investigations, this has resulted in a downward trend of SI's open over 100 days. All incidents meeting SI criteria are discussed at the Weekly Patient Safety Summit (WPSS). Where there is no new learning, differing approaches other than SI investigations are now being considered e.g. AAR, Safety Huddles, and Thematic Reviews to identify if there are improvement opportunities. Transition to PSIRF planned from April 2023. PSIRF training has started and a draft PSIRP is in circulation for consultation. Communication on PSIRF is taking place to staff groups across the trust.

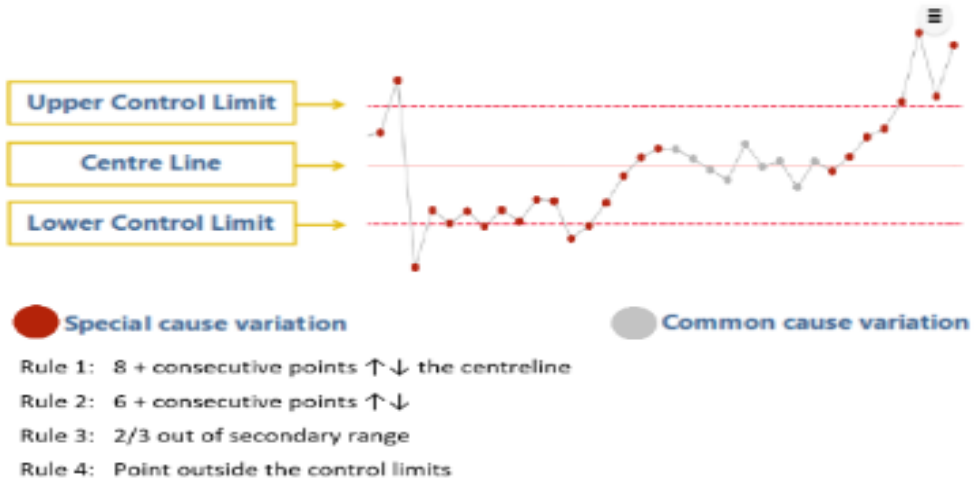
	Indicator	Successes	Risks / Challenges	Actions / Future Plans
Effectiveness Domain	HSMR	The monthly HSMR rates has dropped from 122.34 in October 2022, this is the largest reduction since May 2022	The Trust continues demonstrate 'higher than expected deaths' and is an outlier against its HSMR	The Mortality 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
	SHMI	The overall Trust SHMI has reduced further and is now within the 'expected levels of deaths' with a SHMI of 1.10 The Trust is no longer highlighted at one of the top 12 Trusts with an outlier status by NHS Digital Pneumonia SHMI has reduced further and is now within the 'expected levels of deaths' with a SHMI of 1.03 in August and September 2022 compared with a SMHI of 1.19 at its highest point in 2020. Sepsis SHMI has reduced again to 1.30.	The top 3 common clinical conditions remain Sepsis, Pneumonia and Stroke	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
	Stroke	Stroke SHMI has also improved further with a SHMI of 1.14 in September 2022 The Stroke Service now undertake an SJR review on all deaths	HUTH is one of middle performing Trusts against its peers for Stroke	Continue to deliver the Stroke improvement plan, improving the services and outcomes for patients being cared for on or off a Stroke ward at HUTH Continue to review all Stroke deaths, present the findings and learning to the Stroke M&M Meeting Provide regular updates to the Mortality and Morbidity Committee

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
Responsive Domain	PALS and Complaints	Early Resolution (responding within 10 working days) successfully reducing complaints that move to the full formal process) Successful recruitment to a Band 7 Patient Experience Lead and a Band 6 Patient Experience Manager – to commence in post March and April 2023 Between January 2022 and January 2023 the Emergency Health Group received 66 compliments which is more than the number of complaints they received Patient story in ECA recorded, edited and shared with the team. The team were empowered by the patient story and agreed that they would like to record an apology video back to the patient. An improved position against closing complaints since November 2022; when the backlog recovery plan was instigated. Reaching its highest point of closed complaints in January 2023 since January 2020. An improved position against closing complaints within 40days since November 2022; when the	There is a backlog of logging complaints with the latest delay of 4 weeks Continued support required from the Health Groups, Patient Experience Team to support the closure of complaints in a timely manner and the Quality Governance Heads of Department to support with the increased quality checking activity in the interim to ensure the hard work of the Health Groups is recognised in the data.	The central Quality Governance Team continue to support the Patient Experience Team with the delays logging complaints but also, quality checking of completed complaints and closing complaints. The Patient Experience Team to improve compliance with the KPIs regarding logging, improving responsiveness to complainants and Health Groups and as a result compliance with the 40 day target. KPIs to be closely monitored within the Patient Experience Team. Resource within the team is being strengthen. Establish and embed the Patient Experience Steering Group set up by the Interim Chief Nurse to deliver the patient experience improvement work and learning as set out in the Quality Strategy. Establish and PHSO Steering Group to deliver the PHSO recommendations. Delivery the Complaints Recovery Plan.

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
		backlog recovery plan was instigated; noted in Surgery, Medicine and Family and Women's. Continue weekly challenge meetings with Medicine, Surgery and Family and Women's with improved engagement.		
Well-led Domain	Continuous Quality Improvement	The first QSIR Fundamentals session of 2023. Ongoing QSIR training planned across 2023. The Celebrating Improvement and Learning from Excellence event Taking place on Friday 24th February.	Managing the volume of work generated by Think Tank.	Development of the CQI website. Future development of Think Tank To date.

1.2 EXECUTIVE SUMMARY SCORECARD

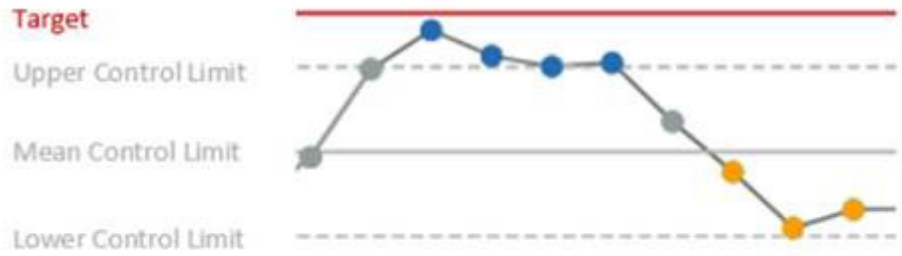
The following provides a high level executive summary of the number of Quality Indicators which are achieving, those which are displaying variance between achieving and failing and those that are consistently failing as detailed on the Integrated Performance Report January 2023.



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'

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 passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target



Common Cause
- No significant change
- Inside control limits

Improvement
- Consecutive Increase
- Above mean
- Above UCL (as appropriate)

Concern
- Consecutive decrease
- Below mean
- Below LCL (as appropriate)

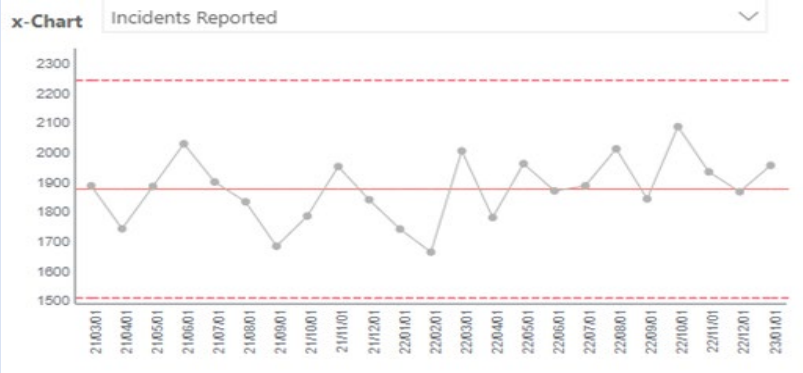
2. SAFE DOMAIN

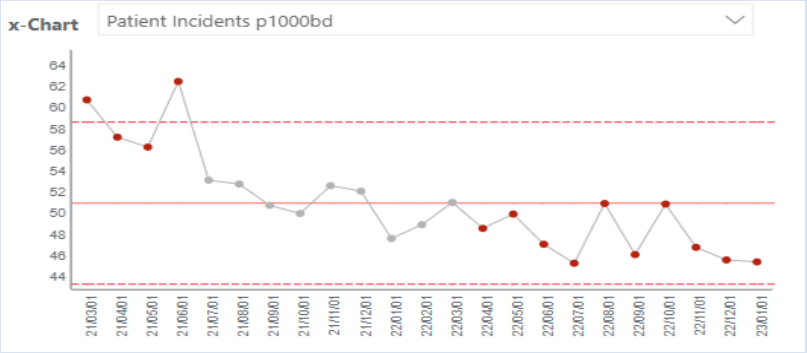
2.1 PATIENT SAFETY INCIDENT REPORT AND INCIDENTS CAUSING HARM

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 35 patient safety incidents per 1000 bed days recorded in January 2023 (n=1571); 1.96 (per 1000 bed days) incidents resulted in moderate, severe or catastrophic harm to the patient.
- The number of incidents of all severities is within control limits and shows a reduction over the last 12 months by per 1000 bed days compared to the previous 12 months. This can be accounted for by a return of increased activity within the Trust with the absolute number of incidents remaining around the mean.
- The number of incidents causing harm to patients (per 1000 bed days) is showing an upward trend over the previous 7 months; although there has been a marginal reduction in the January 2023 data. The trend is within the control limits.

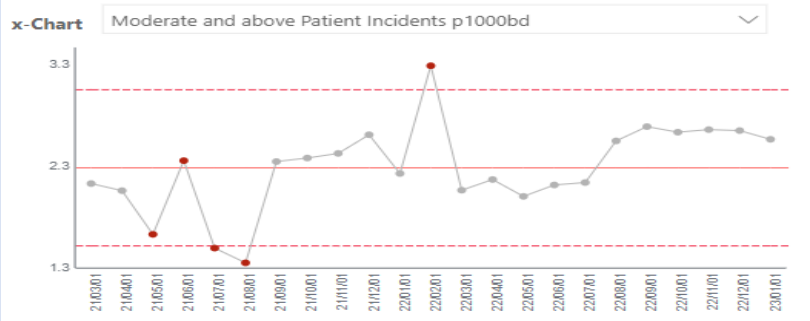
Successes:

- 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:

- The highest reported harms were hospital acquired pressure ulcers with an increase in device related harms followed by hospital acquired infections and inpatient falls.
- There has been an overall reduction in hospital acquired pressure ulcers reported in the Clinical Support Health Group with a total of 2 reported in the month; 19 in Medicine Health Group and 25 in Surgery Health Group, Emergency Medicine Health Group however has increased to 5 incidents.

There were 2 deaths of patients in the month, both relating to treatment and care; 1 deaths in Gastroenterology and 1 in Emergency Medicine Health Group; one incident was declared as a SI.



Actions / Future Plans for Improvement:

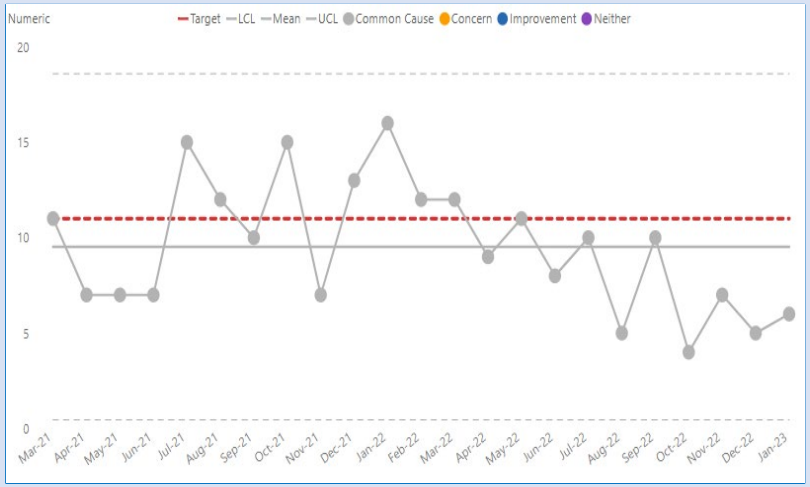
- Quality Improvement Project underway to increase the number of patient safety events being reported and will incorporate work to integrate the transition from the NRLS to Learn from Patient Safety Events service (LFPSE) from April 2023.
- QI work streams aligned to Quality Strategy strategic ambitions for harm free care
- Incidents resulting in death to continue to be reviewed at Weekly Patient Safety Summit (WPSS) for immediate learning.

2.2 SERIOUS INCIDENTS

Number of Serious Incidents reported
Serious Incidents per 1000 bed days

Aim: To reduce the proportion of serious incidents being declared

Target: To learn from serious incident and prevent reoccurrences



What is the chart telling us:

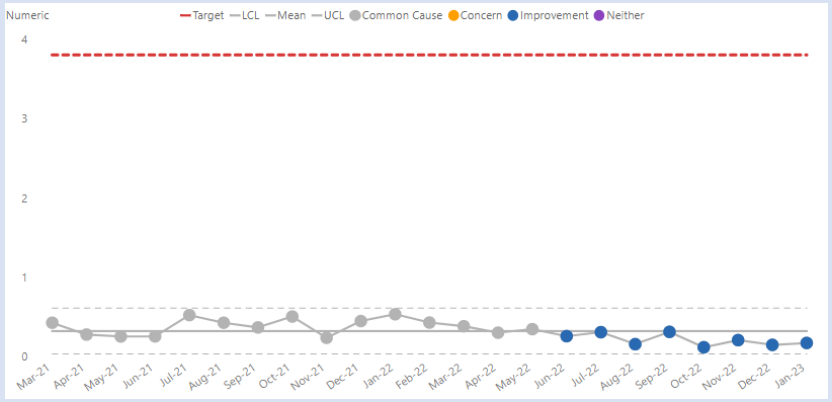
- The Trust declared 6 serious incidents in January 2023 equating to 0.13 serious incidents per 1000 bed days.
- The graphs show common cause variation with no cause for concern with a downward trend since January 2022.

Successes:

- The 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 and sharing information across the HGs.

Key Risks and Challenges:

- The Trust will continue to declare SIs in line with the serious incident framework (2015) until April 2023.
- 2 serious incident resulted in the death of the patient, 1 in emergency medicine health group following a delayed diagnosis and 1 in medicine health group following Sub-optimal care of the deteriorating patient.



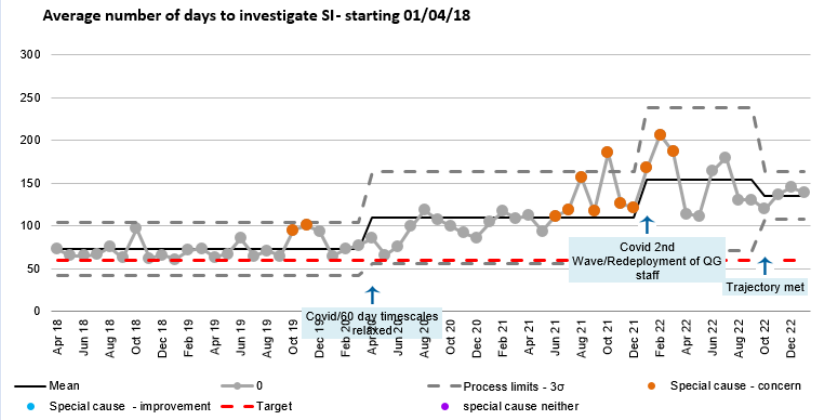
- 3 serious incidents occurred in the family & women's health group, 1 of which was declared as treatment delay in the gynaecology service, 1 incident occurred in Obstetrics service and has been accepted for investigation by HSIB, the other incident was also in the gynaecology service for a surgical / invasive procedure incident.
- 1 serious incident occurred in medicine health group for suboptimal care of the deteriorating patient.
- 1 serious incident occurred in emergency medicine health group for a delayed diagnosis.
- No themes have been identified amongst the incidents which have been declared for SI investigation.

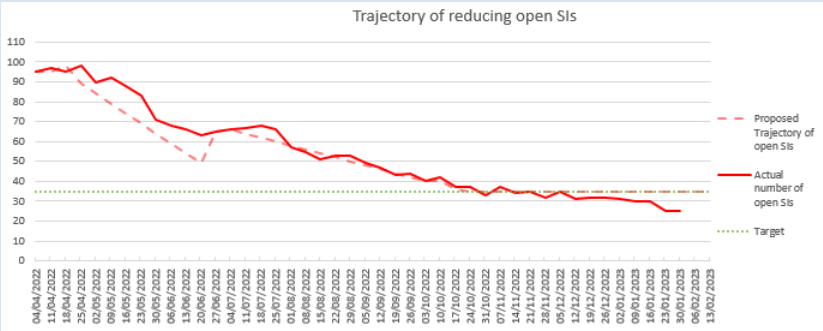
Actions / Future Plans for Improvement:

- 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.
- The PSIRF transition proposal was reviewed at Patient Safety and Clinical Effectiveness committee in February 2023 and has been endorses, this included the Patient Safety Incident Response Plan. The transition proposal will now be subject to ICB Quality committee and Trust board approval.
- To work towards preventing Never Events occurring.

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 has reduced during January but is still outside of the target range. • The number of open investigations has reduced and is still demonstrating a downward trajectory. The trajectory that was set has now been achieved.





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 to investigate.
- The trajectory has been met for the number of investigations open at any one time with 26 open at the end of January 2023 demonstrating a further downward trend.
- 11 incidents were closed in January 2023.
- 5 investigation were closed within 100-day timescales.

Key Risks and Challenges:

- The average number of days to close an investigation continues to be above 100 days.
- The range of days taken to investigate on those closed in January 2023 was 22 to 271 days.
- 5 investigations remained open over 100 days at the end of January 2023 which is again showing a downward trajectory on the previous month.

Actions / Future Plans for Improvement:

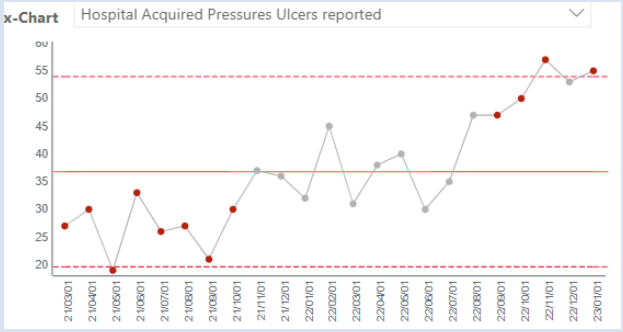
- Work continues to close SIs over 100 days and to ensure families are kept updated.
- The reduction in the number of serious incident investigations being open has resulted in a smaller more manageable caseload that will allow for timelier completion of investigations.
- Sharing the learning from serious 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 commenced in November 2022 to drive a systems approach to investigations and improvement.

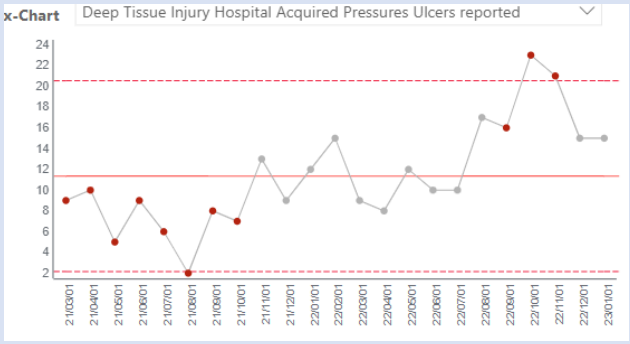
2.4 HOSPITAL ACQUIRED PRESSURE ULCERS CAUSING HARM

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 1.23 pressure ulcers per 1,000 bed days resulting in moderate and above harm in January (n=56).
- The number of pressure ulcers reported has increased and is above the upper control limit for the third month.
- Category 2 pressure ulcers have reduced and are now within control limits.
- DTIs have remained at the same level as last month.
- Unstageable pressure ulcers have increased to 3 incidents, this is within control limits.
- There has been an increase in overall pressure ulcer incidents across the organisation despite the decrease in category 2 pressure ulcers.
  NB the CPS charts do not include device related pressure damage

Successes:

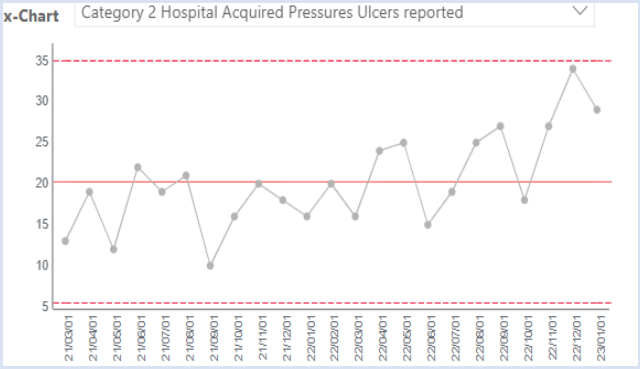
- Fundamental standards reviews for tissue viability are now fully up to date.
- Work is underway with the HDigital team on digitalising the wound chart.
- Safety cross for tissue viability is being relaunched with falls on 1st March 2023
- QR codes for bed profiling have been finalised, work with our external suppliers is now underway to complete this improvement.
- Tissue viability (TV) link nurse training scheduled for 4 sessions this year with the first taking place 21st February 2023
- Wound formulary and negative pressure training dates are live on hey247.

Key Risks and Challenges:

- There were 34 Category 2 pressure ulcers reported; 1 Category 3 pressure ulcer, 23 Deep Tissue Injuries (DTI) and 5 Unstageable pressure injuries.

Actions / Future Plans for Improvement:

- Re-instate high five ward round- dates planned.



- TV link dates in the diary with 4 dates scheduled for the year ahead.
- Draft template has been developed for each directorate to report to the Safer Skin Committee – first reports were received at 1st February 2023 safer skin committee.

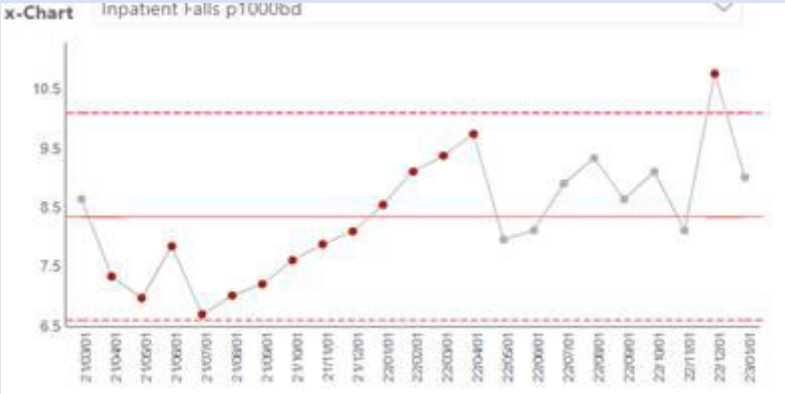
2.5 INPATIENT FALLS CAUSING HARM

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:

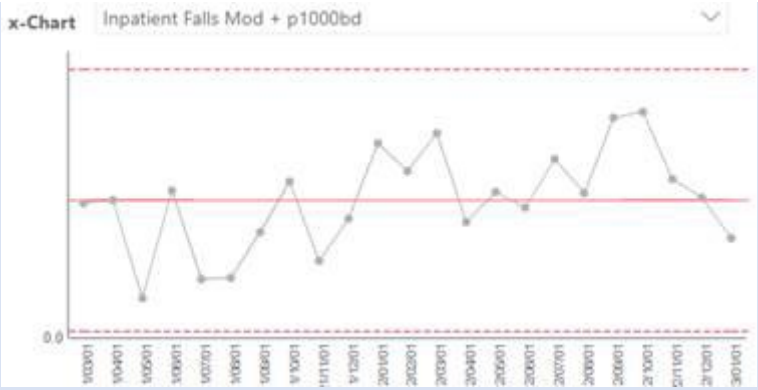
- There were 7.1 inpatient falls per 1000 bed days in January 2023 (n= 321)
- 0.15 (per1000 bed days) inpatient falls resulted in moderate, severe or catastrophic harm to the patient.
- The number of falls being reported over the last month, has significantly reduced but is still at the upper control limit.
- Multiple fallers has increased to 35% of inpatient falls, whilst the overall falls have reduced.
- Following the changes to Datix reporting at least 15% of inpatient falls were No Criteria to Reside Patients, of these incidents less than 1% were moderate and above harm.
- Falls data continues to show a trend with increased falls between 00:00 and 02:00, PDM to meet with Nurse Directors to discuss an improvement plan going forward.

Successes:

- Staff Training continues across the Trust, both online and face to face, moving toward the Trust target of 85% of staff having completed training in line with their role. This has also included staff from Radiology and Ophthalmology.

Falls Training 2022 / 2023

Training	Complete	Not Complete	Grand Total	%
Falls Prevention	277	992	1269	21.8%
Preventing Falls in Hospital: Carefall	42	27	69	60.9%
Preventing Falls in Hospital: Fallsafe	1774	1123	2897	61.2%



Grand Total	**2093**	**2142**	**4235**	**49.4%**

- **These numbers include**; Let's Get Started BSE, Let's Get Started International Nurses, Transition in Practice, HCSW Inductions, Registered Nurse Associate Induction, HCSW Apprentices, 1st year student Inductions at Hull University and existing members of staff.
- **Falls education** is on HEY247 under Clinical Skills Update for Non-Registered Staff (consisting of a full day 2 hours falls, infection control and moving and handling at Suite 22 CHH) and Falls Education 2 hour standalone session at HR.I
- The Falls Education program has been delivered as scheduled during January 2023.
- Flojac education to date, has been delivered to 142 members of staff on a face to face basis.
- The falls team have recruited 69 Falls Champions as part of the network, which is 53% the number required to provide a sustainable support network shows impressive work in a month.

Key Risks and Challenges:

- With the ongoing face to face training continuing to be successful, it had become apparent that there will be no suitable training rooms available at HRI after March 2023. This will affect the Strategic goal of 85% of staff trained with falls. This has been escalated to the Chief Nurse.
- A business case to obtain sufficient flat lifting equipment is in progress, to ensure that safety of staff and the comfort of patients when being moved from the floor is as safe as possible. Discussions have been had with the portering service to facilitate the moving of equipment to facilitate the safe rescue of falls patients.

Actions / Future Plans for Improvement:

- Development of a Falls Champions network, to share lessons learned, best practice and quality improvement initiatives. The aim being to have 1 registered and 2 non registered Champions on each ward, the development of an appropriate training plan is underway.
- 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.
- A long term falls QIP is being discussed, which aims to identify improvement projects to reduce the number of inpatient falls going forwards 2023- 2025, this is being led by the Continuous Quality Improvement team.

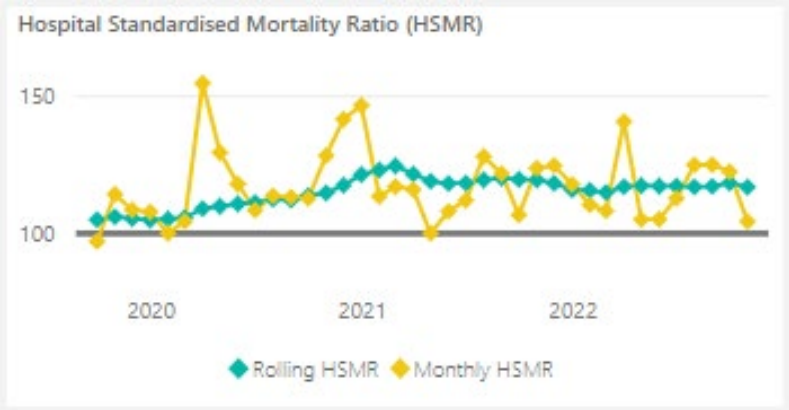
3. EFFECTIVENESS DOMAIN

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 to November 2022.
- HSMR continues to demonstrate 'higher than expected deaths' and is above the national average and target of 100.
- The rolling HSMR is 116.75 and the monthly (November 2022) HSMR is 104.32 which has reduced from 122.34 in October 2022.

Successes:

- The monthly HSMR rates has dropped from 122.34 in October 2022, this is the largest reduction since May 2022.
- The rolling HSMR is steady showing a consistent mortality rate.

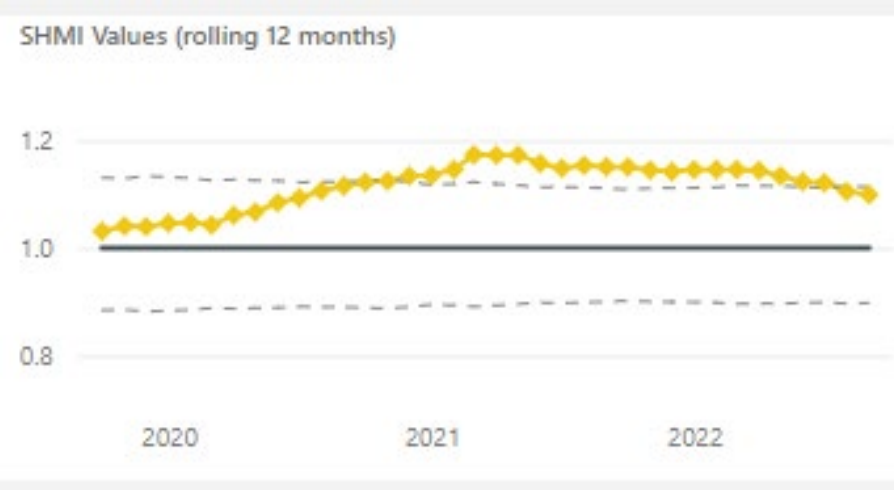
Key Risks and Challenges:

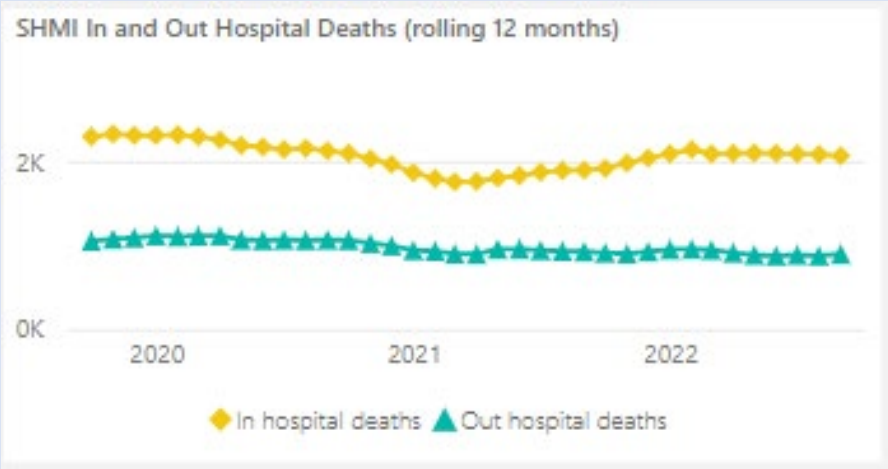
- The Trust continues demonstrate 'higher than expected deaths' and is an outlier against its HSMR.

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.

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:

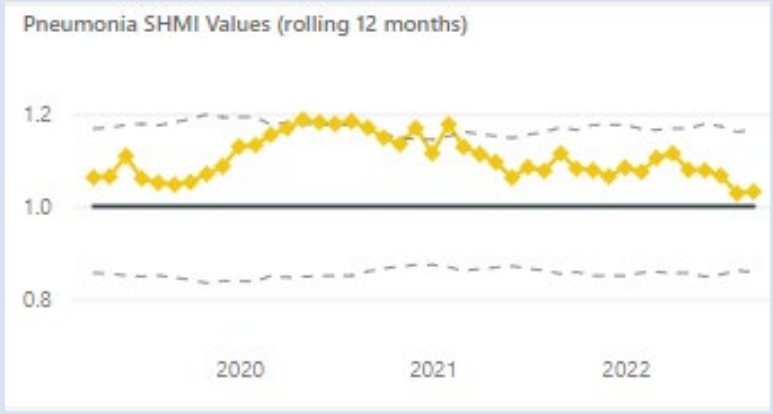
- Charts are displaying performance for a rolling 12 month period. Latest data is September 2022
- Trust SHMI has continued on a downwards trend since the end of 2021 and in September 2022 it dropped further to 1.10 and moved from 'higher than expected deaths' to 'expected level of deaths'.
- The out of hospital deaths remain consistent against the SHMI.
- Pneumonia SHMI continues to demonstrate a downward trend and in September 2022 it moved from 'higher than expected deaths' to 'expected level of deaths' with a SHMI of 1.03 compared with its highest point of 1.19 in May 2020.
- Sepsis SHMI continues to demonstrate 'higher than expected deaths' with an excess of 50 deaths. Although it remains 'higher than expected' performance is demonstrating an improving journey from its highest point of 1.47 in August 2021 to 1.30 in September 2022.
- Stroke SHMI has had a slight increase to 1.14 in September 2022.

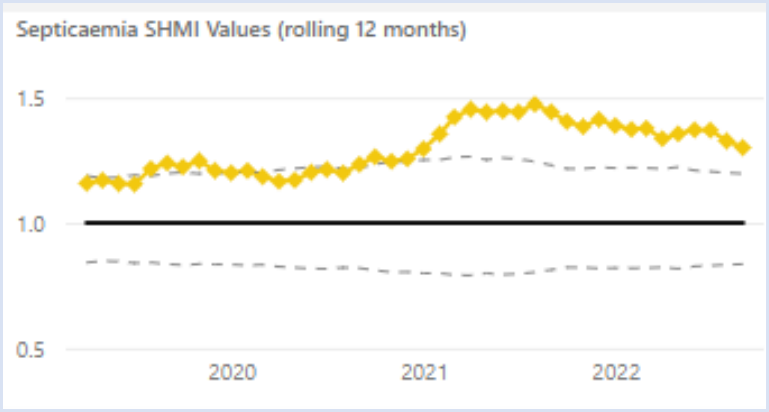
Successes:

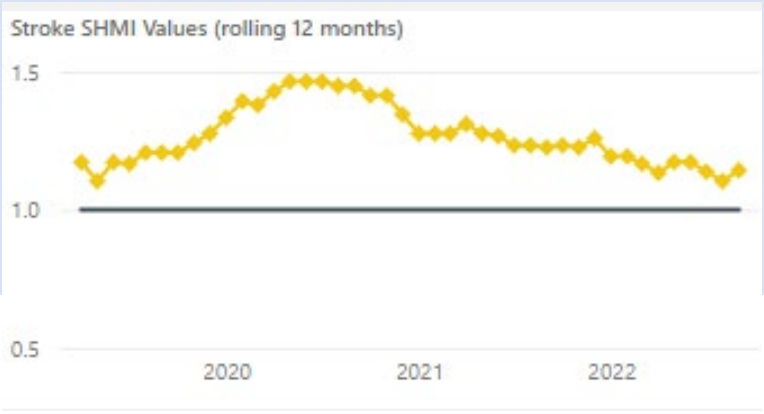
- The overall Trust SHMI has reduced further and is now 1.10 above the national average of 1.0 and the reduction of excess death 380 to 270.
- Although the pneumonia SHMI remains above the national average of 1.0 it has reduced again to 1.03 with the excess deaths also reduced from 35 to 10.
- Sepsis SHMI has reduced again to 1.30.

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.







Actions / Future Plans for Improvement:

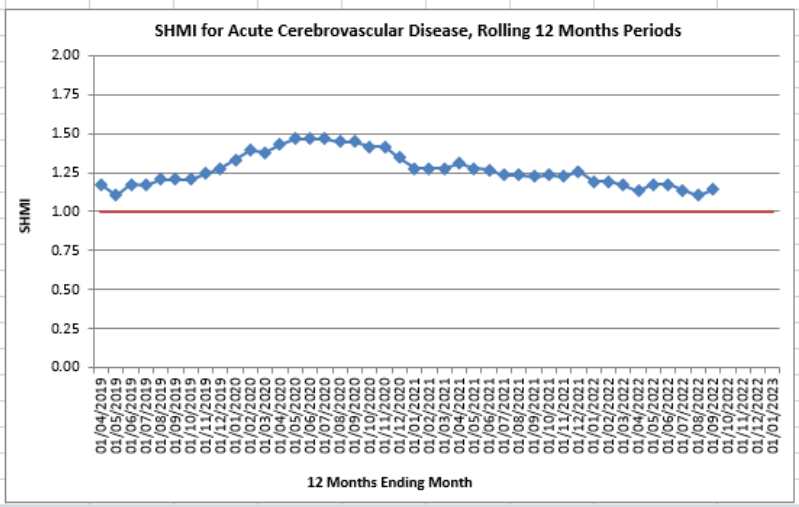
- The Mortality and Morbidity Task and Finish Group continue to meet monthly to closely monitor the mortality data and to work on improving the areas that are highlighting as a potential risk.
- The Mortality and Morbidity Task and Finish Group will run alongside the Sepsis and Pneumonia Steering Groups.
- The Mortality and Morbidity 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.

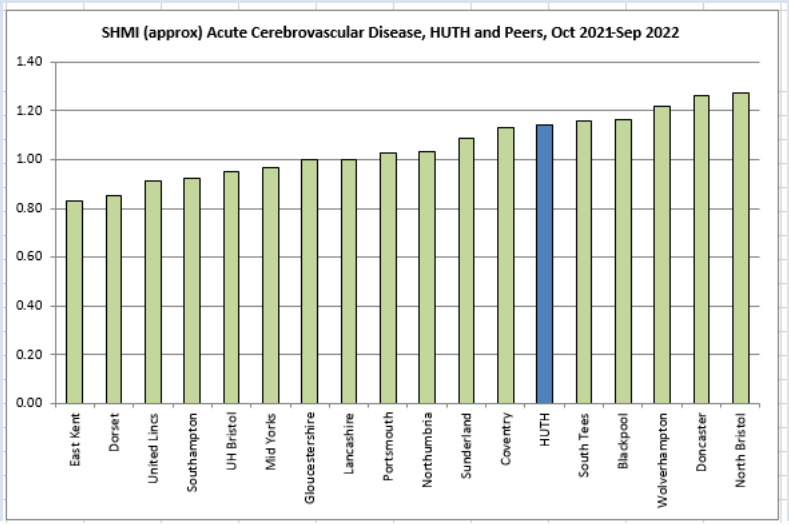
3.3 STROKE

Summary of Stroke 30-day mortality

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:

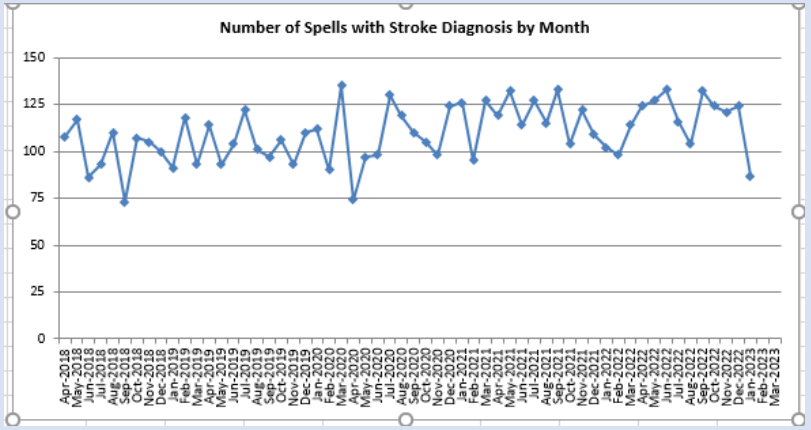
- As detailed in the Mortality section of this report the SHMI for Stroke is higher than the National Level of 1.0 at 1.14; however as both charts demonstrate, the Stroke SHMI is continually reducing

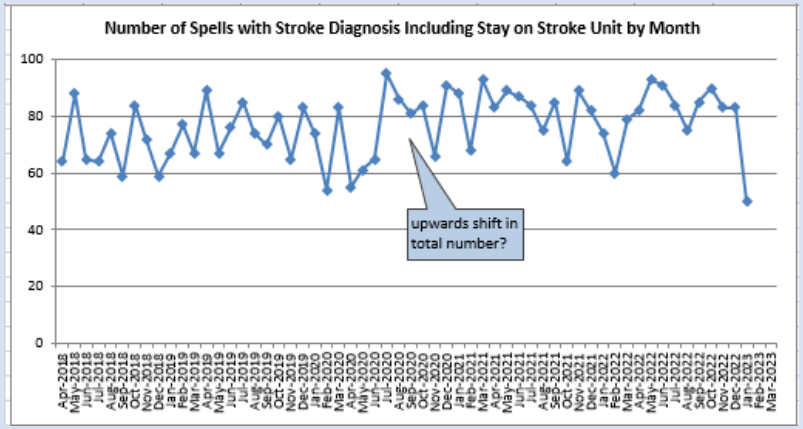
Successes:

- The SHMI for Stroke is higher than the National Level of 1.0 at 1.14; however as both charts in this report demonstrate, the Stroke SHMI is continually reducing
- The Stroke Service now undertake an SJR review on all deaths

Key Risks and Challenges:

- Stroke SHMI continues to be higher than expected





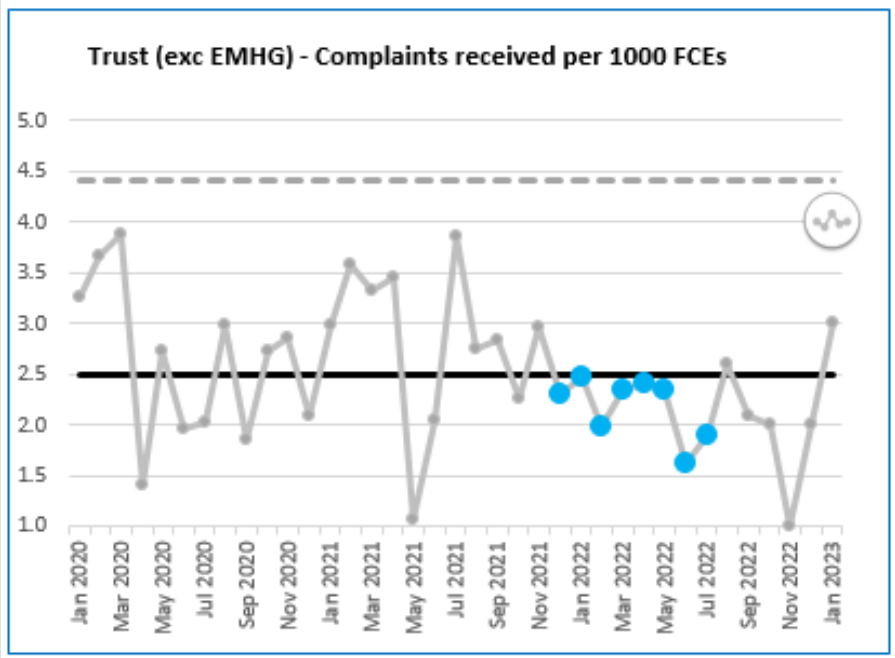
Actions / Future Plans for Improvement:

- Continue to deliver the Stroke improvement plan, improving the services and outcomes for patients being cared for on or off a Stroke ward at HUTH.
- Continue to review all Stroke deaths, present the findings and learning to the Stroke M&M Meeting.
- Provide regular updates to the Mortality and Morbidity Committee.

4. RESPONSIVE DOMAIN

4.1 COMPLAINTS RECEIVED

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:

- There was an increase in complaints received in December 2022 and January 2023 – 84 complaints received.

Successes:

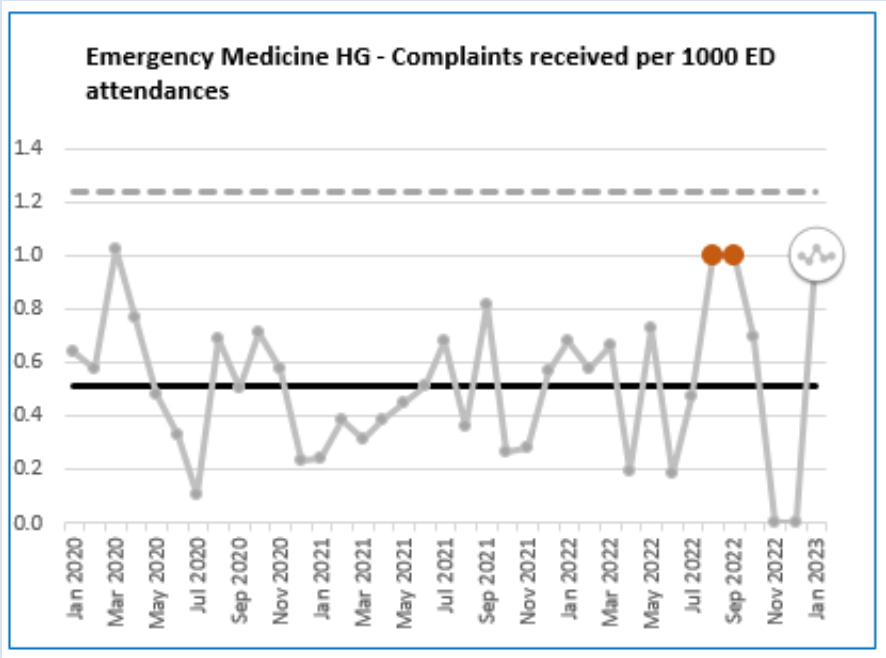
- Early Resolution (responding within 10 working days) successfully reducing complaints that move to the full formal process).
- Successful recruitment to strengthen the patient experience team.

Key Risks and Challenges:

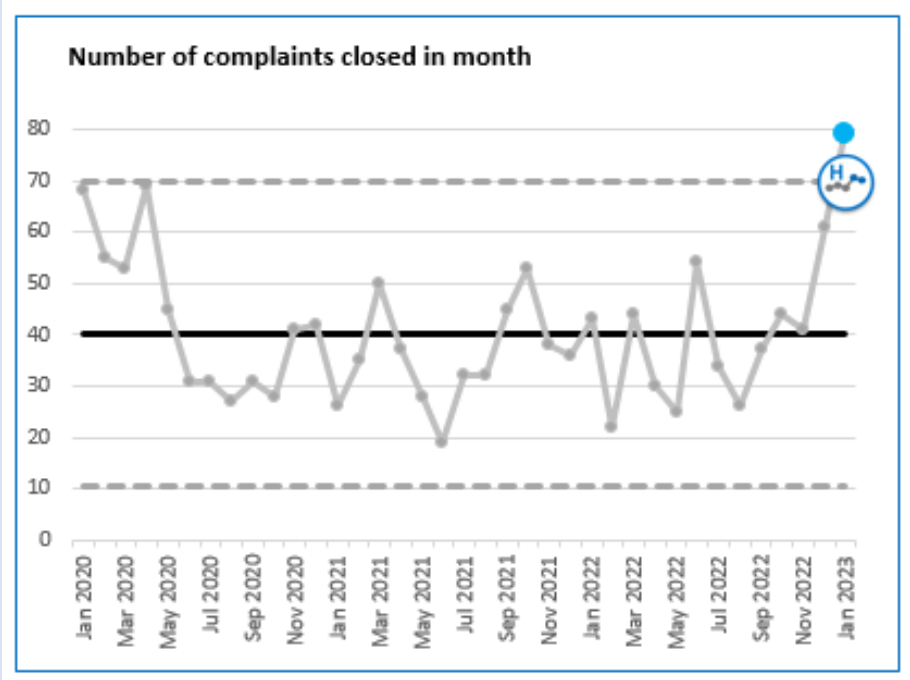
- There is a backlog of logging complaints with the latest delay being 4 weeks.

Actions / Future Plans for Improvement:

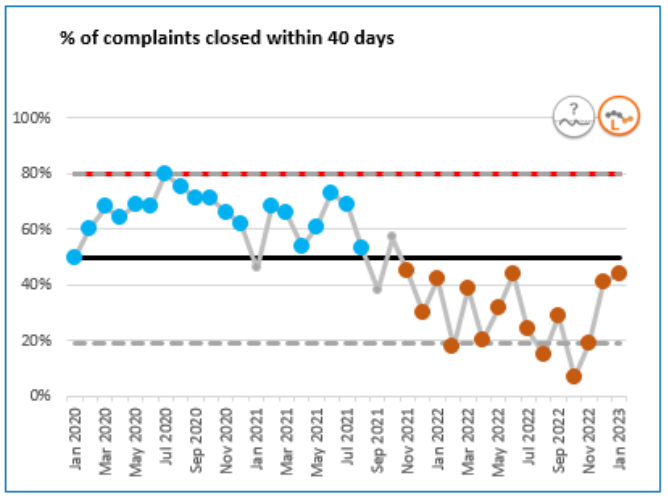
- The central Quality Governance Team continue to support the Patient Experience Team with the delays logging complaints and also, quality checking of completed complaints and closing complaints.
- The Patient Experience Team to improve compliance with the KPIs regarding logging, improving responsiveness to complainants and Health Groups and as a result compliance with the 40 day target.
- KPIs to be closely monitored within the Patient Experience Team.
- Resource within the team is being increased.
- Establish and embed the Patient Experience Steering Group set up by the Interim Chief Nurse to deliver the patient experience improvement work and learning as set out in the Quality Strategy.
- Establish a Model Complaints Standards Steering Group to deliver the PHSO recommendations.

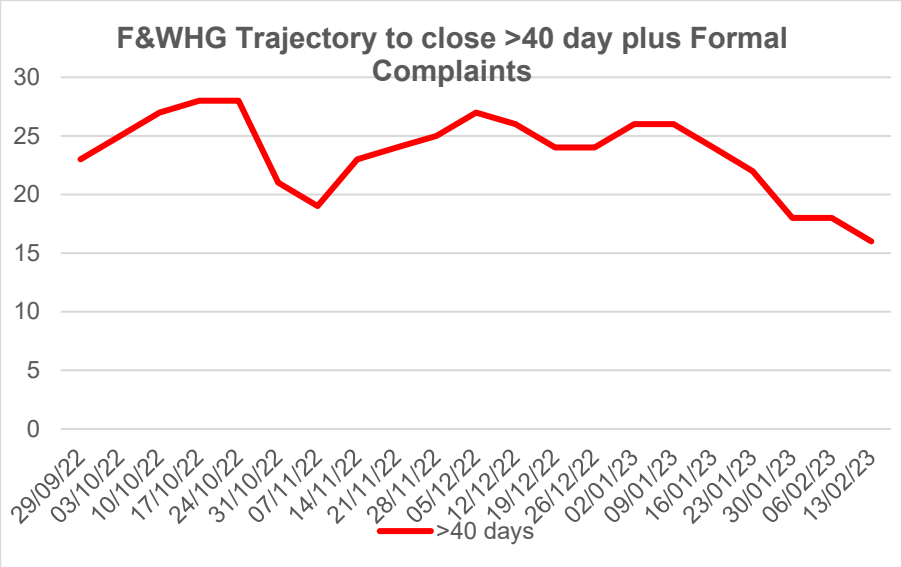
Emergency Medicine HG - Complaints received per 1000 ED attendances	Aim: Minimise formal complaints & increase PALs/Early resolution Target: 0.5
	**What is the chart telling us:** • Common cause variation, remains within upper control limit; however, there has been a slight increase in January 2023. **Successes:** • Between January 2022 and January 2023 the Emergency Health Group received 66 compliments which is more than the number of complaints they received. • EMHG are responsive to actions following complaints. • Patient story in ECA recorded, edited and shared with the team. The team were empowered by the patient story and agreed that they would like to record an apology video back to the patient. **Key Risks and Challenges:** • None **Actions / Future Plans for Improvement:** • Continue to utilise the early resolution where possible to address concerns in a timely manner and reduce the number of formal complaints received. • The central Quality Governance Team continue to support the Patient Experience Team with the delays logging complaints and also quality checking of completed complaints and closing complaints. • The Patient Experience Team to improve compliance with the KPIs regarding logging, improving responsiveness to complainants and Health Groups and as a result compliance with the 40 day target. • KPIs to be closely monitored within the Patient Experience Team. • Resource within the team is being strengthen. • Establish and embed the Patient Experience Steering Group set up by the Interim Chief Nurse to deliver the patient experience improvement work and learning as set out in the Quality Strategy. • Establish a Model Complaints Standards Steering Group to deliver the PHSO recommendations.

4.2 COMPLAINTS CLOSED

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 chart is demonstrating the improved position against closing complaints since November 2022. Reaching its highest point in January 2023 since January 2020. **Successes:** • An improved position against closing complaints since November 2022; when the backlog recovery plan was instigated. Reaching its highest point in January 2023 since January 2020. • Continue weekly challenge meetings with Medicine, Surgery and Family and Women's with improved engagement • Successful recruitment to a Band 7 Patient Experience Lead and a Band 6 Patient Experience Manager – to commence in post March and April 2023. **Key Risks and Challenges:** • Continued support required from the Health Groups, Patient Experience Team to support the closure of complaints in a timely manner and the Quality Governance Heads of Department to support with the increased quality checking activity in the interim to ensure the hard work of the Health Groups is recognised in the data **Actions / Future Plans for Improvement:** • Patient Experience working with colleagues to provide additional support to reduce the backlog. • Continue weekly challenge meetings with Medicine, Surgery and Family and Women's. • Learning from complaints and patients experience to be reflected in action plans and presented to PESC. • Action plans to be closed within timeframe. • Delivery the Complaints Recovery Plan. • Resource within the team is being strengthen. • Establish and PHSO Steering Group to deliver the PHSO recommendations.

% of complaints closed within 40 days





Aim: Increase % of complaints closed within 40 day target

Target: 80%

What is the chart telling us:

- Although performance remains below the target, the chart is demonstrating the continued improvement against the complaints closed within 40 days, especially since November 2022.
- Noted improvements in the complaints closed within 40 days within the target areas of Surgery, Medicine and Family and Women's.

Successes:

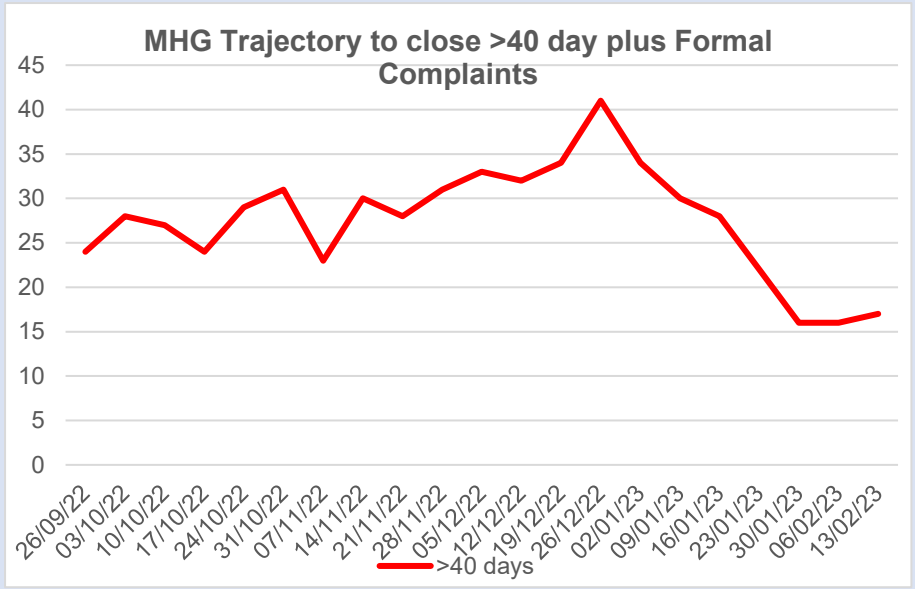
- An improved position against closing complaints within 40days since November 2022; when the backlog recovery plan was instigated.
- Noted improvements in the complaints closed within 40 days within the target areas of Surgery, Medicine and Family and Women's.
- Successful recruitment to the Patient Experience Team.

Key Risks and Challenges:

- Continued support required from the Health Groups, Patient Experience Team to support the closure of complaints in a timely manner and the Quality Governance Heads of Department to support with the increased quality checking activity in the interim to ensure the hard work of the Health Groups is recognised in the data.

Actions / Future Plans for Improvement:

- Patient Experience working with colleagues to provide additional support to reduce the backlog and improve compliance against the gold standard of complaints closed within 40 days
- Continue weekly challenge meetings with Medicine, Surgery and Family and Women's
- Learning from complaints and patients experience to be reflected in action plans and presented to PESC.
- Action plans to be closed within timeframes.
- Delivery the Complaints Recovery Plan.
- Resource within the team in being strengthened.
- Establish and PHSO Steering Group to deliver the PHSO recommendations.


MHG Trajectory to close >40 day plus Formal Complaints
45
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35
30
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26/09/22
03/10/22
10/10/22
17/10/22
24/10/22
31/10/22
07/11/22
14/11/22
21/11/22
28/11/22
05/12/22
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19/12/22
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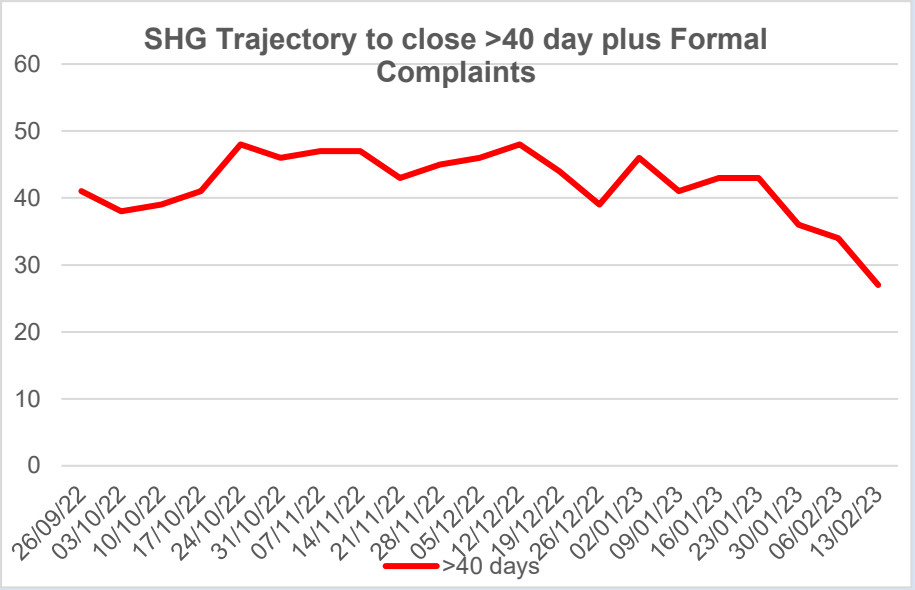
30/01/23
06/02/23
13/02/23
>40 days


SHG Trajectory to close >40 day plus Formal Complaints
60
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03/10/22
10/10/22
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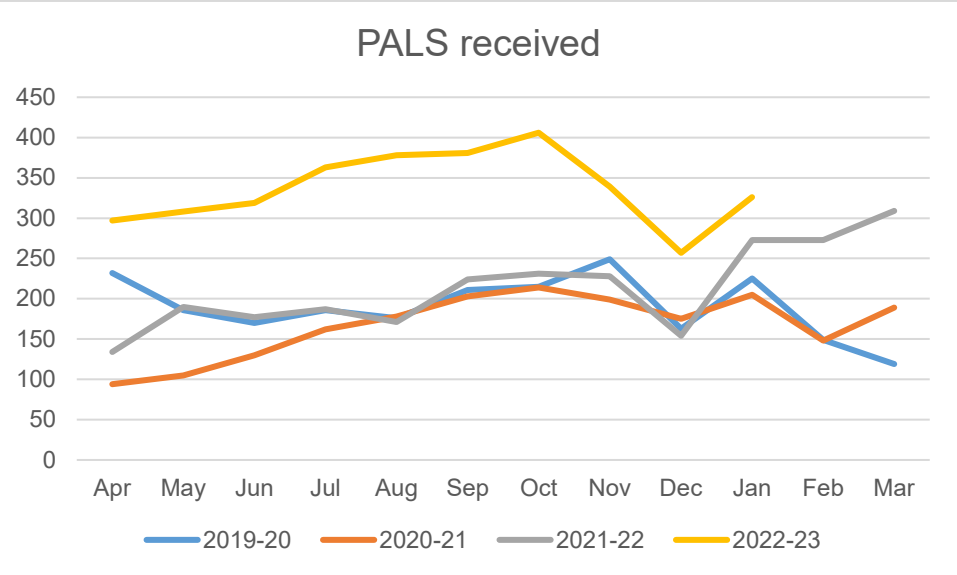
21/11/22
28/11/22
05/12/22
12/12/22
19/12/22
26/12/22
02/01/23
09/01/23
16/01/23
23/01/23
30/01/23
06/02/23
13/02/23
>40 days

4.3 PALS RECEIVED

Number of PALS received by month



Aim: Prevent PALS becoming formal complaints

Target: monitor

What is the chart telling us:

- Expected seasonal decrease which occurs around the Christmas / New Year Bank Holidays, however, as predicted there has been an increase in January.
- Sustained increase in PALS activity during 2022-23.

Successes:

- Early resolutions introduced
- Band 4 Senior PALS Officer (development of an existing PALS team member) in post from 01 February 2023 to lead the day to day activity and challenges.

Key Risks and Challenges:

- PALS team capacity to turnaround cases within 24 hour target.
- Main theme continues to be cancellations, delays and waiting times.

Actions / Future Plans for Improvement:

- Some minor changes to working practices to allow a quicker call and log turnaround time.
- Increased awareness of the requirement for rapid turnaround and early resolution.

5. WELL-LED DOMAIN

5.1 CONTINUOUS QUALITY IMPROVEMENT

Training

Quality Service Improvement & Redesign (QSIR) Fundamentals is a 1-day introductory course in QI tools to empower staff in their improvement journey.

The first QSIR Fundamentals session of 2023. The delegates completing process mapping

The first QSIR Fundamentals session of 2023 was hosted on Wednesday 13th February. **104** members of staff have completed this training since July 2022. The feedback questionnaires have been revised for 2023 to drive improvement in delivery.

The fourth cohort of **QSIR Practitioner** began on the 15th February 2023, with 15 delegates. This 5-day programme runs across 3 months. This cohort includes an ICB candidate, as recommended by the regional system improvement team NHS England.

Quality Improvement Projects

The repository now includes 47 improvement projects being undertaken across the Trust. A digital version of this repository will be included in the in-development CQI website.

5.2 THINKTANK

To date, 168 Think Tank ideas have been submitted via the Think Tank platform. There has been some focus on ensuring the ThinkTank forum is updated regularly, which have resulted in the following:

- 54 ideas are classed as 'in progress'
- 78 ideas are classed as 'to be started'
- 35 ideas are classed as 'completed'

5.3 CELEBRATION AND LEARNING

Celebration Event

The next Celebrating Improvement and Learning from Excellence event took place on Friday 24th February, in the Medical Education Centre Lecture Theatre at HRI. The event was accredited by the Royal College of Anaesthetists and up to 3 CPD credits are available. Certificates of attendance will also be provided to staff attending the celebration event. The agenda included Improvements in staff health and wellbeing, Improvements in Emergency Department, paediatric radiology.

CQI Website

Development of the CQI website is ongoing. This is intended to act as a focal point for Quality Improvement within the Trust, providing a QIPs catalogue and networking opportunities for staff to support their engagement with improvement. This will be complemented by the in-progress 'QI Toolkit', which will offer advice, resources and tools to support staff engagement and education regarding quality improvement.

Agenda Item		**Meeting**	Quality Committee and Trust Board	**Meeting Date**	30 Jan 2023
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	Rebecca Barber Clinical Governance Midwife Helen Yates Neonatal Consultant Lorraine Cooper Director of Midwifery				
Report previously considered by (date)	Quality Committee				

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

Key Recommendations to be considered:

The Committee is requested to:

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

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

Avoiding Term Admissions into Neonatal Units (ATAIN): Learning from Term Admissions Quarter Three 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 NHS Trust in regards Safety action 3: "*Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme"*. Furthermore this report will focus on an action plan to address local themes from Avoiding Term Admissions into Neonatal unit reviews, this will be agreed with the Maternity and Neonatal Safety Champions and Board level champion.

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

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

In Quarter 4 the auditors for this report have focused on the primary reason for admission with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed, in order to develop the action plan.

In addition year 4 of CNST, Trusts are required to report on the number of babies admitted to the NNU that would have met current Transitional Care (TC) admission criteria, but were admitted to the NNU due to capacity or staffing issues. In addition the number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on. Finally reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet

Hull University Teaching Hospitals - Current position

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

Table 2 shows the current position for the year 2022 in **Quarter 1** (01/04/22- 30/06/22) 3.1 % and **Quarter 2** (01/07/2022- 30/09/22) 3.0 %. **Quarter 3** 2.3%. (01/10/22- 31/12/22)

Table 1

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

Table 2

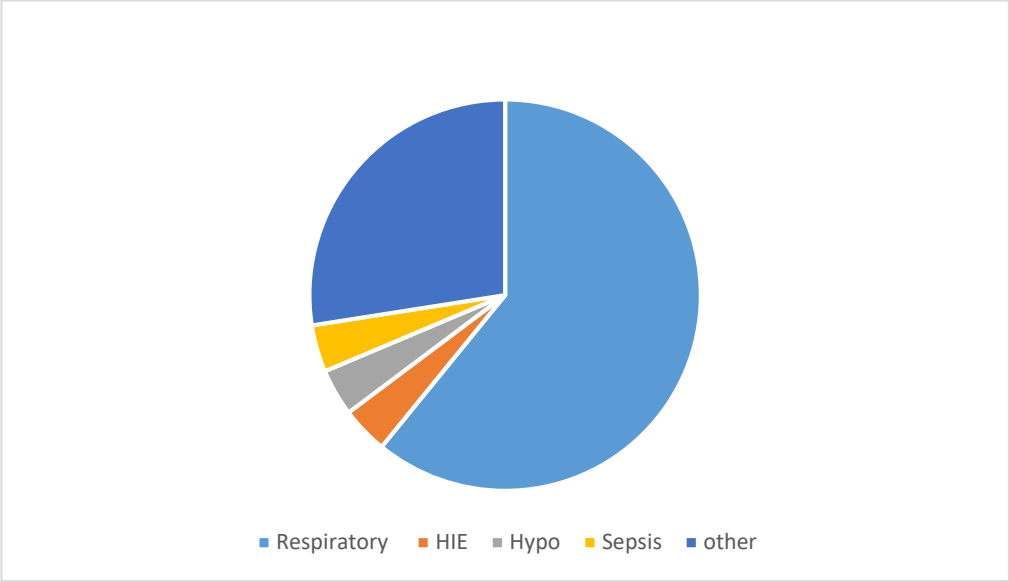
Duration	In born admissions	% of total NNU	% of term admissions
Quarter 1 2022	1250	33.4%	3.1%
Quarter 2 2022	1450	35.6%	3.0%
Quarter 3 2022	1210	39.3%	2.3%

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

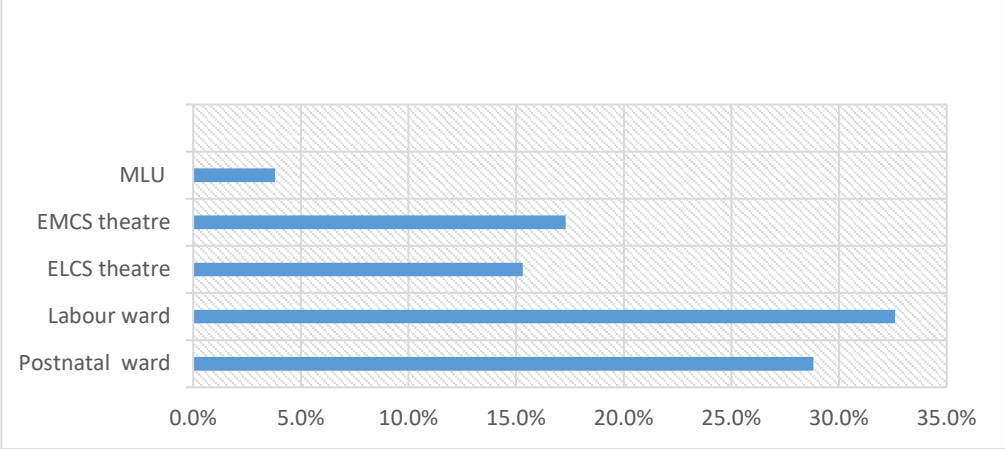
A high-level review was completed of the primary reasons for all admissions, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. Firstly the focus was on gestation as demonstrated below 38% of the cohort of babies are 37+0 – 37+6 weeks gestation.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

Gestation
Unexpected Term Admissions to NICU cases, reviewed through Maternity case review equated to 52 cases in quarter 3. Themes identified are presented below. The average gestation at admission to NICU was 38+0 - 38+6 weeks.

The primary reason for admission to NNU was for respiratory support requiring Continuous positive airway pressure (CPAP).



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



As stated in CNST year 4 all reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet

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

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

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

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

Suitability for transitional care
The number of babies admitted to the NNU that would have met current Transitional Care admission criteria but were admitted to the NNU is 8 compared to 11 in quarter 2 and the number of babies that were admitted to, remained on NNU because of their need for nasogastric tube feeding is 0 as the transitional care support at Hull University teaching Hospital supports NG feeding.

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

Rebecca Barber - Clinical Governance Midwife
Dr Helen Yates - Neonatal Consultant (ATAIN program lead)
Lorraine Cooper – Director of Midwifery
January 2023

Action	Lead	Status
Review of 'Respiratory management of the infant' guideline to ensure high standard of practice standardised	Consultant Neonatologist	Completed
Consideration for development of a criteria for admission to NICU to avoid unnecessary admissions	Consultant Neonatologist	Completed
Development of a Robust system in order to collect data on all Avoidable Term admissions to NNU	Neonatal consultant and Clinical Governance Midwife Local Maternity System	Completed Update – new data collection sheet being used to comply with CNST year 4
Respiratory management platform to be trialled for respiratory support (CPAP) at the bed side on labour ward	Neonatal consultant	April 2022 Extended July 2022
To embed practice of skin to skin at EMCS/ELCS	Labour ward coordinators Infant feeding co coordinators	April 2022 Extend to July 2022

Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee

Agenda Item		**Meeting**	Trust Board Meeting	**Meeting Date**	2023
Title	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4** **Safety Action 6 – Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?** **Element 2 – Process Indicators 4 and 7**				
Lead Director	Joanne Ledger Interim Chief Nurse				
Author	Claire Porteus - Midwifery sister Lorraine Cooper - Director of Midwifery				
Report previously considered by (date)	Quality Committee February				

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

MATERNITY SERVICES
FAMILY AND WOMEN'S HEALTH GROUP

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 - Safety Action 6 – Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two? Element 2 – Process Indicators 4 and 7 Quarter 3 Data 2022

1. Purpose of the Report

The purpose of this report is to provide assurance to the Trust Board that the organisation, to the standard required by the Clinical Negligence Scheme for Trusts (CNST), is compliant with Safety Action 6: Element 2: Process Indicators 4 and 7.

2. Introduction

Saving Babies' Lives care bundle version 2 (SBLCBv2) is a care bundle for reducing perinatal mortality across England published in April 2019. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice. Element 2 covers the risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction, including:

- publication of small for gestational age/fetal growth restriction detection rates and percentage of babies born <3rd centile and >37+6 weeks gestation
- an ongoing case-note audit of <3rd centile babies not detected antenatally (at least 20 cases per year) to identify areas for future improvement and monitoring of babies born >39+6 and 10th centile to provide an indication of detection rates and management of small for gestational age babies

For the purposes of this report, this links to CNST Safety Action 6, Element 2:

Process Indicator 4 – a quarterly audit of the percentage of babies born <3rd centile >37+6 gestation.

Process Indicator 7 – a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks gestation to identify themes that can contribute to fetal growth restriction not being detected & evidence of quality improvement initiative to address any identified problems.

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

3. Requirements for Safety Action 6, Element 2 – Process Indicator 4 –

a quarterly audit of the percentage of babies born <3rd centile >37+6 gestation.

October, November, December 2022 (Quarter 3)

Number of babies born at HUTH = **1211**

Number of babies born at HUTH < 3rd centile & >37+6 = **36**

Percentage = 2.97%

4. Requirements for Safety Action 6, Element 2 – Process Indicator 7 - a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks gestation to identify themes that can contribute to fetal growth restriction not being detected & evidence of quality improvement initiatives to address any identified problems.

The majority of the 36 cases (n=31) were not classified as missed cases and were managed appropriately.

Through the Perinatal Institute Growth Assessment Protocol (GAP) Score system and the Trust's Datix system, missed maternity cases within this criteria are reviewed.

For Quarter 3 (October, November, and December 2022), there were 5 missed cases and of these, it was highlighted that (some cases involved more than 1 of these issues):

- 1 case involved possible incorrect fundal height measurements by midwifery or obstetric practitioners
- 1 case was not referred for ultrasound growth scans when risk factors for growth restriction were identified and 1 further case had incorrect demographics on the growth chart
- 1 case was not commenced on GAP scan protocol at booking when risk factors were identified
- 1 case involved missed attendances for GAP scans or missed attendances at antenatal clinic appointments (therefore missed fundal height measurement opportunities
- 3 cases fell within the 30% variance allowed by the ultrasound parameters or there was a lengthy interval between the final growth scan and the birth, meaning that discrepancies could not be identified

Emails were sent to the relevant practitioners to inform them that they had missed GAP scan referrals, commencement of GAP protocol or included incorrect maternal ethnicities on customised growth charts. Details of ultrasound growth deviations close to the time of birth were sent to the obstetric sonographers for discussion at their multi-disciplinary meeting(s). It continues to remain encouraging that the number of incorrect fundal height measurements has remained low in this quarter, and it is felt that face to face mandatory fundal height assessment/training has been able to identify any issues with individual practitioners.

From the GAP score report produced during this quarter, a GAP newsletter was produced for all relevant maternity staff in early December 2022. This covered current GAP data involving detection rates of babies born under 10th centile, reminders to all staff to refer for growth scans if indicated, commence GAP protocol, highlighted the recent Trust GAP guideline changes and focused on consideration of risk at every contact with pregnant people.

5. Summary

i) For Safety Action 6, Element 2 – Process Indicator 4 **–** a quarterly audit of the percentage of babies born <3rd centile >37+6 gestation has been undertaken

ii) for Safety Action 6, Element 2 – Process Indicator 7 **-** a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks gestation has been undertaken

6. Recommendations

The Trust Board is requested to:

- Receive the above report
- Receive assurance by the team that the relevant audits and review requested by CNST have been undertaken.
- Decide if any further information is required

Claire Porteus – Midwifery Sister
Lorraine Cooper – Director of Midwifery

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust Board Meeting	**Meeting Date**	
Title	**Perinatal Quality Surveillance Tool Q3**				
Lead Director	Joanne Ledger Interim Chief Nurse				
Author	Julia Chambers Lead Midwife Lorraine Cooper Director of Midwifery				
Report previously considered by (date)	Quality Committee February				

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.

PERINATAL QUALITY SURVEILLANCE TOOL

Quarter 3

October – December 2022

1.0 INTRODUCTION

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

2.0 CQC MATERNITY RATINGS

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

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

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

3.0 REVIEW OF PERINATAL DEATHS

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

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
2	3	0	6	2	1	1	2	2	3	2	2

In October to December 2022 we reported:

83823 NND 30 weeks Twin

83851 NND 26 weeks

83905 23 week late loss

85132 37+4 IUD

85087 NND 34+1

84712 NND 24 weeks

84556 22+0 IUD

4.0 HSIB REFERRALS

The following provides numbers of HSIB referrals made:

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
0	0	0	2	0	2	0	1	1	1	0	1

A case was referred and accepted in October & December:

MI-016755 40+0, MLC, bradycardia at full dilatation, ventouse – baby admitted to NICU, seizures & cooling

MI-019971 G1P0 20 week's pregnant maternal death with cerebral venous sinus thromboembolism

5.0 INCIDENTS

The following provides the number of incidents reported:

Severity	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
Moderate	0	0	1	2	2	1	0	2	3	2	1	2
Major	0	0	0	0	0	0	0	1	0	0	0	0
Catastrophic	0	0	0	0	0	0	0	0	0	0	0	1

SUI/2022/24314 – Bradycardia in labour, transfer to Labour Ward from AMLU, Kiwi birth, baby transferred to NICU – required cooling. HIE – HSIB Investigation

W266940 – 20 days post LSCS, return to theatre for laparoscopy, EUA and wash out

SUI/2022/24312 – Failure to refer to Preterm birth prevention clinic – Trust SI

W272030 – Grade 2 LSCS, face presentation, bladder damage at LSCS – repaired DOC undertaken

W271559 – Return to Theatre following EL LSCS due to continued bleeding through dressing. EBL 1600mls.

SUI/2023/336 Maternal Death – cerebral venous sinus thromboembolism

Themes & Actions

There were two serious incidents reported in November

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
0	0	1	0	0	0	0	0	3	1	1	0

SUI/2022/24314 – term baby admitted to NICU following bradycardia in 2nd stage, baby cooled – HSIB investigation

SUI/2022/24312 – failure to be referred to the Preterm birth prevention clinic, SROM at 19+5 weeks – cord prolapse at 20+1 weeks.

6.0 TRAINING COMPLIANCE

CNST Training Data PROMPT, Fetal Monitoring and Neonatal Resuscitation PROMPT

Job Role	Number staff in group	Training completed to date	Training Compliance
Obs Consultants	15	14	93.3%
Obs Registrar	14	1 4	100%
Obs ST1-2	9	9	
Obs Con Anaesthetist	8	7	90%
Obs Anaesthetist	6	6	100%
Labour Ward MW	41	39	94.6%
MLU MW	29	28	
Maple/Rowan	36	34	
Specialist MW	27	25	
ANC MW	30	27	
Community MW	34	34	
Bank MW	9	8	
L & D MA	13	13	97.1%
MLU MA	14	14	
Maple & Rowan	24	23	
ANC MA	11	11	
Community MA	5	5	
Bank MA	4	3	

PROMPT

Due to ongoing social distancing restrictions within the Trust at the start of the year the reduced face to face PROMPT course has remained. The face to face session includes maternal resuscitation, human factors, Eclampsia shoulder dystocia, fetal head dis-impaction, cord prolapse scenarios. The theory content is facilitated with online learning using the K2 programme which covers shoulder dystocia, breech and cord prolapse, PPH and APH.

The content to ensure we cover the three year plan will include ongoing antenatal and intrapartum risk assessment with the a holistic view from a woman's personal perspective, offering her informed choice which we have put online for team training, which was developed by the LMS. Other aspects will include maternal mental health, vulnerable women and families, bereavement care, management of labour, VBAC and uterine rupture, GBS in labour, management of epidural anaesthesia, operative vaginal birth, perineal trauma, maternal critical care and recovery care after general anaesthetic. It will also include obstetric emergencies.

The following PROMPT session was cancelled due to staffing

21st August both Am and PM sessions

Neonatal Resuscitation training

Job Role	Number staff in group	Training completed to date	Compliance
L & D	41	38	**93.2%**
MLU	29	27	
Rowan / Maple	36	35	
Specialist/Managers	27	24	
ANC	30	28	
Community	34	32	
Bank	9	8	
Neonatal Consultants	9	7	**91%**
Neonatal Registrars	15	14	
Neonatal SHO	11	11	
Specialist Snr NICU Nurses	7	7	**96%**
NICU Nurses	97	93	

The following training dates were cancelled due to staffing:-

23rd March AM & PM session

5th April AM & PM session

13th April AM & PM session

15th July AM & PM session

16th August the afternoon session was cancelled due to low numbers, we moved candidates to the am session or reallocated to another date.

CTG Training

Job Role	Number staff in group	K2 completed	Face to face attended	Compliance with both elements	% compliance for CTG training
Obs Consultants	15	13	12	11	**93.3**
Obs Registrar	14	13	12	11	**100%**
Obs SHO	14	6	14	6	**100%**
Labour Ward MW	41	40	37	37	**95.6%**
MLU MW	29	26	29	24	
Maple/Rowan	36	21	33	20	
Specialist MW	27	22	28	21	
ANC MW	30	27	28	25	
Community MW	34	34	33	30	
Bank MW	9	7	6	4	

The following CTG face to face sessions were cancelled

4th and 8th April 2022 due to increased absence with Covid (equated to 38 staff members to re-allocate).

All other sessions ran even with low numbers.
December till August were double session bookings to get as many staff through.

7.0 MINIMUM SAFE STAFFING LEVELS

Birthrate plus Report (December 2021)
Hull University Teaching Hospital NHS Trust (HUTH) in line with national guidance has undertaken a Birthrate plus assessment of midwifery staffing using three months casemix data for the months of April to June 2021.

The Birthrate plus workforce planning system provides each maternity service with a detailed breakdown of the number of midwives required for each area of service in both hospital and community. This allows each service to apply its own allowances for holiday, sickness and study leave and for time spent in travel by community staff, a 21.6% uplift was applied to cover annual, sickness and study leave has been included in the staffing calculations.

The final 2021 Birthrate plus Report for HUTH identified annual activity based on the FY 2020/2021 total births has fallen to 4814 total birth rate. However women have been identified has having more complex health needs falling into categories IV and V and thus requiring an increase in midwifery hours.

The 2021 report identified that compared to data collated in 2018 the overall health needs of the local population have significantly increased than previously reported. This in turn has a direct correlation to the number of midwives required to deliver safe and affective care to women throughout their maternity journey.

The report recommended that the clinical midwifery budget to be set at **187.89WTE** midwives, compared to the previous funded establishment of **175wte**. The report also identified the need to uplift midwifery establishment by a further **9.29WTE** for additional specialist and management roles to support the delivery of key national drivers rather than deliver direct clinical care.

The report was shared with the Trust Board and in collaboration with senior leaders including finance and Chief Nurse the midwifery Budget has been uplifted **187WTE** to reflect the midwives required to deliver direct clinical care.

Following the Ockenden publication and in line with the Royal College of Midwives (RCM) 'Strengthening midwifery leadership: a manifesto for better maternity care', HUTH has uplifted is current Head of Midwifery (HoM) to Director of Midwifery (DoM). The Director of Midwifery presents all maternity reports to the Trust Board with support from the Chief Nurse, which enables the DoM to provide assurance to the Board that key national drivers are being delivered and that services are safe.

The on-going workforce plan and next steps are to strengthen the midwifery leadership team by exploring other roles such as Deputy Head of Midwifery, Consultant Midwives, Advanced Midwifery Practitioners (ACP), and research midwives. The key priority for the service was to ensure the immediate uplift and recruitment of clinical midwives delivering direct patient care in line with Birthrate plus recommendations. However since the Birthrate plus report was received HUTH have introduced the following specialist roles which include:

- Practice learning Facilitator (PLF)1WTE
- 5 International theatre nurses
- Maternity Safety Specialist Role B8a 1WTE
- Business support manager B8b 1WTE to support with Ockenden and CNST
- An extra Midwifery Sister in Community 1WTE

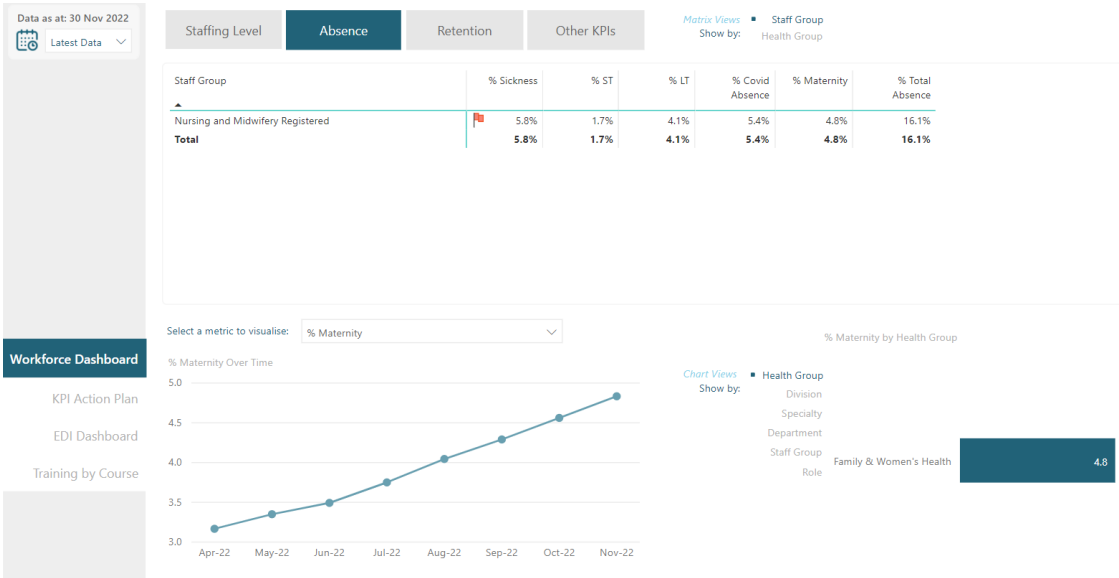
Ongoing workforce reviews are being undertaken to explore additional specialist and management roles to ensure on site senior operation support 24hrs a day 7 days a week.

Maternity Leave

The service has seen an increase in maternity leave amongst qualified midwives and is currently at 3.2% for September 2022 as demonstrated in Figure 2, this equates to 11 midwives/8.84wte currently off on maternity leave.

The service endeavours to recruit into 60% of this vacancy and HUTH have run multiple vacancy adverts over the last six months in an attempt to attract new recruits.

Figure 2: Maternity Leave



Leavers
The pandemic has made professionals review whether they want to continue to work within the NHS, including the midwifery profession.

A recent 2022 RCM survey highlighted that only 5.9% of midwives said that there are enough staff at their organisation for them to do their job properly. This is a fall of 12.5 compared to 2020, where 18.4% of midwives said there was enough staff at their organisation.

This is a significant concern and we know that newly qualified midwives are at a higher risk of leaving within the first two years then the rest of the workforce. This is why HUTH have invested in the Retention, Recruitment and Pastoral Midwife (RRPM) to support ongoing work with existing staff and new starters.

There have been a number of midwives that have given notice since April 2022 with a peak of 15.7% in September 2022, which is demonstrated in Figure 3. All leavers have received an exit interview to understand in more detail the reasons for leaving. The reasons staff have given for leaving are as follows:

- Career progression (promotion)
- Undertake further training such as Health Visiting University programmes
- For a more happier work life balance
- Return to Nursing
- Some midwives have feedback negative behaviour from peers as a reason for leaving

Recruitment
HUTH maternity service works in close partnership with the University of Hull to support workforce planning. In the current climate there is an annual intake of students every September that feeds into HUTH.

HUTH have recently appointed 19 newly qualified registered midwives which equates to 16WTE that commenced in post on 26 September 2022.

We have listened to feedback from core labour ward staff and wider teams to understand what clinical tasks midwives are undertaking that are non-midwifery. The staff voiced concern that undertaking historical surgical scrubbing in theatre is a task that could be undertaken by a theatre nurse. As a direct result of this feedback the service has appointed 5 international nurses, who are currently undertaking a bespoke training package to facilitate the release of midwives from this non midwifery role. Work is on-going with the Trust theatre matron and Chief Nurse to ensure the new model is delivering releasing clinical midwifery hours back into the system.

International recruitment (IR)
On the 11 July 2022 HUTH received a letter from NHS England informing the Trust that they have expanded the offer to join the NHSE Maternity IR Programme to all maternity services. This offer is to support improvements in maternity services and to help with the ongoing workforce gap identified in midwifery.

HUTH submitted a bid in August 2022 for 10 international midwives and are currently awaiting a response from NHSE.

On Boarding for Newly Qualified Midwives
The organisation nursing recruitment has always taken place early into the start of year 3 of the professional programme. Careers events are commenced in Trimester 1 of the academic calendar, with interviews taking place promptly after with candidates who wish to explore employment with HUTH.

This year we have utilised this successful model in midwifery by undertaking a careers event held at the University and offering virtual interviews. This has resulted in students feeling less anxious around employment at the end of the programme, which in turn allows them to concentrate on the final 2 trimesters of the degree programme.

Once employment has been secured with the organisation a 'transition into practice' module commences in Trimester 3 of the programme, which is organised and taught by the HUTH. This is 1 day per week for 6 weeks, a series of sessions delivered by specialist staff such as sepsis, recognition of deterioration and

communication skills to name a few. The student is able to claim practice hours for this element but also assist them in understanding their new employer's policies and procedures, to commence the transition from student into a professional role as soon as possible to again ease anxiety.

Modelling a successful scheme used in nursing, this year we have been able to utilise this well also with the new midwifery recruits. On completion of the academic programme at the university there is usually a period of time 4-6 weeks when the student has finished and is awaiting receipt of an NMC PIN number. During this time in HUTH we offer the student the opportunity to commence on a band 2 posts within their field of employment whilst they await their PIN number. This has proved successful again in relieving anxieties, aiding the transition period and also providing some financial security to the new registrants whilst they await their PIN number. The job description is bespoke to this role, which also allows students to partake in some skills above that of a midwifery assistant, which aids the clinical skills and knowledge continuation from their student journey.

During the band 2 time or within the preceptorship period once the PIN is received the new registrants are invited to a 'let's get started' programme which is led by the trust clinical nurse educators and midwifery team for specialist areas. This covers all the necessary mandatory training, housekeeping activities such as car parking and uniforms alongside some specialist teaching. This period again is designed to provide support, training and preparation for their registered role ahead. We have already undertaken a substantive feedback session with this year's registrants to understand their perspective on this model of recruitment. There are some areas that we need to improve on and change and this is work in progress for 2023. We have already secured a face-to-face careers event in conjunction with our local practice partners and the University to commence the above recruitment process for 2023.

Midwifery Preceptorship
On the 1 April 2022 HUHT appointed a full time Retention, Recruitment and Pastoral Midwife with 2 years funding from NHS England. HUTH are very pleased to be able to introduce the new role into maternity services. The roles have been introduced as safety critical roles and form part of the peoples promise in supporting Trusts to retain their staff and reduce attrition. This is for all maternity staff but encompasses early career midwives, and students. The purpose is to support and encourage staff in the workplace, providing 1:1 support and group sessions the aim being to encourage a positive supportive culture for us all to work in. In addition to this role HUTH has 11 Professional Midwifery Advocates (PMAs) that supports and strengthens the work that we do in supporting staff within the maternity workforce.

Since being in post the Retention, Recruitment and Pastoral Midwife in line with Ockenden recommendations has completed a GAP analysis on the midwifery Preceptorship package. This has been Rag rated by a Clinical Fellow who is leading on Preceptorship in the South of England.

To date the service has updated our document so we have a new Preceptor document (which I have embedded). This has been given to all newly qualified midwives (NQM) this September. The service has also asked for volunteers to be preceptors and to date we have over 20 midwives that have come forward. The Retention, Recruitment and Pastoral Midwife divided them into small groups with the NQM to start the support, which includes link preceptors in community midwifery. We are aware that we have got a lot of work to do to but we are planning training dates for all preceptors and we aspire to complete all requirements identified within the GAP analysis.
Birthrate Plus Report 2021

Birth Rate Plus Red Flags

Maple Ward – 0 red flags were reported from October to December 2022

Rowan Ward – 0 red flags were reported from October to December 2022

Fatima Allen Birth Centre – 0 red flags were reported from October to December 2022

Labour ward – 18 red flags reported from October to December 2022:

- 3 occasions where 1 midwife is not able to provide 1:1 care in established labour

- 2 occasions where the Labour ward Co-ordinator was not supernummary – caring for a woman in established labour
- 2 of these were delay between admission for induction and beginning of process
- 10 were missed or delayed care
- 1 delay in providing pain relief

8.0 SERVICE USER VOICE FEEDBACK

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

November Statistics

Hull University Teaching Hospitals NHS Trust	Northern Lincolnshire and Goole NHS Foundation Trust	York and Scarborough Teaching Hospitals NHS Foundation Trust
321 questions this month	127 questions this month	111 questions this month
384 questions last month	140 questions last month	139 questions last month
12 referrals to GP, midwife or other agencies	6 referrals to GP, midwife or other agencies	2 referrals to GP, midwife or other agencies
3.7% referral rate	4.7% referral rate	1.8% referral rate

9.0 STAFF FEEDBACK

Our Retention, Recruitment and Pastoral Support Midwife, Zoe Dale is undertaking a significant amount of work, in supporting staff clinically on the ward and with restorative clinical supervision. She is working closely with the HR department in meeting with staff to explore themes on culture and the requirement for culture change. She undertakes exit interviews for all staff who wish to accept and has been successful in keeping 2 midwives within the profession. Below is the feedback from one Midwifery Assistant's exit interview:

10.0 EXTERNAL CONCERNS OR QUERIES

11.0

12.0 CORONERS

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

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2021	Oct 2022	Nov 2022	Dec 2022
0	0	0	0	0	0	0	0	1	0	0	0

13.0 CNST

The section of the report provides details on the Trust's progress against compliance with the 10 CNST Standards of Maternity Incentive Scheme Year 4

A letter was received on 23rd December 2021 from NHS Resolution highlighting the decision to pause the reporting procedure for the maternity incentive scheme for a minimum of 3 months.

The Year Four scheme was reviewed and relaunch from 6 May 2022. The scheme's submission deadline has been extended from June 2022 to 5 January 2023 to provide Trusts with extra time to achieve the standards. Interim timeframes within each of the safety actions have also been reviewed and extended.

A further review of MIS Year 4 has been released in October 2022 with alterations to Safety Actions two, four, five, six, eight and nine. These will be updated and reviewed at the next CNST meeting to identify the impact on progress.

A confirm and challenge meeting was undertaken on the 20th December 2022 with the Family & Women's Health Group Quadrumvirate to provide assurance of the level of evidence available to demonstrate compliance with each of the 10 standards of Year Four. Our current reported compliance is demonstrated below:

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 Compliant**	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 Compliant**	**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/

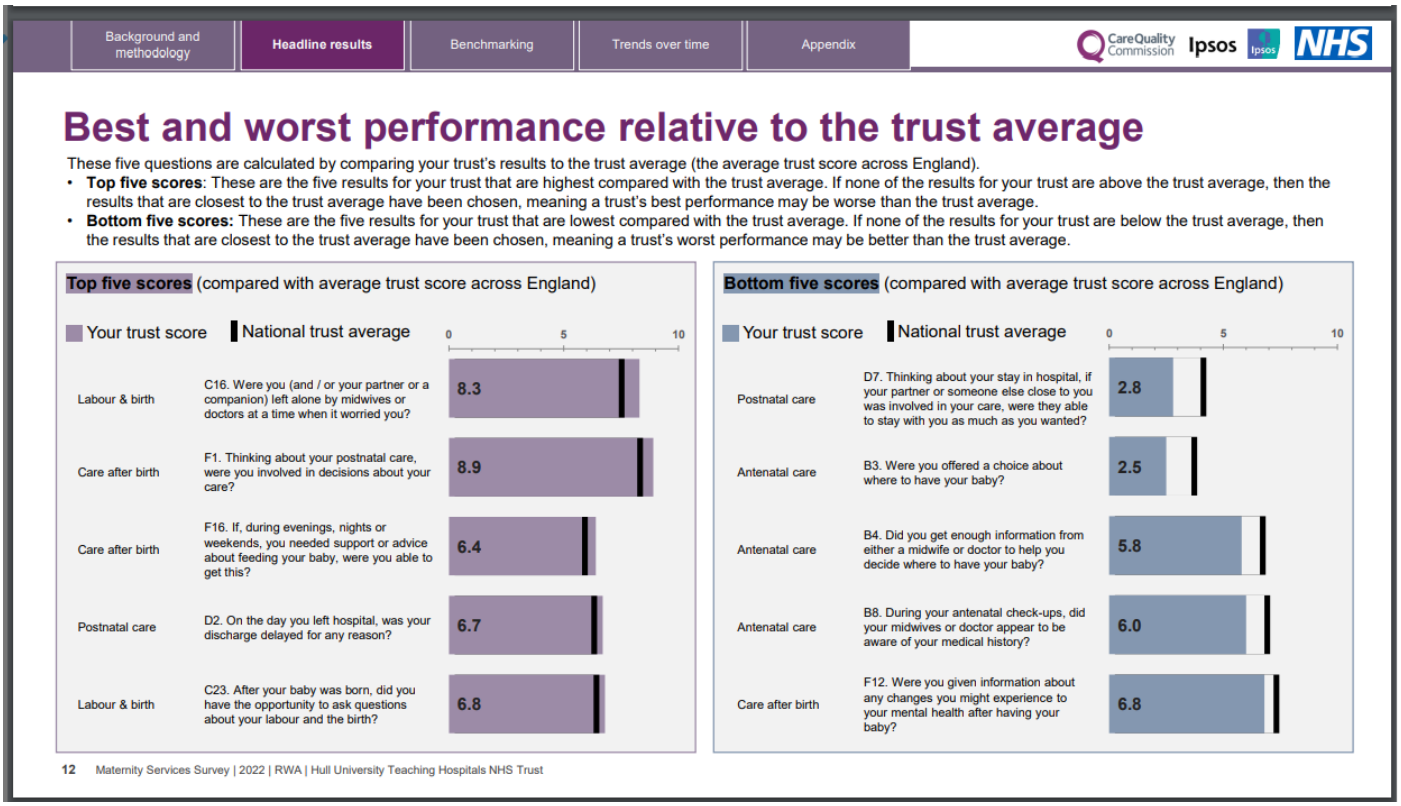
		2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed 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 Compliant**	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.
6	**SBLV2 Compliant**	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific

		variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. 3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.
7	**Maternity Voices Partnership Compliant**	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
8	**Mandatory Training Compliant**	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 Compliant**	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 Compliant**	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.

14.0 NATIONAL SURVEY RESULTS

Maternity Survey 2022 results



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

Humber and North Yorkshire Health and Care Partnership

Perinatal Quality, Safety and Assurance Group (PQSAG) Highlight Report – October to December 2022

LMNS	Humber and North Yorkshire	**Programme Lead**	Becky Case
Trust	**Hull University Teaching Hospital**	**Completed by/date**	Julia Chambers

No of Serious incidents	K2 & PROMPT Compliance	ATAIN Rates	HISIB reported events	No of complaints/PALS - themes
October: 1 Serious Incidents and 1 HSIB (same case) November: 2 Serious Incidents, 0 HSIB December: 1 Serious Incidents, 1 HSIB (same case)	>90% in all staff groups	2.8%	1 x Cooled Baby HIE 1 x Maternal Death	Between Oct – Dec 2022 16 PALS – Staff attitude, Plans of care are the top themes 8 Complaints - care & treatment, communication

Top 5 Perinatal DATIX Themes (combined obstetrics and neonatology)	Top 5 PMRT Themes (combined obstetrics and neonatology)	Top 5 HSIB Themes (combined obstetrics and neonatology)
1/Term baby – unexpected admission to NICU	1/Lack of documentation on partogram	1/Clinical Assessment
2/PPH >1.5 litres	2/Communication	2/Guidelines
3/Delay to treatment – antenatal care	3/Risk Assessment review	3/Communication
4/Growth Assessment Protocol	4/written documentation in appropriate language	4/Escalation
5/Late Booker	5/	5/Training

BAPM 7 KPIs – Local data received via ODN re % of women receiving the interventions:
Please check your unit's data received via ODN.

	Oct22	Nov22	Dec22
Early breast milk	56	93	
Thermoregulation	78	93	
DCC	78	93	
Intrapartum antibiotics	50	30	
Correct place of birth	100	100	
Magnesium sulphate	100	100	
Antenatal steroids	56		

Perinatal - Key Themes from Incident Reviews	Perinatal - Key Safety Interventions Implemented
1/ Fluid Balance completion	1 1/ Recommenced the record keeping audit which does include monitoring fluid balance completion compliance. Fluid replacement was also reviewed as part of the PPH 500-1499ml Audit.
2/ SFH Measurement and escalation Thermoregulation of the Newborn Accidental Arterial Cannulation	2/ SFH measurement and escalation is reviewed at MCR. We are also reviewing the guideline to ensure clarity that following a growth USS-SFH should follow the trajectory of the previous SFH and not the USS.
3/ Thermoregulation of the Newborn	3/ We have placed a mandatory read on Pattie with a reminder to all staff to re-familiarise themselves with the Thermoregulation of the newborn guideline. Nicky Roberts is also developing a handover of care checklist which will include a requirement for babies to have had a normal Temperature recorded prior to transfer to the PN ward.
4/ Accidental Arterial Cannulation 6456	4/

Moments of Excellence / Good Practice Points
• 1/ Positive feedback received from a couple with complex needs who were supported during their pregnancy, adjustments made to support in appointments, continuity of care provider and support during birth. • Successful on ward Baby Abduction simulation – very positive experience with good evidence of knowledge of procedures. Positive feedback received from women on the ward • Great team working across the unit during difficult night shift just prior to christmas – short notice sickness meaning very short staffing levels, woman involved in RTA requiring staff to go to support EM LSCS in main HRI building with acute trauma team – all areas pulled together to support the unit • Compliment received from woman for the kindness and support she had been given through the Medical Obstetric Team clinic during her pregnancy
MVP Service User Feedback Themes (to note this may not be available for every meeting)
No MVP feedback at present

Abbreviations

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

Agenda Item		Meeting	Quality Committee and Trust Board	Meeting Date	
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	Sue Cooper – Bereavement Midwife Lorraine Cooper – Director of Midwifery				
Report previously considered by (date)	Quality Committee February 2023				

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.

Summary

The below summaries Q3 October to December 2022 which is within the reporting period of the CNST year 4 incentive scheme.

a) i.In Q3 the Trust was not fully compliant with the standard. **100%** of cases were notified to MBRRACE-UK within 7 working days. There was a delay in completing information following 2 neonatal deaths as the lead reporter for the neonatal service left the Trust in October.

ii.In Q3 there have been new cases totalling 2 stillbirths and 5 neonatal deaths 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 Q3, PMRT reviews have been completed within 4 months for 4 cases from Q2 in the Trust and 3 reports have been written and published. 1 case remains outstanding which is a joint case with other Trusts demonstrating **80%** compliance. The 3 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 Q3 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 in Q3
- Decide if any further information and/or assurance are required

Sue Cooper
Bereavement Midwife

Lorraine Cooper
Director of Midwifery January 2023

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY PMRT ACTION TRACKER FOR Q3 2022

MBRRACE ID	ACTIONS	Lead	Due date	RAG
80937	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	
81213	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	
81716	Review process to ensure women who are identified as GDM at booking are prescribed Aspirin	AW	30/11/22	
81982	Discuss at Senior Staff meeting birth options are fully discuss prior to delivery in extreme prematurity when there is a history of previous LSCS	KS	31/01/23	
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	
83117	Highlight the need to record information given on Fetal movements. Explore adding as a mandatory field on the new digital maternity records	SC AB	31/03/23	
83553	To review the capacity and organisation of the preterm prevention clinic	WMc	31/03/23	
	Review guidance to ensure Aspirin prescribed when GDM diagnosed following booking HbA1c	RB AW	28/01/23	
Actions now completed (to be received at the PMRT meeting then removed from this tracker)				

Leads

SC – Sue Cooper
JC- Julia Chambers
AH – Anna Harrison
WM – Wendy McKenzie
AW – Amanda Waterton
RB – Rebecca Barber

RAG rating

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

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14 March 2023
Title	PSIRF Transition Approval				
Lead Director	Suzanne Rostron – Director of Quality Governance				
Author	Head of Patient Safety and Improvement				
Report previously considered by (date)	The Quality Committee reviewed the proposal and recommends that the Board approves.				

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

Key Recommendations to be considered:

The Trust Board is recommended to:

- Approve the transition date of the 1 April 2023 for PSIRF
- Endorse the appended PSIRP as endorsed by Quality Committee
- Decide if any further assurance is required at this stage.

Patient Safety Incident Response Framework Transition Proposal
Patient Safety & Clinical Effectiveness Committee
14 March 2023

1. Introduction

This paper outlines the steps taken during the planning phases of the Trust's transition to the Patient Incident Response Framework (PSIRF) and sets out the approach the Trust will take from April 2023 to transition to the new approach to responding to patient safety incidents begins.

2. Background

In mid-August 2022, the National Patient Safety Team (NHSE/I) published the Patient Incident Response Framework (PSIRF), which replaces the Serious Incident Framework (SIF, 2015). The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract. Organisations are expected to transition to PSIRF by September 2023.

The Trust has been preparing for the transition to PSIRF since the original introductory framework was published in March 2020 that was implemented by 'early adopter' sites. The shared learning from these early adopter sites and insight from the Director of Quality Governance whose previous Trust was an early adopter has allowed the Trust to be proactive in preparation for implementation.

Implementation of PSIRF will not be achieved by a change in policy alone, and it cannot be implemented in days or weeks as it requires work to design a new set of systems and processes. The a preparation guide was published to support those leading PSIRF implementation and gives an overview of the phases that those leading PSIRF need to work through, not necessarily in sequence, to deliver the new way of working. It has to be acknowledged that this is transformational and not simply a change in policy.

3. Transition

As previously advised, the plan is for the transition period to PSIRF is to commence on the 1 April 2023. The transition is the start of a continuous improvement cycle and progress will need to be evaluated on a regular basis. The PSIRF steering group, chaired by the Director of Quality Governance, will remain in place for at least the first year of transition to support this. There is no expectation nationally of being 'fully compliant' with PSIRF from the beginning of transition. However, a date needs to be agreed to ensure resource is directed to the transition from the Serious Incident Framework to the PSIRF, whilst developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This transformation, perhaps understandably, challenges committees, boards and some regulators as the oversight model is much more fluid and does not have numbers to measure against.

3.1. Preparation prior to the publication of the PSIRF

Since the appointment of the Director of Quality Governance in early 2021, a number of improvements have been made within the Quality Governance Directorate in preparation of the publication of PSIRF.

As part of the Quality Governance Directorate re-structure, a Patient Safety Team was newly formed. The formation of a Patient Safety Team supports the Trust to achieve the strategic aims of the National Patient Safety Strategy and allows for the drive to minimise patient safety incidents and build on the foundations of a safer culture and safety systems in line with PSIRF phase 2.

As well as the formation of a Patient Safety Team, two Patient Safety Specialists have been appointed whose roles are described as a facilitator and connector to ensure alignment with other elements of the National Patient Safety Strategy.

In addition, a Maternity Patient Safety Specialist has been appointed to support the development of a patient safety culture and safety systems safety and the implementation of PSIRF within maternity services.

Other appointments to support the development of a patient safety culture includes the appointment of an Associate Medical Director for Quality and Safety, and the continuation of a strong Practice Development Matron Team for areas such as patient falls, pressure ulcers, medication and dementia etc.

A Continuous Quality Improvement Team was also formed as part of the restructure to work throughout the trust to help support and engage staff with Quality Improvement Projects in line with the Trust QI Strategy and to ensure that QI and patient safety approaches align and to ensure a joint approach to learn from incident responses (PSIRF Phase 2).

In 2022, the Trust became a Quality Service Improvement and Redesign (QSIR) faculty given it the ability to provide the accredited training to drive improvement across the Trust and to develop a culture of continuous improvement. This included the appointment of Medical QI leads. The Trust currently has 15 qualified Associates to provide this training including medical staff, nursing staff, the Chief Pharmacist and members of the various improvement and OD teams in the Trust.

As part of the Quality Governance restructure, a Risk Management Team was also introduced. This has resulted in improvements across the majority of the services with ongoing work with some Health Groups.

It is also important to acknowledge activity within the OD and Learning Team in terms of staff support (TRiM managers and practitioners and clinical supervision training) and embedding the Trust CQI methodology into all leadership development programmes. PSIRF is very much reliant on an ongoing cultural improvement.

3.2. Progress achieved against the preparation phases

Since the publication of PSIRF in August 2022, a PSIRF Implementation Steering Group has met fortnightly to ensure preparation of the transition from Serious Incident Framework to PSIRF is in line with the PSIRF preparation guide phases

3.2.1. Phase 1: PSIRF Orientation

The initial stage of the PSIRF orientation was to identify the Senior Responsible Officer and to construct a core PSIRF implementation team; this was achieved within a week of PSIRF being published. The implementation team (steering group) has expertise in patient safety incident response, Quality Improvement (including medical QI leads), human factors, risk management and clinical and quality governance.

A work plan was developed to ensure programme management of the implementation plan was monitored and to set ambitions for the steering group.

Key stakeholders have been identified and a number of engagement sessions have been held with more planned before April 2023. Engagement will continue during the transition period.

A Trust Board development session was held in December 2021 and 2022 where a PSIRF presentation on what PSIRF means for the Trust and the implementation plans were discussed; this was positively received.

Engagement sessions/workshops with individual specialties and Health Groups are also being held to generate discussion about PSIRF and to identify local priorities for patient safety incident investigations to be considered for inclusion in the PSIRP (response plan).

The Maternity Patient Safety Specialist presented the Trust PSIRF implementation journey so far and specifically the maternity elements to the local Maternity and Neonatal Systems (LMNS) in January 2023 which was positively received and she has been invited to present at a National conference in April and to lead on the LMNS Yorkshire and Humber development of the maternity PSIRF.

An engagement session was held at the Patient Council in early February 2023 where the role of the Patient Safety Partner was also be promoted as the first step of the recruitment to the role. The role of the Patient Safety Partner is integral to capturing meaningful insight from patients and staff and in strengthening patient safety incident response systems. The Trust already has patient representation at a number of meetings including the Quality Committee.

The ICB has representation at the Trust Quality Committee where progress on PSIRF implementation by the steering group is presented. An ICB representative has been invited to attend the steering group from January 2023. This representative will be encouraged to attend throughout the transition period.

3.2.2. Phase 2: Diagnostic and Discovery

In addition to the points made above about the achievements already made against phase 2, the Trust supports and openness and transparency to allow staff to record patient safety issues, concerns and incidents. The Trust has a good reporting culture and has an established integrated reported system to triangulate information to ensure patient safety risks are identified and responded to effectively. The Trust Freedom to Speak up Guardian also allows staff to feel safe and confident to speak up and allows senior staff to further learn and improve safety systems.

The steering group has reviewed the PSIRF Patient Safety Incidents Response Standards to establish whether the systems and processes currently in place require any additional resource.

One area which has already been addressed were training requirements which PSIRF stipulates should be delivered by an East of England NHS Collaborative Procurement Hub's Training and Development Services Framework accredited supplier; the Trust supplier of choice was Med-led.

A PSIRF Oversight training session was delivered face-to-face to the Chief Executive's Office, Board members and Non-Executive Directors on the 1 November 2022 which introduced the PSIRF and how it should be applied and overseen to support processes related to incident responses.

Senior Leaders including Health Group Triumvirate members attended a 'Human Factors for Senior Leaders' training session delivered over two days in November 2022 which introduced the concept of systems thinking and models of safety. A cohort of clinical staff will receive 'Human Factors for Clinical Leaders' training in late spring.

The first cohort of 20 staff who have been identified as learning response leads attended training on a 'Systems Approach to Learning from Patient Safety Incidents Investigations (PSII)'. This training made up of four modules meets the PSIRF response standards requirements. A second cohort of 20 staff will receive their training in late spring.

Additional competencies for the learning response leads are to be able to apply human factors thinking as well as systems thinking principles. Historically Human Factors training has only being delivered by three medical staff within the Hull Institute of Learning and Simulation (HILS), who are trained as trainers and deliver this training to junior doctors within simulation currently.

To address the required additional resource, 15 staff have undertaken 'Human Factors for Healthcare Train the Trainer' training and are now planning to introduce a 'Human Factors Hub' which will launch with the PSIRF transition. Again, a further cohort of this training will start in the spring.

The Human Factors Hub members are from multidisciplinary backgrounds with representatives from both Clinical and Non-Clinical areas; Consultants, a Midwife, Theatre Staff, Practice Development Matrons, Medical QI leads, members of the HILS team and Continuous Quality Improvement, Patient Safety and Governance Team members

Working with colleagues in the Hull Institute of Learning and Simulation (HILS), the development of the Human Factors Hub will enable the Trust to not only provide its own training in-house to multidisciplinary teams but to be able to provide expert advice that supports continuous quality improvement in addition to patient safety.

The Trust already adopts a human factors approach to responding to patient safety incidents and has utilised clinical simulations in which allow for a scenario based investigation with the staff involved in the incident to re-enact the event and gain an understanding of why the incident happened, to identify contributory factors and to establish what could be learned and actioned to prevent repeat events. The aim is to build on this approach using the most up to date practice in human factors for healthcare.

A Restorative Just and Learning Culture will be strengthened by developing collaborative working with colleagues within the Organisational Department (OD). Support mechanisms are already established for staff who are involved in patient safety incidents with the OD team offering trauma risk management (TRiM) support. TRiM is a trauma-focused peer support system facilitated by trained practitioners, which offers psychological debriefing for people who have experienced a traumatic or potentially traumatic event.

A Just Culture baseline survey is also being undertaken for all services led by the CQI Lead; this will identify any improvements for learning from patient safety incidents to be implemented as the transition period progresses.

3.2.3. Phase 3: Governance and quality monitoring

The Trust has established processes in place for responding to patient safety incidents since the introduction of the Weekly Patient Safety Summit (WPSS) and Serious Incident Review Oversight Group (SIROG) in June 2021. The introduction of these meetings has widened and strengthened clinical engagement in patient safety with the WPSS in particular well represented which enables immediate learning from patient safety incidents to be shared across the Trust.

The Terms of reference of the WPSS have been reviewed as part of the PSIRF requirements to ensure that the Trust still has a robust process to ensure that emergent patient safety issues (those not identified in the PSIRP) have learning responses identified.

The SIROG will be disbanded but will be replaced by a Learning from Patient Safety Events (LfPSE) forum, which will monitor the effectiveness of the systems introduced within the PSIRP and policy and will support the co-ordination of cross-system responses and sharing of insights and information across the Trust to improve safety. As with the SIROG there will be representation from the ICB at the LfPSE forum.

The LfPSE forum will support the Quality Strategy and supporting work-stream groups with a CQI approach and will report to the Patient Safety and Clinical Effectiveness Committees up to Quality Committee.

Celebration events and learning events that were introduced in 2022 will continue as part of the PSIRF transition.

3.2.4. Phase 4: Patient safety incident response planning

Another early preparation for the publication of the PSIRF was a review of patient safety incident data and triangulation of other data sources undertaken in late 2021 to define the patient safety incident profile and which helped to inform the Safe Care Quality Priorities set out in the Trust's Quality Strategy 2022-2025

Further review of the Trust patient safety incident profile also informed a patient harms paper that was presented to the Trust Executive Committee in February 2022.

A maternity thematic review was undertaken in 2022, which, along with the learning from nationally published reports such as the Ockenden report and 'Reading the Signals' (East Kent) has informed a maternity specific appendix to the PSIRP.

Continued oversight of incidents resulting in harm and learning from near miss incidents at WPPS has provided the opportunity to respond to ways the Trust can learn in different ways in preparation for PSIRF. This has included the introduction of facilitated after action reviews and thematic reviews into repeat serious incidents where there was no new learning for example ophthalmic incidents where harm was sustained due to the coronavirus pandemic. The introduction of a CQI approach to patient safety incidents has also meant that there are a number of work streams with safety improvement programmes underway to address contributory factors into patient safety incidents.

In line with PSIRF, having an overarching CQI plan moves away from individual action plans which become unmanageable and disconnected from the wider improvement efforts.

Indeed, there are a number of overdue serious incident actions that have not been delivered; there is a review underway to consolidate these actions and to incorporate them into existing improvement plans where possible.

To enable the different approaches to the learning responses that are set out in the PSIRF to be utilised by all, and patient safety investigations toolkit will be available with guides on how to undertake different investigation responses with templates for learning responses.

3.2.5. Phase 5: Curation and agreement of the policy and plan

The first draft of the PSIRP was presented at the Board Development Session in December 2022 and was circulated for consultation at the December Patient Safety and Clinical Effectiveness Committee. The draft PSIRP was also shared with the ICB for comment.

This paper reflects the work undertaken during all phases of transition preparation work and the development of the PSIRP.

The PSIRP and Policy outlines the Trust's commitment to delivering the required improvement in line with the PSIRF.

3.2.6. Phase 6: Transition

As previously stipulated, there will be a period of transition from April 2023, which will be continuously monitored and the PSIRP amended to reflect the journey and learning during the transition period as the Trust adapts to the new approach.

The Trust will continue to declare serious incidents in line with the current 2015 framework until 31 March 2023 and any serious incident investigations open at that date will be concluded; it is expected that all serious incident investigations will be completed by July 202 in line with 60 working day timescales.

The steering group will continue to meet fortnightly until at least October 2023 (six month period) and will provide the opportunity for re-engagement with stakeholders to ensure the focus remains aligned to the ongoing improvement work as the patient safety incident profile changes. At this stage, the steering group will decide on frequency of meetings for a further six months.

Throughout the transition period, the Trust will share its PSIRF journey with ICB partners as a regional 'early adopter'; to support other organisations with the learning from the transition period and of any amendments to the PSIRP we make along the way.

The ICB Quality Committee approved the Trust's transition as a regional 'early adopter' at its meeting in February 2023 (Appendix 2). This is a mandated part of the transition approval process. The Trust will be supporting the ICB in finalising its formal approval processes. The Director of Quality Governance will be presenting at the ICB Quality Committee in April to share the details of the journey to date and content of this paper.

4. Recommendation

The Trust Board is asked to

- Approve the transition date of the 1 April 2023
- Approve the appended PSIRP, as endorsed by Quality Committee
- Decide if any further actions are required at this stage.

Hull University Teaching Hospitals NHS Trust

Patient Safety Incident Response Plan

Reference number

BETTER
BRIGHTER
GREENER
FAIRER

Document Control

Document Title:	Patient Safety Incident Response Plan
Reference No:	
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Date	**Version**	**Author**	**Revision description** *(Provide a brief outline of the changes made to the document)*

Contents

Introduction

This patient safety incident response plan sets out how Hull University Teaching Hospitals (referred to as HUTH hereafter) intends to respond to patient safety incidents over a period of 12 to 18 months. The aim of this plan is to continually improve and as such this document will be reviewed after a period of 12 months. HUTH will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

The plan is underpinned by our Trust Incidents Policy (CP379) available to all staff via our organisation's intranet (available to staff only).

The Trust is aiming for a transition date of the 1 April 2023. This means that all incidents reported after this time would be investigated under the Patient Safety Incident Framework (2022) and that the Serious Incident Framework (2015) would not be applied.

**A specific PSIRF policy will provide further clarity for staff on pathways for escalation, methods of review, safety action development, quality improvement plans and monitoring arrangements.*

Defining our patient safety incident profile

The patient safety risk process is a collaborative process. To define the HUTH patient safety risks and responses for 2023/24 the following stakeholders were involved.

- Trust staff – through data from incidents reported onto the HUTH Local risk management system (DATIX)
- Senior leaders across the Health Groups – through a series of engagement/briefing sessions
- Patient group – through a review of the thematic content of complaints, patient advice and liaison service (PALs) contacts and litigation claims*
- Commissioners/ICS partner organisations – through partnership working with the ICS patient safety and quality leads
- ICB attendance at Trust Quality Committee

*HUTH aims to incorporate wider patient perspective in future PSIRF planning through the recruitment of patient safety partners (PSP)

The HUTH patient safety risks were identified through the following data sources:

- Analysis of five years of DATIX incident data 2016-2021
- Analysis of themes arising from the Weekly Patient Safety Summit 2021-2022
- Key themes from complaints/PALS/claims/inquests
- Key themes identified from specialist committees (e.g. falls, pressure ulcers, nutrition, safer medication practice committee)
- Themes form the Learning from deaths Annual Report
- Themes from a review of patient harms (2022)
- Output of stakeholder event discussions

Local patient safety risks related to national priorities have been defined as the list of risks covered by national priorities that HUTH anticipates will require a response in the next 12 months. Table 1 sets out the full of national priorities that require a response.

The local response to patient safety risks have been defined as the list of risks identified through the stakeholder approach and the data analysis described above.

Table 2 lists the top local patient safety risks that represent opportunities for learning and improvement at HUTH.

HUTH patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses include mandatory patient safety incident investigation (PSII) in some circumstances or review by, or referral to, another body or team, depending on the nature of the event.

Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not to have been due to problems in care (i.e. incidents meeting the learning from deaths criteria for PSII) require a locally led PSII.

Table 1 below sets out the national mandated responses.

	National priority	Investigation Response	Learning Response
1	Incidents that meet the criteria set in the Never Events list (2018)	Locally led Never Event including clinical simulation within the SEIPS framework	Full safety action plan with appropriate elements included in other CQI plans
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII utilising the SEIPS framework	Full safety action plan with appropriate elements included in other CQI plans
3	Maternity and neonatal incidents meeting HSIB criteria	Referral to HSIB for independent PSII	
4	Child deaths	Refer for Child Death Overview Panel review.	
5	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the Panel review	
6	Safeguarding incidents in which: • Babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse / violence. • Adults (over 18 years old) are in receipt of care and support needs by their Local Authority	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding	

	National priority	Investigation Response	Learning Response
	• The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.	Partnership (for children) and local Safeguarding Adults Boards.	

HUTH patient safety incident response plan: local focus

HUTH considers that all of the incident types set out in Table 2 have relevance for all our inpatient services. This is an organisation-wide PSIRP however there are separate PSIRP plans for individual services (e.g. maternity) set out at appendix II.

All incident types below will have a PSII undertaken by staff who have received specialist training required to undertake a PSII.

Table 2 sets out local responses

	Incident Type	Investigation Response	Learning Response
1	Administration of wrong medication or wrong dose resulting in major or catastrophic harm	PSII	Full safety action plan with appropriate elements included in other CQI plans
2	Deterioration of a patient waiting for handover on an ambulance for ≥1hr to a NEWS score of 5+ resulting in major or catastrophic harm	PSII	Full safety action plan with appropriate elements included in other CQI plans

Where an incident does not fall into any of the categories above; an investigation and/or review method described in appendix I may be used by the team at ward level and where required facilitated by a member of the Patient Safety team

Local methods such as the national PMRT and SJR tools and/or structured local proformas (e.g. falls and pressure ulcers) may be used. The completion of a narrative response on the Datix incident module is also appropriate.

Table 3 sets out patient safety themes and investigation options

	Incident Type	Investigation Options	Learning Response
1	Harms identified in the Quality Strategy • Inpatient falls • Hospital acquired pressure ulcers • Catheter associated UTI • Avoidable VTE • Hospital acquired infections • Medication errors	AAR PSA MDT review, Walkthrough analysis Observational analysis Quarterly thematic review	One page learning response template Update on Quality Strategy improvement programme for that theme

	Incident Type	Investigation Options	Learning Response
2	Incidents linked to established working groups e.g. • Nutrition • End of life care • Dementia • Mental Health	AAR PSA MDT review, Walkthrough analysis	One page learning response template Update on improvement programme for that theme Quarterly thematic review
3	Risk to patient safety themes e.g. • Deteriorating patient/Sepsis • Ambulance handovers • Overcrowding • Access to treatment	AAR SWARM huddle MDT review Clinical simulation	One page learning response template Improvement plan Quarterly thematic review
4	ReSPECT/Advanced Plans not identified	AAR PSA	Quarterly thematic review and improvement plan
5	Service level determined reviews e.g. • Failed intubation (regardless of outcome) • Failed grafts	AAR SWARM huddle MDT review Clinical simulation	One page learning response template Improvement plan Quarterly thematic review
6	Moderate and above harms	AAR SWARM huddle MDT YCFF Walkthrough analysis Observational analysis Link analysis	One page learning response
7	Cluster of near miss, no harm and / or low harm	Thematic review	Thematic review report and improvement plan
8	Emerging patient safety risks / themes - identified at the weekly patient safety summit	Thematic review	Thematic review report and improvement plan
9	Learning from Excellence/things that go well (Safety II)	AAR Thematic reviews	One page learning response template Quarterly thematic review

Appendix I – Maternity PSIRP

Maternity Patient Safety Incident Response Plan

Within the maternity services at HUTH a range of system based approaches will be utilised in order to respond to and learn from patient safety incidents. This approach is central to improving perinatal quality surveillance therefore improving outcomes for the women and their families. With maternity patient safety incidents like all aspects of incident responses under the Framework, the Board are accountable for the quality of incident responses and fundamentally for reducing the reoccurrence and risk as a result of incidents. This is particularly relevant to Hull University Teaching Hospitals Board-level Maternity Safety Champions and the Non-Executive Director appointed to work alongside the champions as set out in the Maternity safety and culture policy.

In order to ensure a collaborative and collective approach, the Regional and Local Maternity Neonatal systems (LMNS) as well as the Maternity voices partnership have been involved in the development of this Maternity Patient Safety Incident Response Plan.

Maternity patient safety incidents requiring referral to HSIB

In line with the National mandated responses set out in table 1 of the HUTH PSIRP, patient safety incidents meeting the 'Each Baby Counts' and Maternal Death criteria listed below meet the requirements for a patient safety incident investigation (PSII). As such, they must be referred to the Healthcare Safety Investigation Branch (HSIB) or Special Healthcare Authority when in place, through the web portal provided to all trusts, for an independent PSII, and incidents will be referred to HSIB.

Babies who meet the criteria to be referred to HSIB for investigation include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes:

- Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life.
- Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days).
- Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic ischaemic encephalopathy; or was
- Therapeutically cooled (active cooling only); or had decreased central tone, was comatose

Maternal deaths that meet the criteria to be referred to HSIB:

Deaths of women while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).

Maternity patient safety incidents not referred to HSIB: local focus

Table 1 below sets out how HUTH Maternity service intend to response to different maternity incidents. As with all patient safety incident responses under the PSIRF, the focus is on examining and understanding how to reduce the risk of future incidents.

Table 1

	Incident Type	Investigation Options	Learning Response
1	Postpartum haemorrhage 500mls to 1499mls	PSA	One page learning response template Quarterly thematic review
2	Avoidable Term admission to NICU	MDT review PSA	One page learning response template Quarterly thematic review
3	Incidents affecting pregnant women where an interpreter was required	AAR PSA SWARM huddle MDT Walkthrough analysis	One page learning response template Quarterly thematic review
4	Maternity incidents resulting in moderate harm or above when a consultant on call not attending is a factor	AAR SWARM huddle MDT Walkthrough analysis Observational analysis	Thematic review report Update to improvement plan relating to theme
5	Early pregnancy loss which do not meet the perinatal mortality review criteria	AAR SWARM huddle MDT Walkthrough analysis Observational analysis	Thematic review report Update to pre term birth improvement plan
6	• Massive obstetric haemorrhage cases over 1.5 Litres systematically reviewed • Severe pre-eclampsia/eclampsia • Any woman requiring ICC care • Maternal or fetal morbidity following spontaneous vaginal birth, shoulder dystocia or operative delivery • Transfer to ICU • Ruptured uterus • Neonatal low cord gases	MDT review	One page learning response template Quarterly thematic review

	Incident Type	Investigation Options	Learning Response
	• Severe Sepsis • Cord prolapse • Third and fourth degree tears • Postnatal readmission		
7	All perinatal deaths from 22+0 days gestation until 28 days after birth*; (*excluding termination of pregnancy and those with a birth weight <500g if the gestation at birth is not known);*	MDT Review	Thematic review report and improvement plan if outcome of review is graded above below C Local PSII if outcome of care review is graded A or B
8	Undiagnosed foetal abnormality	MDT SWARM huddle	
9	Failed ventouse/forceps delivery leading to LSCS	AAR SWARM huddle MDT Observational analysis	Thematic review report and improvement plan
10	Incidents relating to safeguarding	MDT SWARM huddle	Thematic review report and improvement plan
11	Delayed recognition of a deteriorating women	AAR	One page learning response template Quarterly thematic review

Appendix II – Glossary

AAR – After action review

AAR is a structured facilitated discussion following an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents.

Deaths thought more likely than not to have been due to problems in care

Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

MDT – Multidisciplinary team (MDT) review

An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walkthroughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.

Never Event

Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Never Events list 2018 (updated February 2021)

Observational analysis

Observations help us move closer to an understanding of how work is actually performed, rather than what is documented in training, procedures or equipment operating manuals (work as prescribed), how we imagine work is conducted (work as imagined) or how people tell us work is performed (work as disclosed).

PSA – Patient safety audit

A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g. in a policy or guideline).

PMRT - Perinatal Mortality Review Tool

Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.

Perinatal Mortality Review Tool | NPEU (ox.ac.uk)

PSII - Patient Safety Incident Investigation

PSIIs offer an in-depth review of a single patient safety incident or cluster of incidents to understand any system factors that contributed to the incident. Recommendations and improvement plans are

then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the health groups and specialist risk leads supported by analysis of local data.

PSIRF - Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The principles and practices within the PSIRF embody all aspects of the NHS Patient Safety Strategy and wider initiatives under the strategy.

SJR - Structured judgement review

Developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths; the SJR blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

SWARM – SWARM Huddle

The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.

Walkthrough analysis

Walkthrough analysis is a structured approach to collecting and analysing information about a task or process or a future development (eg designing a new protocol).

The tool is used to help understand how work is performed and aims to close the gap between work as imagined and work as done to better support human performance.

YCFF – Yorkshire Contributory Factors Framework

The Yorkshire Contributory Factors Framework is a tool which has an evidence base of 16 domains for optimising learning and addressing causes of patient safety incidents by helping staff identify contributory factors of patient safety incidents. The underlying aim of this tool is not to ignore individual accountability for unsafe care, but to try to develop a more sophisticated understanding of the factors that cause incidents. These factors can then be addressed through changes in systems, structures and local working conditions.

Hull
Health and Care Partnership
Creating a healthier Hull

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Suzanne Rostron
Director of Governance
Hull University Teaching Hospital Trust

2nd Floor
Wilberforce Court
Alfred Gelder Street
Hull
HU1 1UY

Email: deborah.lowe5@nhs.net
www.humberandnorthyorkshire.icb.nhs.uk

8 March 2023

Dear Suzanne

I would like to confirm that the ICB Quality Committee of the 23rd of February 2023 considered the Trusts request to transition to the Patient Safety Incident Response Framework (PSIRF) from the 1st of April 2023. This request was agreed on the understanding that the ICB are still required to assess the Trusts readiness for this transition in line with national guidance. This is described in Phase 5 of the PSIRF preparation guide – draft policy and plan and the oversight roles and responsibilities document.

Whilst it is acknowledged this is a transitional journey, and there is still a significant amount of work to do, the committee do not want to delay the implementation of moving to a better and safer way of working under PSIRF. As previously discussed, the ICB continue to develop its own PSIRF policy, inclusive of the sign off process based on the national standards, and it was agreed by the quality committee that this will be applied to the Trust as the first provider to transition within our ICS to assess the Trusts readiness, and to formally sign off, once agreed, the Trusts PSIRP and policy.

We wish therefore to invite you to attend the next ICB Quality Committee that is scheduled for the 27th of April 2023, and present assurances in respect of the following key areas:

- Present your Patient Safety Incident Response Plan (PSIRP), ensuring any comments and queries made by stakeholders have been reviewed, considered and responded to.
- PSIRF programme delivery template / plan for implementation phases 1-5 – reporting by exception any areas ongoing.
- Oversight structures for implementation phases 1 - 6 and governance of assurance reporting.
- The change engagement plans and EQIA for patients, carers and wider stakeholders.

The Quality Committee have now appointed Hull Place Director of Nursing, Deborah Lowe to support the Trust in achieving the wider links with the Patient Safety

Hull Health and Care Partnership
Creating a healthier Hull

NHS
Humber and North Yorkshire
Integrated Care Board (ICB)

Collaborative and Learning Forums across the ICS. As previously agreed, Deborah will now attend the Trust PSIRF steering Group, along with the Patient Safety Lead for Hull place. Deborah will also continue as the ICB member of your internal Trust Quality Committee.

The Quality Committee recognise the work and progress undertaken to date and assurances provided to the ICB Director of Nursing Michelle Carrington, Lead for Patient Safety and wish to congratulate the Trust on this achievement.

Kind regards

Debbie Lowe

Interim Director of Nursing and Quality

Report to the Board in Public
Quality Committee
February 2023

Item: Venous Thromboembolism (VTE)	Level of assurance gained: Limited

The chief medical officer presented the committee with an in-depth review into the improvements made by the trust has made with VTE risk assessment and prophylaxis compliance.

Data collection was suspected during covid and there was a noted deterioration when reinstated, improvement initiatives were introduced to improve compliance. There are several areas within the trust where initiatives have resulted in sustained improvement to more than 90%.

Although very low number of SI's compared to the patients who are risk assessment and administered VTE prophylaxis on a daily basis, the consequences of these incidents are devastating.

The challenges, risks, initiatives and next steps were shared with the committee.

With clear patient safety implications, it is crucial that VTE risk assessment remains a priority of the trust. A follow-up paper would be provided in 6 months.

Item: Tissue Viability	Level of assurance gained: Reasonable

The committee received a presentation on hospital acquired pressure ulcers it was noted that there had been an upward trend over the last 12 months.

Approximately 25% of pressure ulcers were as a result of device and there was some targeted work in critical care and HOB areas.

There is evidence of good practice and staff knowledge remains high. The Tissue Viability team shared the actions currently being undertaken to improve the trajectory.

Item: Board Assurance Framework (BAF)	Level of assurance gained: Reasonable

The BAF was shared with the committee with the recommendation to amend the current and target risk on BAF 3.1 and 3.2. The actions were on track however with the maintained operational pressures the expected improvements had not been achieved.

BAF Quality 3.1 was agreed by the committee to be amended to Current 4 x 4 and target 3 x 4 to reflect the ongoing challenges.

BAF Patient Harm 3.2 was agreed by the committee to be amended to Current 4 x 4 and target 3 x 4 to reflect the ongoing challenges.

BAF6 Research and Innovation was agreed to remain the same, although it was noted the investment requested was not received.

Item: CQC Report	Level of assurance gained: Reasonable

A report was received with a number of appendix for assurance on the progress of the ED immediate action plan and the completion of the factual accuracy.

The draft report was received on the 2nd February and the response was submitted to the CQC by the 16th February. The draft report highlights breaches in the regulations that the Trust is required to address as 'must' and 'should' do actions. Some of these concerns were those highlighted in the initial letter of intent regarding the Emergency Department and as part of our initial feedback from this CQC. A number of key improvement work streams are required to address the areas for improvement, working groups are being set up to commence the improvement work.

The Safety Oversight Group have reviewed and amended the Terms of Reference and Work Plan to reflect the improvement plans and work streams.

The ED immediate action had 43 actions, 37 have been completed, 4 implemented and monitoring, 1 requires further update and 1 is overdue. Assurance visits have been undertaken on weekly to demonstrate the safety elements are being embedded into practice.

Item: Mortality - Learning from Deaths framework	Level of assurance gained: Substantial

The committee received the report for quarter 3 which is a summary of mortality statistics and learning from deaths in line with the requirements set by NHS Improvement, outlined in the national framework.

The In-Hospital Mortality, HSMR (Hospital Standardised Mortality Ratio), SHMI (Summary Hospital Level Mortality Indicator) data was shared. The SHMI was now within the expected ranges and no longer an outlier above the upper control limits.

December 2022 saw a seasonal increase of in-hospital mortality. Over 36 months, the main SHMI contributor conditions remain as Pneumonia, Covid-19, Sepsis and Stroke

The Trust adopted the structured judgement case note review system to undertake reviews. The Trust is also enrolled in the LEDER program and has trained reviewers who undertake reviews on patients who die both within the Trust and outside of the Trust, forming part of the wider LEDER network.

Potential themes have been identified and care standards that require improvement have an improvement plan in place.

Scrutiny was undertaken on 97% of deaths that fall under the remit of the Medical Examiner's office (n=742), including 158 referred to coroner and 76 taken for investigation.

Item: CNST Maternity	Level of assurance gained: Reasonable

The committee received reports on;

Avoiding Term Admissions into Neonatal units Programme, which has seen a decrease in the number of term admissions since 2016 with quarter 3 2022/23 reporting 2.3%. All unexpected term admissions to NNU are reported through the DATIX system and investigated through the weekly Maternity Case Review multi-disciplinary meeting.

Saving Babies' Lives care bundle version two, for reducing perinatal mortality. The risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction. There 1211 babies born in quarter 3, 36 of which were born < 3rd centile & >37+6. The majority of the 36 cases (n=31) were not classified as missed cases and were managed appropriately. The 5 missed cases which were reviewed and any training issues identified with individuals.

Perinatal Quality Surveillance Tool, there were seven perinatal deaths reported in quarter 3. There were two HSIB referrals made in the quarter. There were 4 incidents reported. Training compliance was shared. Midwifery staffing is challenging with high vacancy and maternity, student midwifes have been recruited and will join in September.

Perinatal Mortality Review Tool, the Trust are achieving all standards. Risks identified are on risk register and mitigated risks and are looking at business case.

Item: Patient Experience Update	Level of assurance gained: Reasonable

The committee received a revised report which provided a comprehensive update on the;

PALS - Between April 2022 and January 2023 the Trust has received 3,308 PALS and has experienced an increase in concerns raised over the last three years, with an increase of 103.8% since 2020/21. There are 60 PALS concerns open, with the longest one open since June 2022.

Complaints received; There are 178 open complaints with the longest open since April 2021. Out of the 178, there 52 complaints under investigation, 64 under investigation and over the 40 day target and 54 complaints re-opened as a 2nd, with the longest open since March 2021. There are 8 complaints open with the Parliamentary and Health Service Ombudsman (PHSO). Three are coming to a conclusion with agreed payments totalling £4100.

Complaints closed; Since November 2022, the Trust has achieved the 'close 40 complaints per month' and has sustained this position along with an increase in performance against the closing of complaints within 40 days target, however, further improvements are required to achieve 80% of complaints closed within 40 days.

National Surveys; 180 (47%) responses were received for the Maternity Survey 2022 with 44% of respondents given birth to their first baby. The service improved in four areas, remained the same in 41 and deteriorated in one area. The Trust's overall benchmark is 'worse than expected'.

PHSO Recommendations, An initial assessment has been undertaken against the NHS Complaint Standards and a recommendation made; however this is under further review as it was undertaken in 2021. A Complaints Standards Working Group is being established to lead how we implement the new standards and make improvements to how we manage and learn complaints.

Patient, Public and Carer Council (PP&CC); In October 2022, this was changed to merge the youth and adult patient and public councils to diversify the membership and input of the group, empowering the voices of the younger members and to encourage learning between the younger and older members based on their knowledge and experiences. The PP&CC is going from strength to strength and since October 2022.

Volunteers; The Trust has a total of 467 volunteers active at the moment. Volunteers have dedicated 2,026 hours to volunteering over the month of January 2023 saving the Trust £18,051.66.

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

- Operational Update
- Safety Oversight Group
- Patient Safety and Clinical Effectiveness Sub-Committee Escalation Report

Hull University Teaching Hospitals NHS Trust

Trust Board

14th March 2023

Title:	National Staff Survey 2022 – summary report
Responsible Director:	Chief of Workforce – Simon Nearney
Author:	Director of Communications – Myles Howell

Purpose:	Inform the board of the Trust's performance in the 2022 staff survey and associated actions.	
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:	Deterioration of overall performance since 2021. People Strategy is under review and action plan being developed.	

Recommendation:	That the board note the performance and the actions being taken to achieve an improvement in 2023.

Hull University Teaching Hospitals NHS Trust

National Staff Survey 2022 Summary Report

Trust Board 14 March 2023

1. Purpose

The purpose of the report is to provide a summary of the Trust's National Staff Survey 2022 feedback.

2. Background

All NHS trusts are required to survey their workforce annually using the National Staff Survey. The survey comprises around 100 questions. The NHS England benchmark reports are themed in line with the seven NHS People Promise areas:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

In addition the reports include two other key themes: Staff engagement and Morale. Each themes is comprised of clusters of questions from the survey.

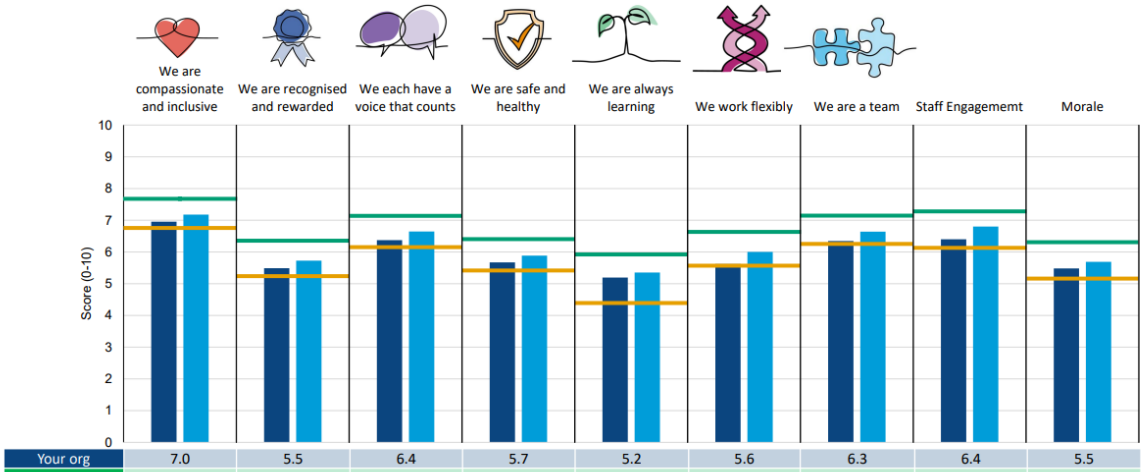
In 2022 the survey was conducted during October and November and sent by email to all HUTH staff. 37% of staff (3160 people) completed the survey, compared with 44% in 2021.

3. Key Issues

The Trust's performance in the national Staff Survey has deteriorated since 2021. This reflects the overall performance nationally however in some areas Trust staff are reporting more negatively than the national average.

4. Key themes performance

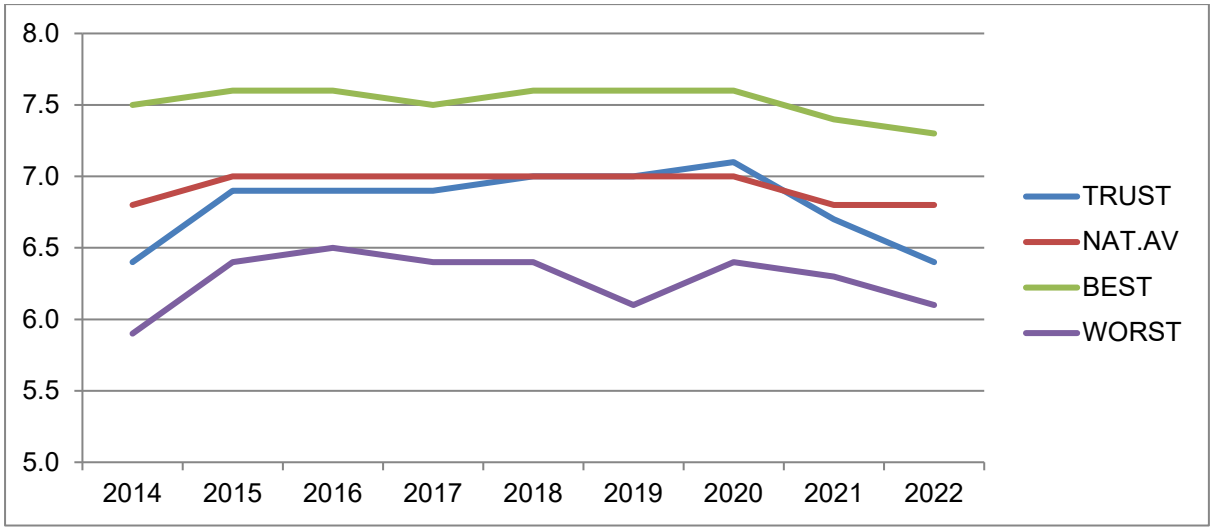
The Trust's performance against the nine key themes in the survey is shown below, compared to the national average, the best performing trust and worst performing:



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.0	5.5	6.4	5.7	5.2	5.6	6.3	6.4	5.5
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	3155	3157	3143	3147	2956	3150	3153	3159	3159

5. Staff engagement

The Trust has used Staff Engagement as a key measure of culture since 2014. The chart below shows the Trust's performance in every staff survey since then, alongside the national average, best performing trust and worst performing trust.



6. Initial actions to take

Work is underway to address the key issues raised by the feedback in the National Staff Survey:

- Full review and relaunch of the HUTH People Strategy
- Focus on 'People First' culture
- Identification of key actions/objectives for executive team and health groups
- Publication of full action plan
- Manager briefing sessions arranged for Spring 2023

7. Recommendations

The board is asked to note the 2022 National Staff Survey feedback and performance and the proposed initial actions.

Hull University Teaching Hospitals NHS Trust
Trust Board

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14/03/23
Title	Gender Pay Gap Reporting				
Lead Director	Simon Nearney, Director of Workforce and OD				
Author(s)	Employment Policy and Resourcing Manager Workforce Planning, Intelligence and ESR Systems Manager				
Report previously considered by (date)	This report was tabled at the Workforce Education and Culture Committee on 13/02/23.				

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:

Gender Pay Gap legislation requires all employers of 250 or more employees to publish their gender pay gap data at 31 March each year. This forms part of the Trust's public sector equality duty under the Equality Act 2010.

The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2023) and by the same date every subsequent year. It must be published on the Trust's website in a way that is accessible to staff and the public, and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format.

The report was tabled at the Workforce Education and Culture Committee on 13/02/23 for review and approval.

The Trust Board is requested to approve the report.

Once approved by the Board, the report will be published on the Trust and Gov.UK websites to meet statutory deadlines (by 30 March 2023).

Hull University Teaching Hospitals NHS Trust

Trust Board – 14 March 2023

Gender Pay Gap Reporting

1 PURPOSE OF THIS REPORT

The purpose of this report is to share with and seek Board approval for the Trust's Gender Pay Gap Reporting data for the pay period including 31 March 2022, prior to subsequent publication of the data in line with statutory requirements.

2 BACKGROUND

Gender Pay Gap legislation requires all employers of 250 or more employees to publish their gender pay gap as at 31 March each year. This forms part of the Trust's public sector equality duty under the Equality Act 2010. The Equality and Human Rights Commission has the power to enforce any failure to comply with the regulations.

This report includes the statutory requirements of the Gender Pay Gap legislation, but also provides further context.

The gender pay gap shows the difference between the average (mean or median) earnings of all male and all female employees. It is expressed as a percentage of men's earnings. It is a measure of disadvantage.

The gender pay gap is not the same as equal pay. Equal pay is about ensuring men and women doing similar work or work that is different but of equal value (in terms of skills, responsibility, effort) are paid the same. A gender pay gap could reflect a failure to provide equal pay but it usually reflects a range of factors, including a concentration of women in lower paid roles and women being less likely to reach senior management levels.

3 REPORTING REQUIREMENTS

The Trust is required to publish six gender pay gap measures;

- **Mean pay gap** – the difference between the mean hourly rate of pay (excluding overtime) of male and female employees
- **Median pay gap** – the difference between the median hourly rate of pay (excluding overtime) of male and female employees
- **Mean bonus gap** – the difference between the mean bonus paid to male and female employees who received a bonus in the relevant pay period
- **Median bonus gap** – the difference in the median bonus pay for male and female employees who received a bonus
- **Bonus distribution by gender** – the proportions of male and female employees who received bonus pay
- **Pay distribution by gender** – the proportion of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands

The measures are calculated using a 'snapshot date'. For public sector organisations this is the pay period which includes 31 March 2022. The figures must be calculated using the mechanisms set out in the gender pay gap reporting legislation.

The Trust is required to publish the information within one year of the snapshot date (i.e. by 30 March 2023) and by the same date every subsequent year. It must be published on the Trust's website in a way that is accessible to staff and the public,

and retained on this for a period of three years. The report must also be uploaded to the Gov.UK website in the prescribed format.

4 THE PROPOSED GENDER PAY GAP REPORT FOR 2022

The Trust's overarching Gender Pay Gap Report is attached for the Board's approval (see Appendix 1). This includes supporting narrative with key findings to help understand the Gender Pay Gap Reporting outcomes.

5 RECOMMENDATION

The Trust Board is requested to note and approve the contents of this report.

Once approved by the Board, the report will be published on the Trust and Gov.UK websites to meet statutory deadlines (by 30 March 2023).

Simon Nearney
Director of Workforce & OD
March 2023

APPENDIX 1

Hull University Teaching Hospitals NHS Trust

Gender Pay Gap Reporting

1 BACKGROUND

Gender Pay Gap legislation requires all employers of 250 or more employees to publish their gender pay gap as at 31 March each year. This forms part of the Trust's public sector equality duty under the Equality Act 2010. The Equality and Human Rights Commission has the power to enforce any failure to comply with the regulations.

Hull University Teaching Hospitals NHS Trust employs 9714 staff in a range of roles, including administrative, medical, nursing, allied health professionals and managerial roles (figures at 31 March 2022 including casual workers/bank).

The Trust uses the national job evaluation framework for Agenda for Change staff to determine appropriate pay bandings; this provides a clear process of paying employees equally for the same or equivalent work.

The national pay grades used in the Trust have a set of points for pay progression, linked to length of service and performance. Therefore, the longer the period of time that someone has been in a grade the higher their salary is likely to be, irrespective of their gender.

This report includes the statutory requirements of the Gender Pay Gap legislation, but also provides further context.

The gender pay gap shows the difference between the average (mean or median) earnings of all male and all female employees. It is expressed as a percentage of men's earnings. It is a measure of disadvantage.

The gender pay gap is not the same as equal pay. Equal pay is about ensuring men and women doing similar work or work that is different but of equal value (in terms of skills, responsibility, effort) are paid the same. A gender pay gap could reflect a failure to provide equal pay but it usually reflects a range of factors, including a concentration of women in lower paid roles and women being less likely to reach senior management levels.

2 GENDER PAY GAP DATA 2022

The figures set out below have been calculated using the standard methodologies used in the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, utilising the national NHS Electronic Staff Record Business Intelligence report functionality.

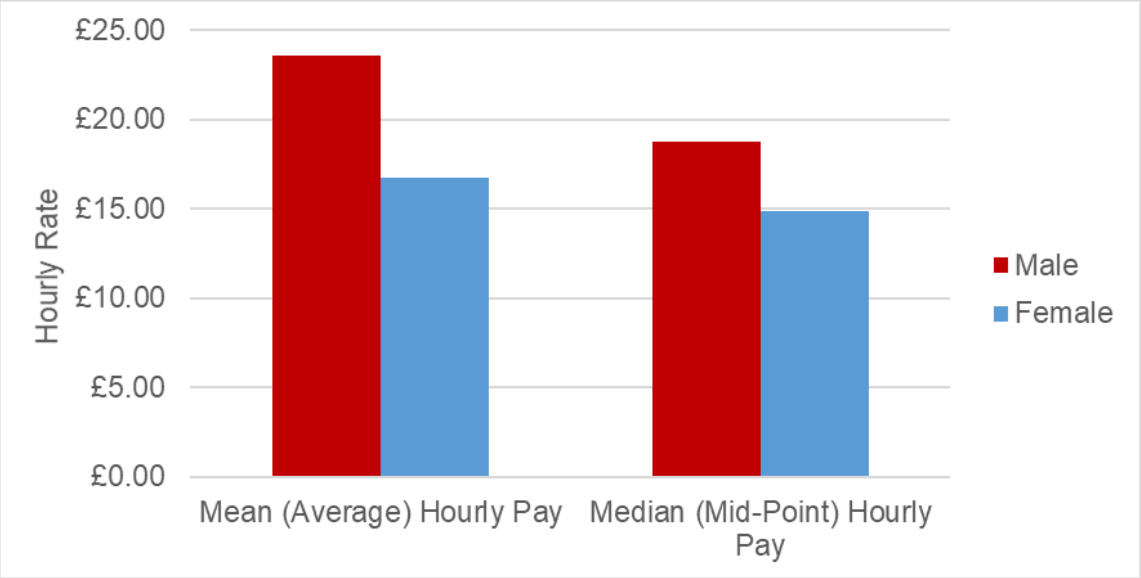
The analysis does not look at whether there are differences in pay for men and women in equivalent posts. Therefore, the results will be affected by differences in the gender composition across the Trust's various professional groups and job grades.

National reporting requirements require the Trust to report the six gender pay gap measures to one decimal point (these six measures are shown in bold italics throughout the document), however to assist the Trust better analyse the data and progress made, the data is also shown to two decimal places.

Hull University Teaching Hospitals NHS Trust's Gender Pay Gap Data for the snapshot date of 31 March 2022 is as follows:

2.1 Mean and Median Gender Pay Gap

Gender	Mean (Average) Hourly Pay	Median (Mid-Point) Hourly Pay
Male	£23.61	£18.76
Female	£16.73	£14.89
£s difference	£6.88	£3.87
% difference	29.14% ***(29.1%)***	20.63% ***(20.6%)***



- The mean gender pay gap is 29.14% (i.e. this means that women's average earnings are 29.14% less than men's). This reduction of 0.36% or £0.19 on the previous reporting period shows a small but improving picture.
- The median gender pay gap is 20.63% (i.e. this means that women's average median earnings are 20.63% less than men's). This is an increase of 0.78% or £0.34 on the previous reporting period.

Note; Gender pay gap calculations are based on ordinary pay which includes; basic pay (including for Medical and Dental staff Additional Programmed Activities), allowances (including shift premiums), extra amounts for on-call, pay for leave but excludes; overtime, expenses, payments into salary sacrifice schemes (even though employees opted into the schemes voluntarily, as they provide a benefit in kind), Clinical Excellence Awards (CEAs) and pensions.

2.1.2 Key Findings

- The Trust has an overall gender split of 76.58% female and 23.42% male staff. The mean and median gender pay gap can be explained by the fact that while men make up only 23.42% of the workforce, there are a disproportionate number of males, 39.32% in the highest paid (upper) quartile, (predominantly medical staff) with 60.68% being female.
- The mean gender pay gap for the whole economy, based on April 2022 data, (according to the Office for National Statistics Annual Survey of Hours and Earnings figures is 13.9% while the Trust's mean gender pay gap is 29.14% in favour of males. The median gender pay gap for the whole economy is 14.9%, compared to the Trust average of 20.63%. Medical staff pay has a strong impact on the mean and median data.

- If Medical staff were *excluded* from the data above, the mean (average) hourly pay gap is 4.41% or £0.71 (a 0.73% or £0.14 increase since the previous reporting period). There is now no hourly pay gap based on the median (mid-point), (a reduction of 0.72% or £0.10 since the previous report).
- The mean gender pay gap for medical staff is 14.54% (an increase of 0.6% or £0.27 since the previous reporting period). The median gender pay gap for medical staff is 12.48% (a reduction of 2.62% or £0.94 since the last return). Nationally the Consultant workforce is predominately male.
- In the current reporting period (2022) the male mean pay (£23.61) falls in the upper quartile, and the female mean pay (£16.73) falls in the upper middle quartile.
- The median pay for males (£18.76) falls in the upper middle pay quartile and female median pay (£14.89) falls in the lower middle quartile.
- The Trust operates a number of salary sacrifice schemes. The overall percentage of staff who pay into salary sacrifice schemes (76.32% female/23.68% male) closely reflects the Trust's gender split.
- This headline (female/male split) disguises the impact on the Trust's gender pay gap data, including the mean and median female averages and also where females fall in pay quartiles (i.e. they might otherwise fall into a higher quartile).
- The percentage of female staff in the lower/lower middle and upper middle quartiles who pay into salary sacrifice schemes is disproportionate (83.52%, 80.97% and 83.81% respectively). Within the upper quartile the percentage of males who pay into salary sacrifice schemes is disproportionate (42.48%). 79.41% of females pay into two or three salary sacrifice schemes, compared to 20.59% of males.
- This is because the gender pay gap calculations are based on pay *excluding* the value of payments made into salary sacrifice schemes (even though employees opt into the schemes voluntarily, as they provide a benefit in kind). Payment into these schemes therefore reduces the basic salary and hourly rate of pay.

2.2 Pay Quartiles by Gender

Quartile	Male			Female			Total
	Headcount	% Headcount	Mean (Average) Hourly Pay	Headcount	% Headcount	Mean (Average) Hourly Pay	
Lower	375	16.11%	£10.06	1953	83.89%	£10.20	2328
Lower Middle	445	19.12%	£13.23	1883	80.88%	£13.27	2328
Upper Middle	446	19.16%	£17.92	1882	80.84%	£17.92	2328
Upper	915	39.32%	£36.46	1412	60.68%	£27.67	2327
Total	2181	23.42%	£23.61	7130	76.58%	£16.73	9311

2.2.1 Key Findings

- The table above shows that in the lower quartile female employees are paid more than male employees giving a gender pay gap of -1.39% or -£0.14p. In the lower middle quartile female employees are paid more than male employees giving a gender pay gap of 0.30% or -£0.04p **(a change from the previous return when males were paid more)**. In the upper middle quartile both male and female employees are paid the same so there is no gender pay gap **(a change from the previous return when males were paid more)**. In the upper quartile the gender pay gap increases to 24.11% or £8.79.
- Based on the Trust's overall gender split (76.58% female and 23.42% male), there is no significant gender pay gap in the lower, lower middle and upper middle quartiles. Whilst there remains a disproportionate number of males (39.32%) in the upper quartile compared with females (60.68%), the percentage of males in the upper pay quartile has decreased from 40.16% in 2021 to 39.32% in 2022, a

0.84% decrease. The mean hourly pay gap for the upper quartile has risen from £8.51 to £8.79, a £0.28 increase on the previous reporting period.

2.3 Mean and Median Gender Bonus Gap including Long Service Awards and Percentage of Male/Females Receiving a Bonus Payment

Gender	Mean (Average) Yearly Bonus Pay	Median (Mid-Point) Yearly Bonus Pay	% Receiving Bonus
Male	£8,293.79	£6,575.02	16.51% ***(16.5%)***
Female	£5,208.96	£6,575.02	2.61% ***(2.6%)***
£s difference	£3,084.83	£0.00	
% difference	37.19% (***37.2%)***	0.00% ***(0.0%)***	

2.3.1 Key Findings

- The mean gender bonus gap is 15.46% when Long Service Awards[1] are excluded from the data (a decrease of 17.36% since the previous reporting period), rising to 37.19% (a decrease of 16.86% since the last report) when they are included in line with national guidance.
- The median gender bonus gap is 0% (the same as the last reporting period). This is because the median bonus pay for males and females this reporting period, both including or excluding Long Service Awards, is £6575.02 (a CEA).
- The improvements in the nationally reported mean and median bonus gap figures (i.e. including Long Service Awards) compared to the two previous reporting periods need to be treated with caution as they are largely due to changes in the allocation of local CEAs in light of the COVID-19 pandemic.
- The changes meant local CEAs did not run for the financial year 2021/22. As was the case in 2020/21, the award money was distributed equally amongst eligible consultants who chose to opt in to receive a share of this money. These consultants received the payment as a one-off, non-consolidated payment in place of normal local CEA rounds, due to exceptional circumstances.
- The distribution of male employees receiving a bonus is 16.05% excluding Long Service Awards (up 3.91% since the last reporting period) and 16.51% when Long Service Awards are included (up 3.74% on the previous reporting period).
- The proportion of female employees receiving a bonus is 1.88% excluding Long Service Awards (up 0.31% compared to the last reporting period) and 2.61% when included (up 0.19%).

2.4 Bonus Type by Gender

Bonus Type	Male		Female		Total Headcount
	Headcount	%	Headcount	%	
CEA / Discretionary	351	72.22	135	27.78	486
Long Service Awards	10	16.13	52	83.87	62
Total	361	65.88	187	34.12	548

2.4.1 Key Findings

- This year the Trust has two types of bonus that meet reporting requirements. The first is Long Service Awards, which accounts for 11.31% (a reduction of 5.06%) of

[1] The Long Service Award scheme is applicable to any employee, whether male or female, who has achieved 25 years substantive service within the NHS. Staff are invited to attend an awards ceremony to be presented with a certificate and a token gift to the value of £50 in recognition of their contribution and commitment.

payments. The second is CEAs, which account for 88.69% (an increase of 5.06% of payments (CEAs are awarded based on the performance of Consultant Medical staff subject to national and local eligibility criteria in recognition of excellent practice over and above contractual requirements).

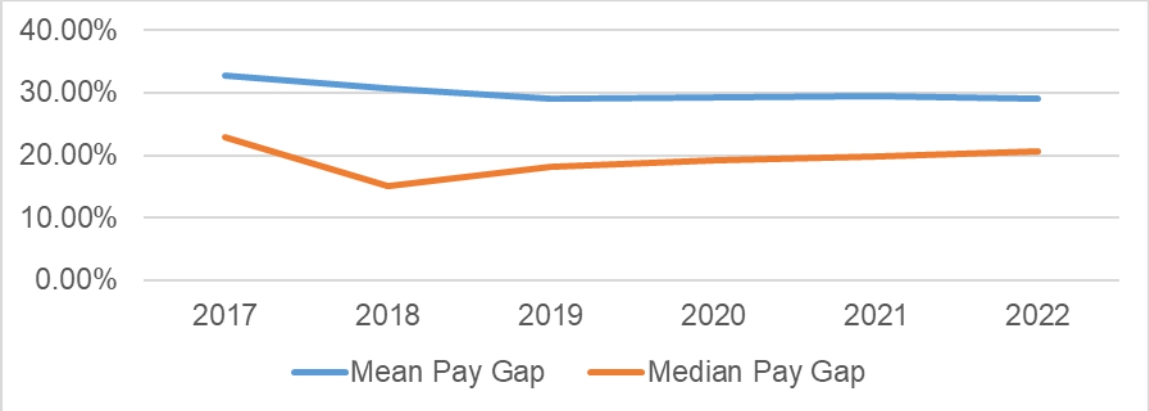
- The Trust's gender bonus data is distorted by the Trust's Long Service Award scheme as, given the gender makeup of our workforce, more females receive an award. Calculations have therefore been made both including and excluding this data.
- The gender split for all bonus pay is 34.12% female and 65.88% male (a 3.49% increase on the gender split, in favour of males, since the last reporting period). However as 27.81% of female bonus pay is the £50 Long Service Award (a reduction of 7.48% since the last reporting period) and only 2.77% for men (a reduction of 2.19%), this results negatively on mean bonus pay.
- If Long Service Awards are excluded, the mean bonus pay gap reduces from 37.19% (£3,084.83) to 15.46% (£1,318.38).
- The gender split for those receiving a CEA/discretionary payment has increased by 1.32% since the last reporting period and is 27.78% female and 72.22% male.
- CEA and discretionary points payments range from £1,508.04 to £59,477.04.
- Nationally agreed changes to the local CEA scheme effective from 1 April 2018 are starting to gradually impact on the Trust's gender pay gap data.

3 SUMMARY OF RESULTS AND ACTIONS

The Trust is committed to ensuring all staff are treated and rewarded fairly irrespective of gender.

The Trust has compared the mean and median gender pay gap since statutory reporting began.

Gender Pay Gap 2017 to 2022



	2017	2018	2019	2020	2021	2022
Mean Pay Gap –	32.85%	30.74%	29.04%	29.21%	29.50%	29.14%
Median Pay Gap –	22.89%	15.12%	18.18%	19.21%	19.85%	20.63%

This demonstrates that the Trust is gradually making inroads to tackle its gender pay gap, albeit with fluctuations along the way.

The Trust is using the workforce gender pay gap figures to help understand the underlying causes for its gender pay gap and to identify suitable steps to minimise it.

Some elements of the Trust's gender pay gap have a historical/national context which will take a period of time to resolve.

The Trust's gender pay gap data, which shows the difference in average pay between men and women in the workforce, reflects that the Trust has a majority of men in higher paid roles, predominantly medical staff.

The mean and median hourly pay gap percentages across the health sector and bonus pay gaps are significantly affected by the presence of the Medical Consultant body, due to both their high base wage and the historical differences in bonuses awarded under the CEA scheme.

The Trust's mean gender pay gap at 29.14% is 0.36% lower than the previous reporting period. The median gender pay gap at 20.63% is 0.75% higher. These are above the national averages of 13.9% (mean) and 14.9% (median). Excluding medical and dental staff the Trust figures would be 4.41% and 0.00% respectively.

Payment into salary sacrifice schemes continues to impact on the Trust's gender pay gap data. Whilst the overall percentage of staff who pay into the schemes closely reflects the Trust gender split this headline figure disguises the impact on mean and median female pay averages, and where females fall in pay quartiles (i.e. they might have otherwise fallen into a higher quartile).

The mean gender bonus gap has reduced in this last reporting period, with the median gender bonus gap remaining at 0%.

The Trust's gender bonus data remains distorted by three main factors; the Trust's Long Service Award scheme, payment of higher (accumulated) bonuses under the old pre-April 2018 CEA scheme for Consultant Medical staff (where there is a greater proportion of men), and the current national requirement (with the exception of the local CEAs for 2020/21 and 2021/22) to pro-rata CEA bonus payments for part-time Consultants (the large majority of whom are female).

4 NEXT STEPS

The Trust is committed to addressing the gender pay gap and is undertaking a range of actions and initiatives to reduce this including:

- The Trust has been working in partnership with staff side colleagues to achieve the Menopause Workplace Pledge as part of its commitment to supporting staff experiencing menopause symptoms. Research indicates approximately 10% of staff actually give up their jobs, cut their hours or pass up promotion because they struggle with what can be varied and often long-lasting symptoms. Guidance and practical resources to help staff and their managers understand the Trust's approach to the menopause are being developed which will include establishing support networks, special drop-in clinics and safe spaces to share views and ideas.
- 'Itchy Feet Clinics' will be launched in 2022/23. These will serve as a first port of call for staff who are wanting a change or who are considering leaving the Trust. The clinics take the form of a personal discussion to explore what is making staff feel this way with a view to finding solutions. These could take the form of more flexible working options, additional training or some other kind of personal support, depending on staff's circumstances. The aim is to give staff the support they need to feel valued in their role, to enjoy coming to work, and to avoid losing highly experienced and skilled colleagues (potentially staff who are higher paid) from the Trust altogether.
- Future changes to the national CEA scheme and local CEA schemes has the potential to improve the Trust's gender pay gap bonus indicators moving forward. New contractual provisions for local CEAs took effect from 1 April 2022. HUTH, as

have many other NHS Trusts, are continuing equal distribution during 2022/23 to take the opportunity to design and develop a local system for the future payment of CEAs, with a key focus on equality, diversity and inclusion and minimising any potential bias linked to specific protected characteristics including gender. Therefore the new local scheme will be effective from 1 April 2023. The impact of the new local system will begin to show in the gender pay gap 'snapshot' data as at 31 March 2024, given awards are paid in arrears.

Solutions to the gender pay gap lie in culture changes both in society and organisations. Closing the gap will take time, and progress will not be linear.

Nationally most of the issues driving gender pay gaps require a longer term view.

The Trust believes, however, that over time, it's commitment to fostering inclusion, fairness and flexibility will be reflected in its gender pay gap figures, building a strong foundation for individual and organisational growth.

The Trust will continue to take steps to reduce its pay gap and continue to explore best practise across the sector and beyond.

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14th March 2023
Title	Freedom to Speak Up Guardian report – Quarter 3 2022/2023 report				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	HUTH Freedom to Speak Up Guardian				
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 3 report of the work and activities of the Trust's Freedom to Speak Up Guardian. • The Trust Board are asked to approve Appendix 1 – NHS England Board self-reflection and planning tool with the improvement plan. • 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 Quarter 3 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 Quarter 3, 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 Q3 2022/2023

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

- October 2022 was the national awareness month for Freedom to Speak Up. The FTSUG concentrated on the theme 'FTSU for Everyone' through the start of the implementation of the Trust's Speak Up Champion Network:
    - Staff members were invited to submit an expression of interest to become a 'Speak Up Champion'.
    - The FTSUG developed a bespoke training package including videos of the conversations champions could expect to be having with staff, kindly filmed by members of the Trust drama group. The first training sessions were delivered e to 12 new Champions. Additional Champions will be trained throughout 2023.
    - Support to the Champions was established through bimonthly peer support and development sessions; the first session was held in December 2022.
    - Regular communications to the Champions including a newsletter was developed.
    - The Digital Communications team developed branding and logos for the Speak Up Champion Network to promote awareness and identify Champions across the Trust.
    - All aspects of the Speak Up Champion Network is compliant with the National Guardian Office guidance for 'Developing Freedom to Speak Up Champion and Ambassador Networks'.
- The FTSUG has delivered several dedicated awareness sessions for FTSU at the mandatory 'Let's Get Started' nursing induction programme, for newly qualified nurses and those returning to practice.

- The FTSUG was one of the key note speakers at the HUTH Staff Disability conference and spoke about speaking up and the importance of psychological safety.
- As part of the Well Led inspection, the FTSUG was interviewed by the CQC and discussed the arrangements for speaking up at HUTH and the initiatives including the Speak Up Champion Network.
- The FTSUG continues to work as an ally of each of the staff networks. As part of this the FTSUG participated in 'Bridging the Gap' disability awareness training to further support the role and staff raising disability related concerns.
- Partnership working has continued with other areas of the Trust including the Safeguarding Adults team, the new Chair of the BAME Staff Network and monthly 121s with the Chief Nurse have commenced.

4. Freedom to Speak Up Internal Audit

During December 2022 the FTSUG participated in providing information to the RSM team for an internal audit of the FTSU service.

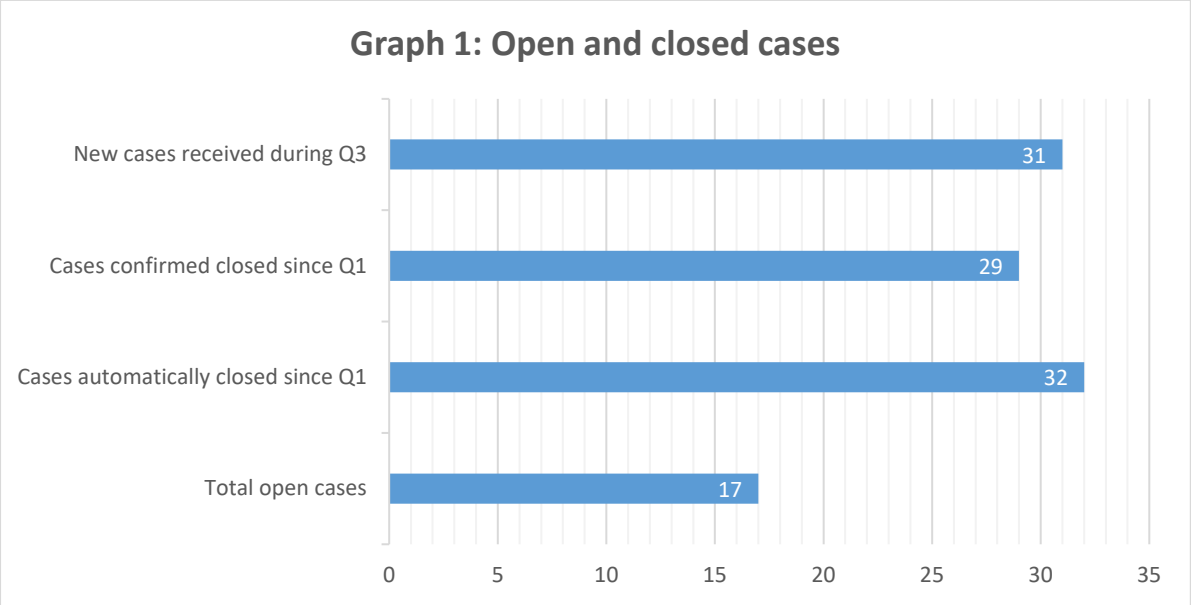
The audit concluded that the Board can take substantial assurance that the controls upon which the organisation replies to manage this risk, are suitably designed, consistently applied and effective. Four low level actions were identified; which the FTSUG was already progressing as business as usual.

5. Trust contacts during 1st October 2022 to 31st December 2022

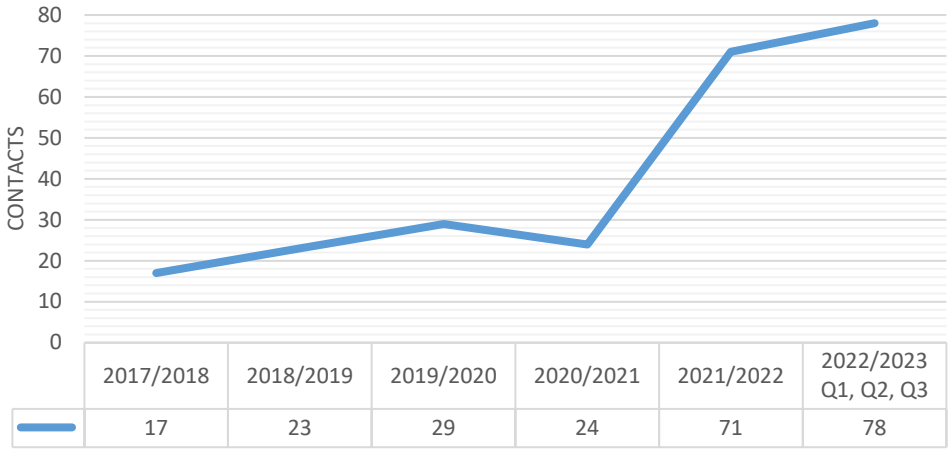
The FTSUG reports on individual contacts received from members of staff, students, trainees and volunteers, to the Trust Board each quarter in the public board meeting. It is also the responsibility of the FTSUG to submit the quarterly data to the National Guardian Office.

Graph 1 summaries the total numbers of open and closed cases (data extracted at 31.12.2022).

Graph 2 shows a comparison of the number of individual contacts received during Q1, Q2 and Q3 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.

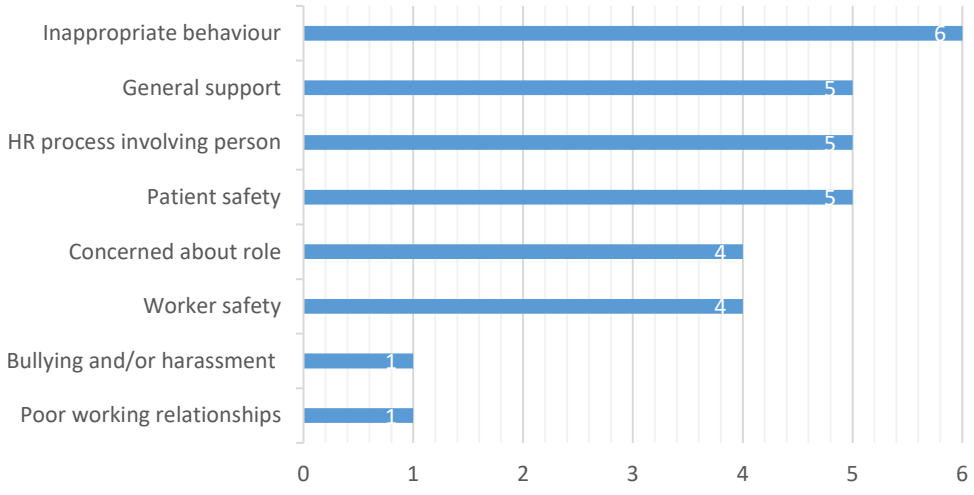


Graph 2: Individual contacts to FTSUG

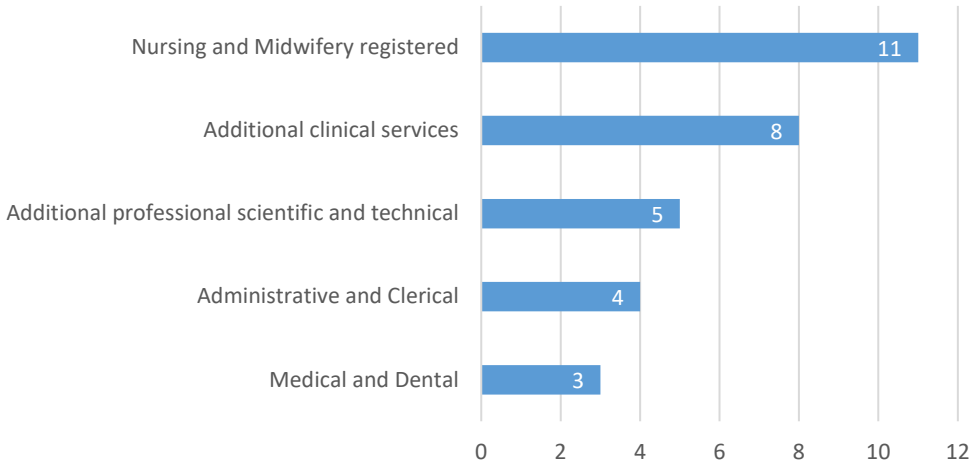


	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023 Q1, Q2, Q3
	17	23	29	24	71	78

Graph 3: Themes of concerns raised during Q3



Graph 4: Concerns raised by professional group



Comments and observations:

- The number of individual concerns raised to the FTSUG during quarter 3 increased again to 31. All concerns were raised personally to the FTSUG and none were received anonymously. The number of cases year to date (78) has now exceeded the annual total for 2021/2022 (71).
- The FTSUG has seen an increase in the number of cases brought by nursing/midwifery staff and has discussed this with the Chief Nurse.
- The reasons for the concerns are mixed; with no overall theme. The most common reason for raising a concern was in relation to inappropriate behaviour; however this represents 6 out of 31 concerns.
- The FTSUG is seeing more concerns being raised from staff members who had previously contacted the FTSUG regarding a different concern. This potentially could represent staff members having trust in the work of the FTSUG and feeling confident in raising concerns through this channel.
- Approximately one third of the cases were recorded as the staff member became aware of the FTSUG role by being recommended e.g. staff network, colleagues, staff support services, line manager. This indicates the FTSUG is becoming more broadly known about.

6. Trust Board self-reflection and planning tool

NHS England has published an improvement tool designed to help Trusts to identify their strengths and any gaps that require work. In January 2024 NHS England will write to Trust Boards for assurance that work has been completed and at least one progress update has been provided.

The outputs of the Trust Board development session on 8th February 2023 and the surveys circulated in advance to the Board, Executive Lead, None-Executive Director and Head of Organisational Development is contained in Appendix 1. The Board is asked to approve Appendix 1, including the resulting improvement plan.

7. Conclusions

The number of individuals approaching the FTSUG continues to increase and year to date has exceeded the 2021/2022 annual number of concerns. The implementation of the Speak Up Champion Network has begun and will be rolled out formally from quarter 4 onwards.

8. 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. The Trust Board are asked to consider and approve the contents of Appendix 1 self-reflection and planning tool.

HUTH Freedom to Speak Up Guardian
March 2023

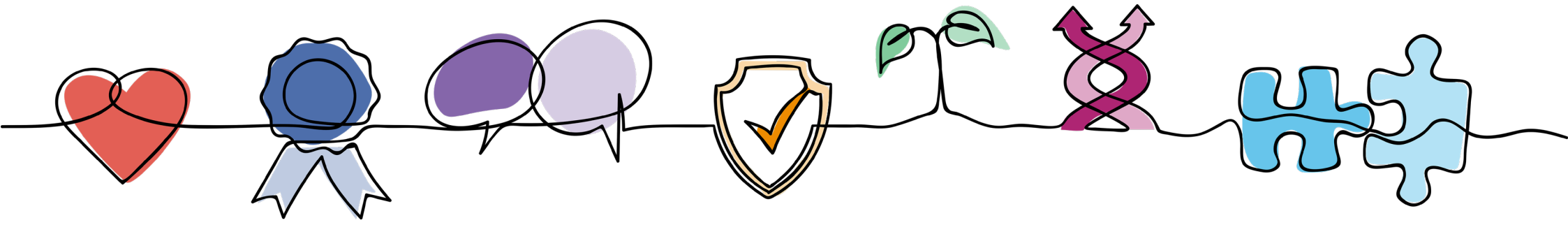
National Guardian
Freedom to Speak Up

Appendix 1

NHS

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

1 = significant concern or risk which requires addressing within weeks

2 = concern or risk which warrants discussion to evaluate and consider options

3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

1. Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
1.1 I am knowledgeable about Freedom to Speak Up	4
1.2 I have led a review of our speaking-up arrangements at least every two years	3
1.3 I am assured that our guardian was recruited through fair and open competition	4
1.4 I am assured that our guardian has sufficient ring fenced time to fulfil all aspects of the guardian job description	5
1.5 I am regularly briefed by our guardian(s)	5
1.6 I provide effective support to our guardian(s)	4

Enter summarised evidence to support your score.

Senior Lead comments:

- Dedicated role introduced in 2021 as opposed to being part of the Director of Corporate Affairs role. This has enabled focus with protected time to take forward the service, make it more accessible and increase contacts.
- A superficial review informed this decision. The formal reviews need to be undertaken on a bi-annual basis with wider engagement.
- Regular catch ups with the Head of FTSU and open access if required.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Scheduled assessments and review of associated improvement programmes of speaking up arrangements.
2. Continue to grow contacts via the champions and promotion to identify themes for learning and improvement programmes.

2. Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
2.1 I am knowledgeable about Freedom to Speak Up	Yes
2.2 I am confident that the board displays behaviours that help, rather than hinder, speaking up	Yes
2.3 I effectively monitor progress in board-level engagement with the speaking-up agenda	Yes
2.4 I challenge the board to develop and improve its speaking-up arrangements	Yes
2.5 I am confident that our guardian(s) is recruited through an open selection process	Yes
2.6 I am assured that our guardian(s) has sufficient ring fenced time to fulfil all aspects of the guardian job description	Yes
2.7 I am involved in overseeing investigations that relate to the board	Yes
2.8 I provide effective support to our guardian(s)	Yes

Enter summarised evidence to support your score.

Non-Executive Director Lead comments:

- This area of work has improved significantly – regular one to one conversations mean that I am fully conversant with activity and actions.
- Reporting is excellent, providing lots of relevant information to the board. As staff become more aware and confident, this may lead to higher reporting (already evident) so need to keep an eye of time requirements.
- With regard to overseeing investigation relating to board, I would had there been any, but to date this has not been the case.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Continuous development around culture of organisation.
2. Champions within staffing groups, at different levels.

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

3. Statements for senior leaders	Score 1–5 or yes/no
3.1 The whole leadership team has bought into Freedom to Speak Up	Yes
3.2 We regularly and clearly articulate our vision for speaking up	Yes
3.3 We can evidence how we demonstrate that we welcome speaking up	Yes
3.4 We can evidence how we have communicated that we will not accept detriment	4
3.5 We are confident that we have clear processes for identifying and addressing detriment	5
3.6 We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	4
3.7 We regular discuss speaking-up matters in detail	Yes

Enter summarised evidence to support your score.

Board comments:

- Receive reports at Board. I meet FTSUG quarterly.
- Reports to meetings. Minutes of WTC, WECC and Board meetings. Trust communications, FTSU promotions, conversations to address issues raised and action taken and meetings with colleagues.
- We regularly receive reports on this at Board and Committees.
- We did have an update recently on the FTSU and how that was being received. It was noted we are still improving however I felt assured we were on the right path. From my perspective I think we just more trending. Reports have been good.
- I have spoken to individual members on a personal basis and am happy with the measures that have been taken.
- As the NED Lead, I have regular catch ups with our Freedom to Speak Up Guardian. Huge improvements have been made, which is reflected in the increased awareness and subsequent approaches made.
- Raising Concerns at Work (whistleblowing) policy includes a clear principle about detriment and no tolerance to others who harass, victimise and/or bully an individual raising a concern under the policy.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

1. Include in the 2023 communications plan, clear messages that detriment will not be accepted or tolerated at HUTH.
2. Quarterly feedback survey will be sent to staff who speak up. Consideration will be given to including a question regarding whether they experienced positives behaviours that encouraged them to speak up.

4. Statements for the person responsible for organisational development	Score 1–5 or yes/no
4.1 I am knowledgeable about Freedom to Speak Up	5
4.2 We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	3
4.3 We have adapted our organisational culture so that it becomes a just and learning culture for our workers	3
4.4 We support our guardian(s) to make effective links with our staff networks	4
4.5 We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	3

Enter summarised evidence to support your score.

- We have very good links with our FTSU Guardian through our Workforce and OD Governance routes operationally right through to Board Level Committees such as Workforce Educational and Culture Committees.
- We have recently reviewed our organisational values (Barrett Cultural Barometer) alongside the NHS Staff Survey Results. This is showing an increase in behaviours in our culture that are not conducive to a compassionate, inclusive and just culture at HUTH. A new programme is being created to promote kindness and professionalism for launching in spring/summer 2023. We have taken action yet hence the score of 3 on points 2 and 3 but we do have plans to fully embed. We would expect the score to increase next year.
- There are very effective links between the FTSUG and the Staff Networks. A good example is FTSUG involvement in the Zero Tolerance to Racism Circle group.
- Data use is good in some areas e.g. Zero Tolerance. There does need to be a renewed look at how we support staff to speak up, notice patterns and then act upon them. We are triangulating cultural data in some areas to take bespoke action but we need to consider a data and intelligence set up that allows us to be better at spotting and taking action when patterns arise. Using a proactive vs reactive approach.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review our programmes of delivery to ensure that the FTSUG process and person is clear/explicit. This would be done with better involvement of FTSUG operationally in content creation. This is alongside being explicit how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbiotic way as a leader.
2. Bring clear speak up processes into our bespoke cultural transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an “internal consultant” to bring expertise into bespoke work design.
3. Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators.
4. Development of a Trust wide Professionalism and Kindness programme that supports just and speaking up culture.

5. Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
5.1 We have considered all relevant intelligence and data when making our decision about the amount of ring fenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes
5.2 We have reviewed the ringfenced time our Guardian has in light of any significant events	Yes
5.3 The whole senior team or board has been in discussions about the amount of ring fenced time needed for our guardian(s)	Yes
5.4 We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	Yes

Enter summarised evidence to support your score.

- The need for ring fenced time for the FTSUG role was identified and documented as part of the Quality Governance directorate restructure. The 'Head of Freedom to Speak Up' role was added to the structure and the post recruited to. The restructure and new organisational structure had Board approval.
- The FTSUG also performs a role in the Quality Governance team, and can flex their hours between their job responsibilities.
- The funding for the Head of Freedom to Speak Up role was approved by the Board.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

None required.

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

6. Statements about your speaking-up policy	Score 1–5 or yes/no
6.1 Our organisation's speaking-up policy reflects the 2022 update	No
6.2 We can evidence that our staff know how to find the speaking-up policy	3.75

Enter summarised evidence to support your score.

Board comments:

- Regular reports.
- I put a 3 as likely more a reflection on myself in terms of knowing how to find the evidence.
- Much higher awareness than previously, continue to articulate and spread the word.
- The Trust plans to implement the new speaking-up policy published by NHS England. Implementation is currently in progress and the new policy is currently being converted into the agreed Trust policy format and will be ratified appropriately e.g. at Workforce Transformation Committee. The Trust must implement the new policy before January 2024.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Implement the new NHS England speaking-up policy before January 2024. This is also an action recorded from an audit of the speaking up service conducted during December 2022.
2. Involve key stakeholders (e.g. Staff Support Networks) in the consultation process of the policy. Add communication of the new implemented policy to the 2023 Communications Plan.

7. Statements about how speaking up is promoted	Score 1–5 or yes/no
7.1 We have used clear and effective communications to publicise our guardian(s)	4.37
7.2 We have an annual plan to raise the profile of Freedom to Speak Up	Yes
7.3 We tell positive stories about speaking up and the changes it can bring	4
7.4 We measure the effectiveness of our communications strategy for Freedom to Speak Up	No

Enter summarised evidence to support your score.

Board comments:

- Regular reports.
- Unclear how we do this, due to confidentiality issues. We have been able to anonymously give some examples however.
- When the current FTSUG came into post in June 2021; there was a focus on communicating the role. This has included a dedicated Pattie page and 'frequently asked questions', Daily Update emails, Pattie focused news articles, inclusion in Junior Doctor, Let's Get Starting Nursing, newly qualified Midwives and corporate inductions, presentations at team meetings, building a network across the Trust, becoming an ally of each Staff Network, drop in sessions (in and outside of working hours), keynote speaker at Staff Disability Network conference, marketing materials and other actions.
- Anonymous case studies (where appropriate and with consent) have been included in the Trust public Board reports.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Include in the feedback survey for staff members approaching the FTSUG, a question asking how the staff member knew about the FTSUG role. Review this data and identify any improvements to widen the awareness of the role and speaking up.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

8. Statements about training	Score 1–5 or yes/no*
8.1 We have mandated the National Guardian's Office and Health Education England training	No
8.2 Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
8.3 Our HR and OD teams measure the impact of speaking-up training	No

Enter summarised evidence to support your score.

- The Health Education England (HEE) speaking up e-learning modules are available through the Trust HEY24/7 online learning platform; this has made it easier for staff to access the training. Staff do not need to create a separate HEE login and completion of the e-learning is recorded on their Trust training record.
- The Board discussed and agreed not to mandate the HEE training. The Board did not want to increase the amount of mandatory training required by staff and felt communications were already in place to raise awareness about the FTSUG, and speaking up should be inherent in everything we do and what we do every day.
- The Board felt awareness was already being raised in training e.g. part of good medical practice for the GMC to raise concerns and in other guises e.g. Stop The Line.
- The FTSUG presents at the Doctors in Training inductions throughout the year, at the Let's Get Starting newly qualified and return to practice Nursing inductions and the newly qualified Midwives inductions. The FTSUG is referred to in the virtual global induction by the Head of Organisational Development and information is included in the induction handbooks for apprentices and student nurses and midwives.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Regular and effective communications across the Trust about speaking up to be incorporated into the 2023 Communications Plan. To include further reminders about the availability of the e-learning modules as self-managed learning.

9. Statements about support for managers within teams or directorates	Score 1–5 or yes/no
9.1 We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	4.25
9.2 All managers and senior leaders have received training on Freedom to Speak Up	No
9.3 We have enabled managers to respond to speaking-up matters in a timely way	4.25
9.4 We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	3.87

Enter summarised evidence to support your score.

Board comments:

- Regular reports which are fully presented and scrutinised at Board.
- I have heard from staff that they understand the procedure. In creating a safe culture it is a journey. We are still on the journey and expect us to grow further.
- Reporting suggests we have improved massively in this area, and positive outcomes have been achieved
- Board discussed in section 8 that the HEE e-learning training will not be mandated.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review with the Organisational Development Team whether it is appropriate for speak up training to be incorporated into any of the programmes of delivery.

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

10. Statements about triangulation	Score 1–5 or yes/no
10.1 We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
10.2 We use triangulated data to inform our overall cultural and safety improvement programmes	3.75

Enter summarised evidence to support your score.

Board comments:

- Reports and discussions at Board.
- Overall I think we can improve how we triangulate data. Again a journey we are on.
- I think we are getting there, but there may still be areas where improvement could be made.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review what triangulation of data is possible including what data can be obtained e.g. patient safety, staff survey. Link in with the Head of Organisational Development.

11. Statements about learning for improvement	Score 1–5 or yes/no
11.1 We regularly identify good practice from others – for example, through self-assessment or gap analysis	No (partial)
11.2 We use this information to add to our Freedom to Speak Up improvement plan	No
11.3 We share the good practice we have generated both internally and externally to enable others to learn	No (partial)

Enter summarised evidence to support your score.

- HUTH FTSUG has regular meetings with Northern Lincolnshire and Goole NHS Foundation Trust and York and Scarborough Teaching Hospitals NHS Foundation Trust FTSUGs and an initial meeting with the Humber Teaching NHS Foundation Trust is planned for March 2023. The purpose of these meetings has been to ensure peer support and to identify and discuss best practice.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review the self-reflection and planning tool outputs from at least two other Trusts. Identify any best practice applicable to HUTH and incorporate into the Freedom to Speak Up improvement plan.

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

12. Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
12.1 Our guardian(s) was appointed in a fair and transparent way	Yes
12.2 Our guardian(s) has been trained and registered with the National Guardian Office	Yes

Enter summarised evidence to support your score.

- Current FTSUG recruited in line with the HUTH recruitment policy in May 2021.
- Current FTSUG completed the training provided by the National Guardian Office in May 2021, and completed the most recent mandatory modules during 2022. The FTSUG engages with ongoing CPD e.g. webinars hosted by the National Guardian Office and completed BAME staff training in February 2023.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. No actions required.

13. Statements about the way we support our guardian(s)	Score 1–5 or yes/no
13.1 Our guardian has performance and development objectives in place	Yes
13.2 Our guardian receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
13.3 Our guardian has access to a confidential source of emotional support or supervision	Yes
13.4 There is an effective plan in place to cover the guardian's absence	Yes
13.5 Our guardian provides data quarterly to the National Guardian's Office	Yes

Enter summarised evidence to support your score.

- The FTSUG's appraisal is up to date and 2023 objectives relate to the delivery of key pieces of work related to speaking up.
- The FTSUG has monthly one-to-one meetings with the Executive Lead and the Chief Nurse. Regular one-to-one meetings are held with the Chief Executive, Chairman and Director of Workforce.
- The FTSUG's has access to the National Guardian Office provided PAM Assist and if required, access to psychological supervision provided by the HUTH Staff Psychology team.
- A guidance document detailing the absence arrangements for the FTSUG is in place and agreed between the FTSUG and the Executive Lead.
- The FTSUG completes each quarterly return to the National Guardian Office – this can be evidenced through the information submitted to the portal.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. No actions are required.

14. Statements about our speaking up process	Score 1–5 or yes/no
14.1 Our speaking-up case-handling procedures are documented	Yes
14.2 We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	Yes
14.3 We are assured that confidentiality is maintained effectively	Yes
14.4 We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	4
14.5 We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	Yes

Enter summarised evidence to support your score.

Board comments:

- Reports and feedback.
- Question 14.4, I am stating that as that is the message I have provided to employees. I would note I have had not had any feedback that a positive experience has not occurred and from the discussions with managers, staff do bring concerns forward.
- The evidence from regular reporting indicates increased engagement and positive outcomes.
- At a recent one-to-one meeting, the Chief Nurse has asked the FTSUG to follow up any cases with senior nurse's staff that have been directly escalated by the FTSUG.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Implement requesting for feedback from senior nursing staff when concerns are escalated directly by the FTSUG, as per the request of the Chief Nurse.

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

15. Statements about barriers	Score 1–5 or yes/no
15.1 We have identified the barriers that exist for people in our organisation	3.5
15.2 We know who isn't speaking up and why	3.1
15.3 We are confident that our Freedom to Speak Up champions are clear on their role	4.13
15.4 We have evaluated the impact of actions taken to reduce barriers?	3.5

Enter summarised evidence to support your score.

Board comments:

- Reports and feedback from Guardian at board meetings.
- In recent surveys some of the feedback regarding bullying, and other experiences from staff to me are an indication that we have some improvement to make we know who may not feel safe speaking up and why.
- More junior staff, or staff with a protected characteristic - do we have evidence around reporting numbers? If lower than the average, needs addressing.
- It could be difficult to answer 15.2 confidently.
- Discussed the use of triangulation of data e.g. staff survey.
- The Trust is aware of the whistleblowing concerns that go direct to the CQC, and not via the FTSUG. Focus on communication of positive outcomes of speaking up and the HUTH FTSUG.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review if triangulation is possible including what data can be obtained e.g. patient safety, staff survey.
2. Review the 2023 communications plan and include positive stories, where possible, of speaking up.

16. Statements about detriment	Score 1–5 or yes/no
16.1 We have carried out work to understand what detriment for speaking up looks and feels like	3.75
16.2 We monitor whether workers feel they have suffered detriment after they have spoken up	Yes (7) / No (1)
16.3 We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3.87
16.4 Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes (7) / No (2)

Enter summarised evidence to support your score.

Board comments:

- Discussions at Board.
- As the NED lead, I have regular conversations, but don't necessarily oversee the review of allegations. I do, however, review the overall report and discuss as appropriate.
- When speaking with the FTSUG, staff members are reminded they can re-contact the FTSUG if they are subject to detriment after speaking up. Current FTSUG has had 1 case of detriment brought to them in 18 months of being the Guardian. That was escalated appropriately to a senior staff member.
- The feedback survey for staff speaking to the FTSUG is due to launch in March 2023 and will include questions about what was the outcome of the staff member speaking up. This may assist in providing data and any narrative.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Monitor the feedback survey responses for information on staff subject to detriment and where possible, to understand the circumstances.
2. Review the new national speak up policy template and include reference to the processes if a staff member feels subject to detriment.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

17. Statements about your speaking-up strategy	Score 1–5 or yes/no
17.1 We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	No
17.2 We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	N/A
17.3 We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	N/A
17.4 Our improvement plan is up to date and on track	N/A

Enter summarised evidence to support your score.

Board comments:

- This Board self-reflection and planning tool will inform the improvement plan and freedom to speak up strategy for the Trust.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. This Board self-reflection and planning tool will inform the improvement plan and freedom to speak up strategy for the Trust.
2. Regularly review the freedom to speak up strategy and improvement plan and report on progress updates to the Trust Board on a regular basis.

18. Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
18.1 We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	Yes
18.2 Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	Yes
18.3 Our speaking-up arrangements have been evaluated within the last two years	Yes

Enter summarised evidence to support your score.

- The FTSUG has developed a feedback survey for staff who had spoken to the FTSUG. This will allow the individual to feedback on the experience of the FTSUG and the response of the wider Trust to the concern raised. This survey will include the mandatory question set by the National Guardian Office to ask each individual whether they would speak up again.
- The FTSUG is a qualified QSIR Associate and is using the PDSA cycle to review the feedback survey process.
- The HUTH speaking up arrangements were evaluated and amended in May 2021, to ensure the FTSUG had ring fenced time to perform the role.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. No actions identified.

19. Statements about assurance	Score 1–5 or yes/no

19.1 We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
19.2 We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
19.3 Our guardian(s) provides us with a report in person at least twice a year	Yes
19.4 We receive a variety of assurance that relates to speaking up	Yes
19.5 We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3.75

Enter summarised evidence to support your score.

Board comments:

- Board reports and discussions, presentations with analysis from Guardian.
- Yes to these, again based on some survey responses, as FTSU relates to culture we have some work to do to be 100%. This work along with PSIRF should start bringing it all together.
- Would be interesting to see longer term results/actions as a result of speaking up.
- The Board discussed they have oversight when the FTSUG presents at the Workforce and Culture Committee and at Public Trust Board quarterly, with a comprehensive report and a comparison with the previous year and a breakdown of the reasons for the concerns. The FTSUG has extensive relationships across the Trust with various services such as the Chaplaincy Team, and attends the HR divisional meeting to discuss themes and support.
- The Board will be updated soon on the results of the internal audit – speaking up gained substantial assurance.
- The Chief Nurse has asked that when a concern is escalated by the FTSUG direct to a senior nurse/midwife that this is followed up to ensure action and learning.
- Where possible, anecdotal examples could be shown to the Board. The Board recognised this could be difficult and that an individual's anonymity should be protected.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. The feedback survey for staff speaking up will be launched in March 2023 and will include a free text box if respondents are comfortable feeding back their experiences. Review the answers from the feedback survey, and include any appropriate case studies (with consent of the staff member) in future Board reports.

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Scheduled assessments and review of associated improvement programmes of speaking up arrangements.	30/06/23	Executive Lead
2. Continue to grow contacts via the champions and promotion to identify themes for learning and improvement programmes.	31/03/24	FTSUG
3. Continually review the speak up champion network, to promote champions within different staffing groups and at different levels across the Trust.	31/03/24	FTSUG
4. Update the 2023 speaking up communications plan. To include: • Clear messages that detriment will not be accepted or tolerated at HUTH. • Communication of the new national speak up policy once ratified. • Further reminders about the availability of the e-learning modules as self-managed learning. • Incorporate, where possible, positive stories of speaking up.	31/12/23	FTSUG Request communications from senior leaders.
5. Launch the feedback survey for staff who have spoken up to the FTSUG. To include: • Consideration will be given to including a question regarding whether they experienced positives behaviours that encouraged them to speak up. • Include in the feedback survey for staff members approaching the FTSUG, a question asking how the staff member knew about the FTSUG role. Review this data and identify any improvements to widen the awareness of the role and speaking up. • Monitor the feedback survey responses for information on staff subject to detriment and where possible, to understand the circumstances. • A free text box if respondents are comfortable feeding back their experiences. Review the answers from the feedback survey, and include any appropriate case studies (with consent of the staff member) in future Board reports.	31/03/23	FTSUG
6. Review our programmes of delivery to ensure that the FTSUG process and person is clear/explicit. This would be done with better involvement of FTSUG operationally in content creation. This is alongside being explicit how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbiotic way as a leader.	31/03/24	Head of Organisational Development
7. Bring clear speak up processes into our bespoke cultural transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an “internal consultant” to bring expertise into bespoke work design.	31/03/24	Head of Organisational Development

8. Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators.	31/03/24	Head of Organisational Development
9. Development of a Trust wide Professionalism and Kindness programme that supports just and speaking up culture.	31/03/24	Head of Organisational Development
10. Implementation of the new NHS England speaking up policy. To include: • Implement the new NHS England speaking-up policy before January 2024. This is also an action recorded from an audit of the speaking up service conducted during December 2022. • Review the new national speak up policy template and include reference to the processes if a staff member feels subject to detriment.	31/12/23	FTSUG
11. Involve key stakeholders (e.g. Staff Support Networks) in the consultation process of the policy.	31/03/23	FTSUG
12. Review with the Organisational Development Team whether it is appropriate for speak up training to be incorporated into any of the programmes of delivery.	31/05/23	FTSUG
13. Review what triangulation of data is possible including what data can be obtained e.g. patient safety, staff survey. Link with action 8 above.	31/03/24	FTSUG
14. Review the self-reflection and planning tool outputs from at least two other Trusts. Identify any best practice applicable to HUTH and incorporate into the Freedom to Speak Up improvement plan.	31/12/23	FTSUG
15. Implement requesting for feedback from senior nursing staff when concerns are escalated directly by the FTSUG, as per the request of the Chief Nurse.	31/03/23	FTSUG
16. Create a freedom to speak up strategy. To include: • Inclusion of this improvement plan created by the Board self-reflection and planning tool. • Regularly review the freedom to speak up strategy and improvement plan and report on progress updates to the Trust Board on a regular basis.	31/03/24	FTSUG

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1. Share speak up arrangements with other Trusts. To include: recruitment and ring fenced time for the role, locally agreed absence arrangements, creation of the speak up champions network, involvement with other services across the Trust and being an ally of each staff network.	30/09/23	FTSUG

Hull University Teaching Hospitals NHS Trust

Trust Board

Tuesday 14 March 2022

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	14/03/22
Title	Guardian of Safe Working – Q2 Report				
Lead Director	Professor Purva, Chief Medical Officer				
Author	Guardian of Safe Working				
Report previously considered by (date)	This report is considered at the 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		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 receive the report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st October – 31st December 2022

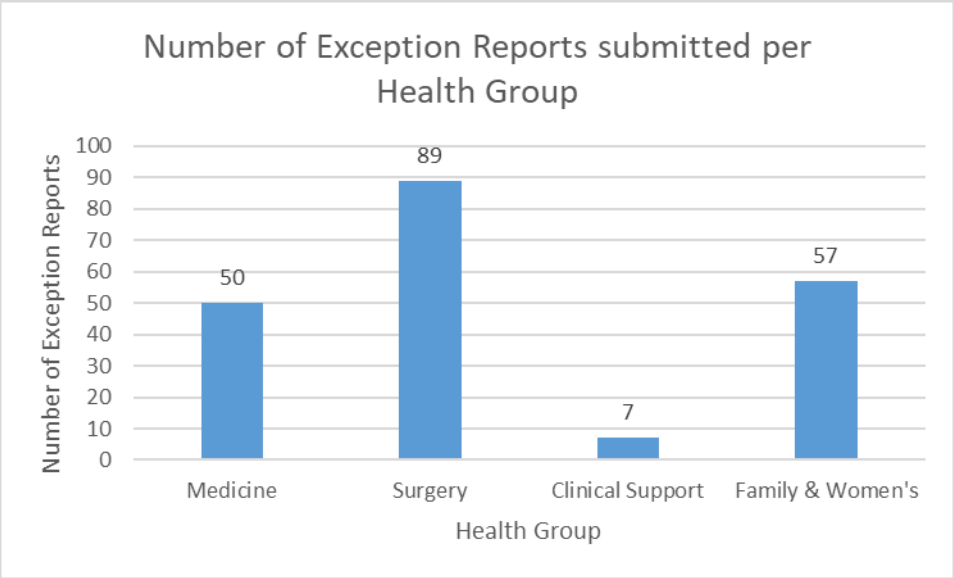
Executive Summary

The Guardian Report for this Workforce, Education and Culture Committee meeting covers the quarter from 1st October– 31st December 2022.

Exception Reporting patterns and responses

There were a total of 203 exception reports (203 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:

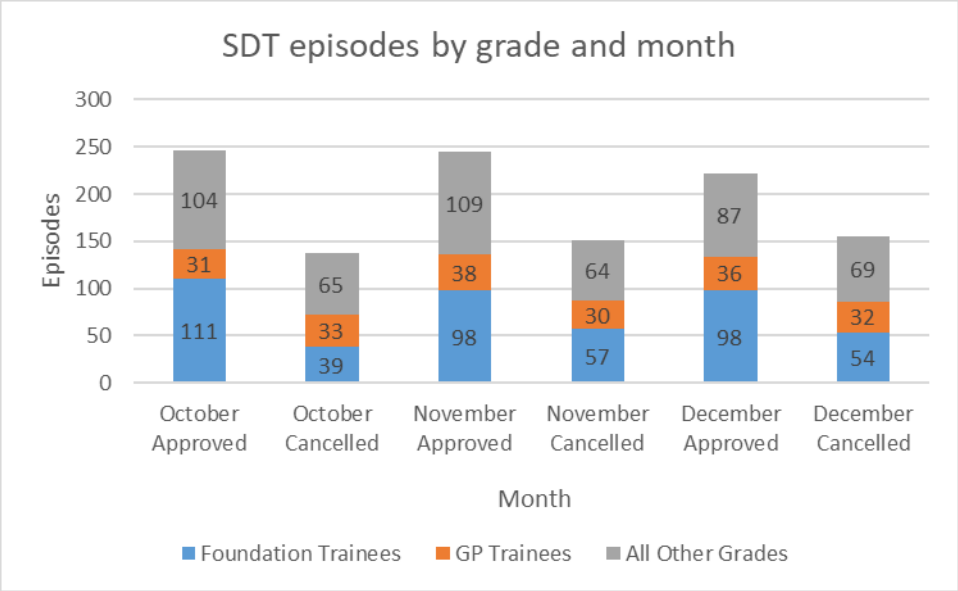
The Surgery health group have received the highest number of exception reports submitted for this quarter. This is due to a number of issues being highlighted across many rotas in the Surgery health group meaning more than one exception report is submitted per shift completed, further details are provided in this report.

Issues:

1. E Roster: 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. In the month of November 3% of rotas were at gold standard (fully functional on e-roster, single point of truth), 37% at green standard, 33% at blue and 27% at red. This is an improvement from previous performance however this still falls short of the target of having all rotas on eroster. Phase 1 and hopefully phase 2 of the increased medical staffing resources will continue to improve this situation.

2. Phlebotomy: The lack of support from Phlebotomy was highlighted as an issue via exception reporting. The Trust has approved a business case which is hoped to improve the service this year and prevent junior doctors away from educational / training opportunities. So far we have not received any exception reporting regarding phlebotomy.

3. Self Development Time: There were 11 reports that were submitted within this quarter for missed self-development time between 1st October and 31st December. This issue has also been raised at the Junior Doctors Forum. Trainees are expected to receive this time within their working week to complete the requirements of their ARCP. SDT has been in place for GP trainees and was introduced for Foundation Trainees in August 2020. The Trust has not committed to giving SDT time to all other trainees although some departments do allocate it to their juniors.
4. In the month of October there were a total of 383 episodes requested, 246 approved (64%) and 137 (36%) cancelled. In November there were 396 requested, 245 approved (62%) and 151 (38%) cancelled. For December there were 376 episodes requested, 221 approved (59%) and 155 (41%) cancelled.
   The statistics are analysed from eRoster, it can be seen that as an increased amount of rotas become fully functional on eRoster more SDT episodes are requested.



5. Routine ECGs: The issue of ECGs in Wards 6/60 and Ward 7 has been raised by trainees. The GOSW has had meetings with the Matrons of the wards to discuss upskilling of Nursing and Auxiliary Staff to support the juniors in this task and future meetings are arranged with the matrons to check on progress.

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 4 recommendations stated above

Professor Mahmoud Loubani
Consultant Cardiothoracic Surgeon
Guardian of Safe Working Hours

Encl:
Appendix 1: Board Report GSW 1st October – 31st December 2022

Appendix 1

Hull University Teaching Hospitals NHS Trust

Quarterly Report on Safe Working Hours
Doctors and Dentists in Training
1st October – 31st December 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 October to December 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):	579.20
(establishment)	653
Number of doctors / dentists in training on 2016 TCS (total FTE's):	579.20
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)

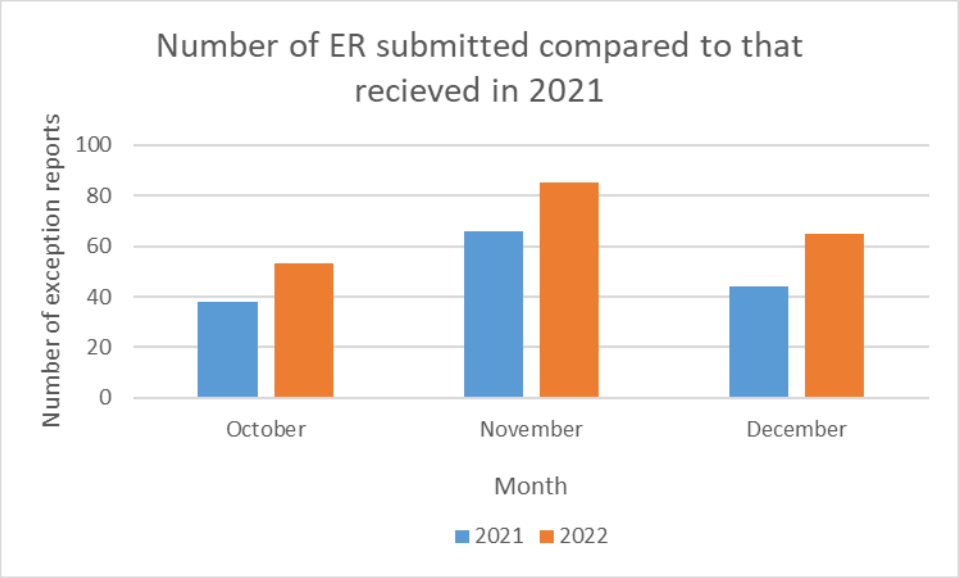
Information on exception reporting is detailed within the junior doctor's contract (pages 37-39)

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 203 exception report episodes submitted between 1st October and 31st December 2022 with 236 carried forward from the previous quarter.

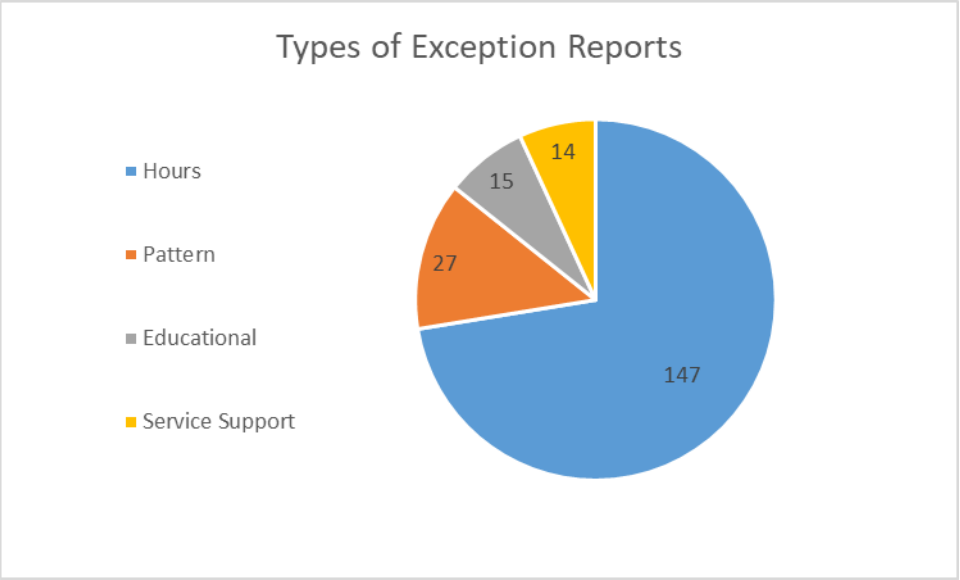
Exception reports from 2021 in comparison to 2022.



The graph above shows the number of exception reports from October to December 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 49 exception reports submitted per month in 2021 compared to an average on 68 a month in 2022.

This data can also be compared against the previous year.

Types of exception reports received 1st October – 31st December 2022

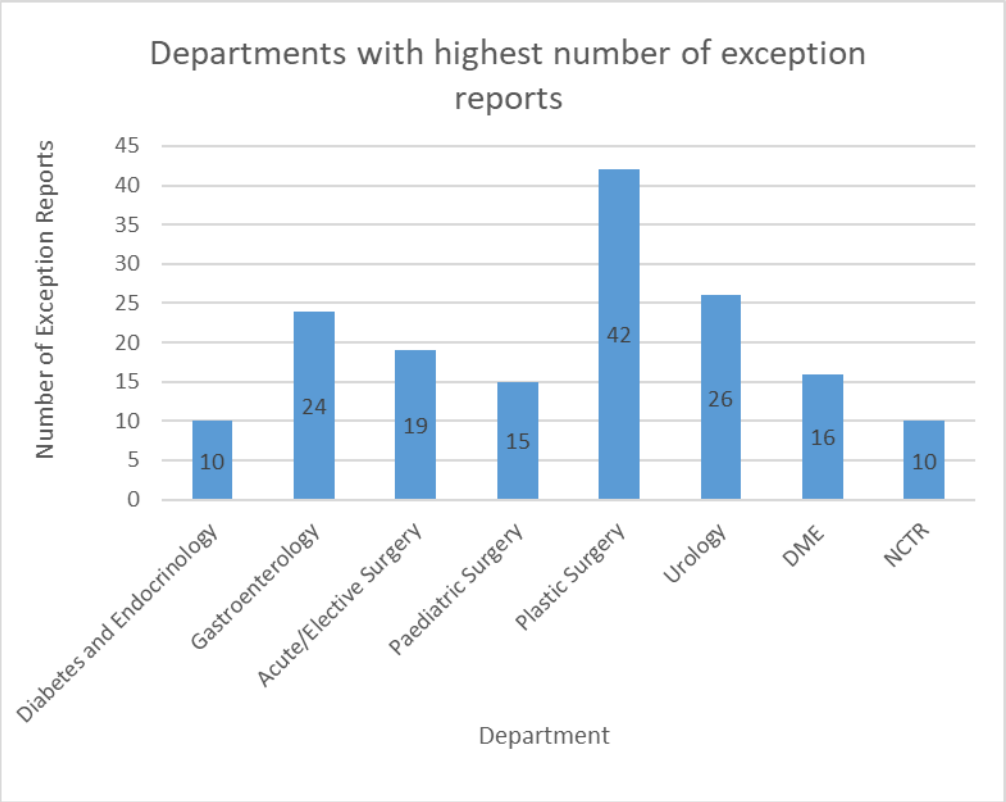


Due to increases in service demand, staffing shortages and prioritising patient care the most frequent type of exception report is submitted is in relation to a difference in hours worked. During this quarter there were a number of rotas highlighted to be working additional call out hours beyond their agree work schedule. While the rota was updated and implemented, they were asked to exception all instances of any variation from their work schedule. This means that there was often more than one exception report submitted for a single shift, for example: additional hours worked, rest not received, educational opportunities missed, different pattern worked. Due to this the average received by month increased from 49 to 68. To

compensate the trainee for the additional hours worked, TOIL and payment are offered in addition to this a GoSW fine may be applicable if the additional hours broke any rota rules. Due to inability to attend mandatory teaching, educational exception reports were submitted, and reviews advised the doctors to ensure they were attending the next sessions. For missed self-development time, this time is able to be reallocated as foundation and GP trainees require 2 hours of SDT every week. Where doctors feel there has been a lack of service support, this may be from vacancies or sickness gaps and feeling unsupported by the rota or lack of engagement from colleagues exception reports are submitted to highlight the issue and come to a resolution to prevent it happening in the future.

Exception reports (episodes) by specialty 1st October – 31st December 2022

The following graph shows the top 8 departments with the highest number of exception reports submitted.

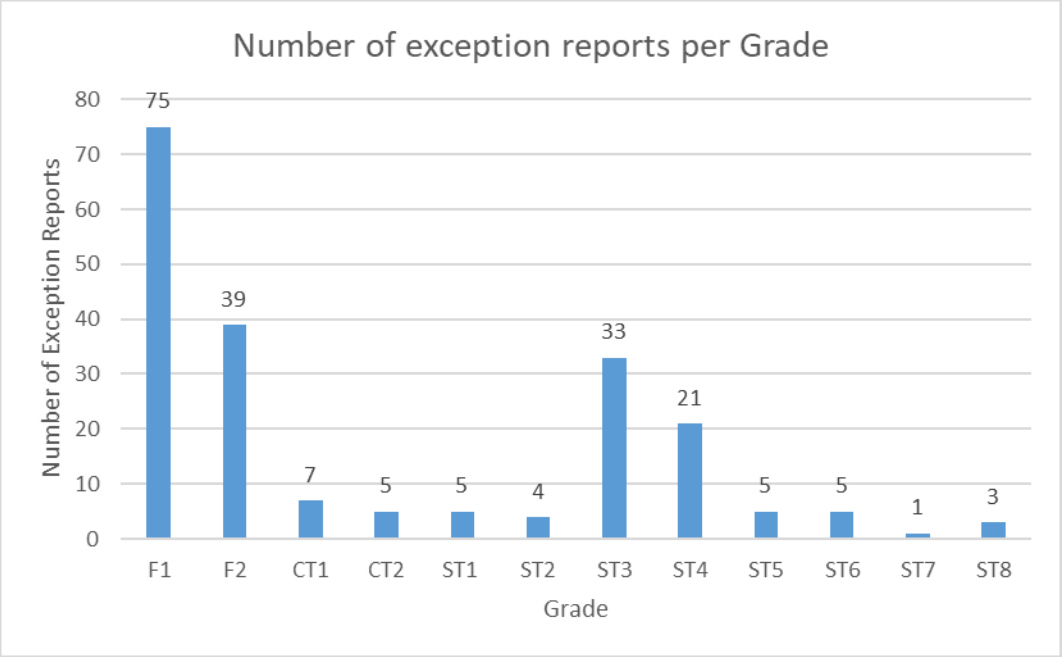


Plastic Surgery received the highest number of reports within this quarter from October to December 2022. This is somewhat expected as early October it was recognised the offline rota which was being worked is non-compliant due to being called out overnight during on-call shifts, this meant it is consistently breaching on two different rota rules (5 hours continuous rest, 8 hours rest in a 24 hours period). In addition to this their call out hours were lower than what the service demands so we have worked with the department to redesign the rota creating a more accurate reflection of what is worked.

Within the other departments exception reports showed there were a multitude of ways doctors are working away from their agree work schedule. Most commonly due to a high workload and prioritising tasks such as IDL's before finishing shift. There was also a common theme of no relevant person to be able to handover safely to so in order to maintain patient safety the trainee stayed beyond required hours, this is covered in service support and additional hours exception reports. Some departments such as Urology have made it

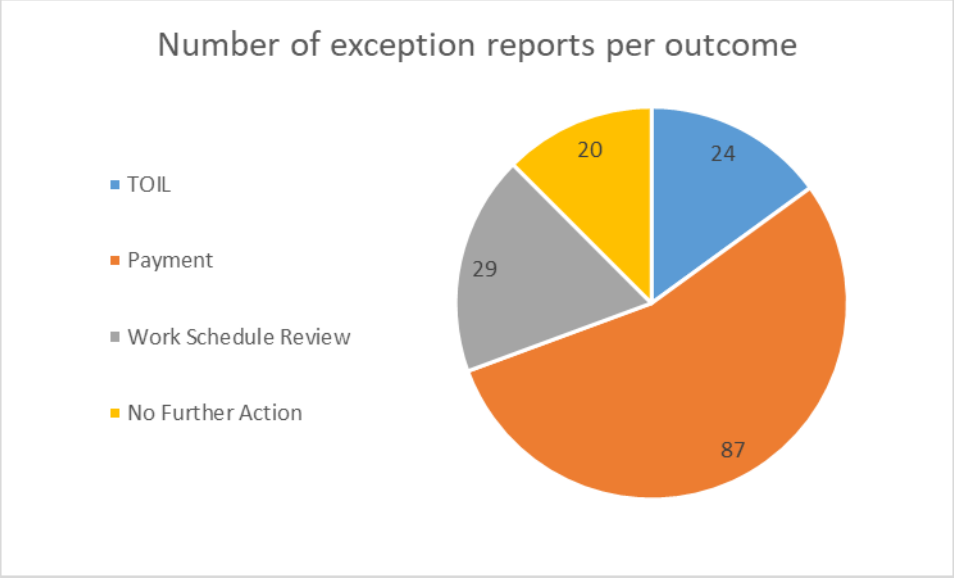
apparent that educational needs are not being met. This is due to rota vacancies meaning that less trainees are required to more work and not able to take their SDT.

Exception reports (episodes) by grade 1st October – 31st December 2022



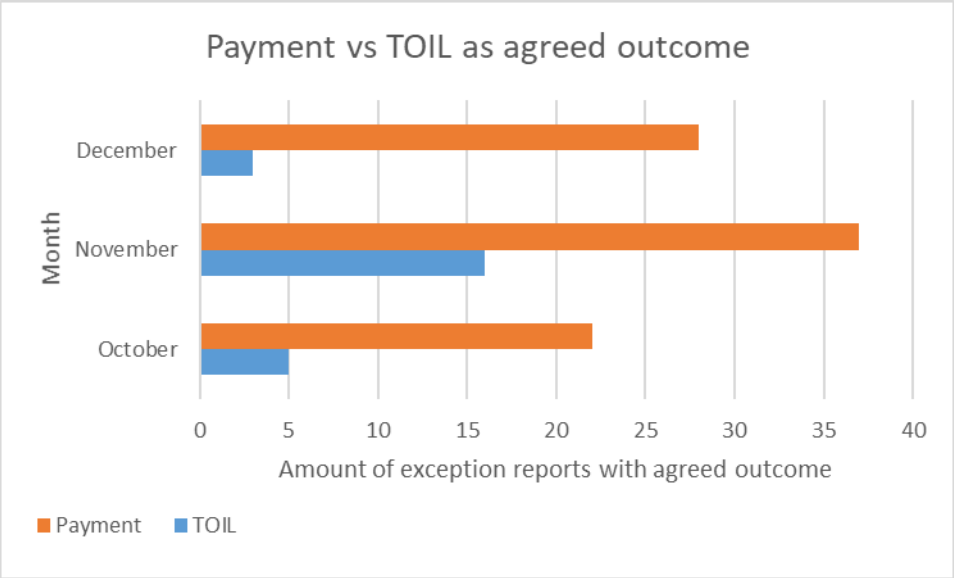
FY1 trainees were the grade with highest submission rate from October to December 2022. This is due to higher sickness rates and pressures upon lower grades, there are circumstances which will only affect junior trainees such as missed SDT or mandatory training further increasing the number of exception reports submitted. There has been an overall increase in submission rates but specifically in higher grades, as the e-roster roll out project continues and offline rotas are discovered to be non-compliant from lack of transparency.

Outcomes of completed exception reports 1st October – 31st December 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 difference in hours being the highest submission option. TOIL follows payment with roughly one third 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 roughly 20% of outcomes as rotas are recognised to be offline and non-compliant meaning the rota needs to be updated and taken through the organisational change policy. The increased frequency of exception reports for a particular area or rota show that it needs to be investigated and likley changed to ensure it is an accurate reflection of the work being completed.

Payment and TOIL trends by month 1st October – 31st December 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. E-Roster 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 22 fines have been issued within this quarter:

Grade	Dept where occurred	Rules Broken	Reason for working over
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called at 2am to review patient and perform surgery.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called at 2am to discuss referral.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called in to review two patients at 2am.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called in to operate from 11pm to 2:30am.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called in to review several patients between 22:00 – 03:30am.
F2	Urology	Maximum 13 hour shift	Doctor was required to work 1 hour overtime due to high workload from short staffing.
F2	Urology	Minimum 11 hours rest	Doctor was required to work 1 hour overtime due to high workload from short staffing therefore did not receive adequate rest.
F2	Urology	Maximum 13 hour shift	Doctor was required to work 1.5 hours overtime due to a backlog of jobs and multiple acutely unwell patients, they worked additional hours to safely handover.
F2	Urology	Minimum 11 hours rest	Doctor worked 1.5 hours overtime due to a backlog of jobs and multiple acutely unwell patients, they worked additional hours to safely handover and consequently did not receive adequate rest.

F2	Urology	Maximum 13 hour shift	Doctor worked 1.5 hours overtime as there were multiple acutely unwell patients and emergency admissions requiring immediate attention.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was resident until 1am and called again 02:20 to then review patient at 05:00.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called out several times throughout their NROC shift meaning adequate rest was not received.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called at midnight to review a referral and remained resident until 03:30am.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called to review a patient at 02:30 so did not receive adequate rest.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was resident until 2am returned to NROC state but was then called again 2:30.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called 23:30 to discuss a patient they were then reviewed at 3:30.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was resident until 01:47am, they were called twice for referrals, then reviewed the patient at 5am and handed over 6:30am.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was called out at midnight to review two patients, then called out again 1:30 – 3:30 to review and stayed resident until patient was admitted to ward.
Specialty Registrar	Paediatric Surgery	5 hours continuous rest (on-call)	Doctor was resident to review acutely unwell patients from 12 – 2am.
F1	Upper GI	Maximum 13 hour shift	Doctor was required to work 1.25 hours overtime due to high workload and short staffing.
F1	Upper GI	Minimum 11 hours rest	Doctor was required to work 1.25 hours overtime due to high workload and short staffing meaning adequate rest could not be received.

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

The following rotas were under review between October and December 2022, all relevant health groups are aware.

- Rota 28 – General Surgery
- Rota 66 – Paediatric Surgery
- Rota 8 – Oncology
- Rota 22 – Cardiothoracic Surgery
- Rota 133 – Neurosurgery
- Rota 23 – Vascular
- Rota 25 – Acute/Elective Surgery
- Rota 42 – Urology
- Rota 32 – Neurosurgery
- Rota 40 – Plastic Surgery
- Rota 14 – DME
- Rota 121 – Cardiothoracic Surgery

a) Locum bookings 1st October – 31st December

i) Bank 1st October – 31st December

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 150 Medical Staff signed up to the 'Remarkable Bank' and with ongoing advertising and recruitment to secure more external staff onto the Bank. Doctors rotating away from HUTH are also asked if they wish to remain on HUTH's Remarkable Bank after they rotate.

The information in this table only covers shifts that have been booked by the Medical Staffing Team and the Emergency Department. 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 1538 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**
F1	55	51	503	462.50
F2	664	462	6392.1	4411.1
CT/GPSTR /ST1-2	503	427	4320.7	3431.7
ST3+	316	314	2668.5	2647.5
Total	**1538**	**1195**	**13884.30**	**10713.80**

Locum Bookings (bank) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine	188	188	1600.45	3967.78
Breast Surgery	7	7	85	85
Cardiology	31	31	267.25	267.25
Chest Medicine	13	13	127.5	127.5
Clinical Oncology	21	21	201.30	201.30
Colorectal	21	20	238	227
CT Surgery	5	5	52	52
ED	737	459	7051	4181
Elderly Medicine	29	29	225.75	225.75
Endocrinology	16	15	160.50	148
ENT	6	3	42.50	30
Gastroenterology	6	5	52.50	44.50
Infectious Diseases	37	37	306.50	306.5
Medical Oncology	10	10	75	75
NCTR/Winter Ward	52	52	405	405

Neurology	90	90	739	739
Neurosurgery	13	13	164.50	164.50
Oral and Maxillofacial Surgery	32	32	376	376
Paediatric Surgery	52	19	301	153.5
Renal Medicine	1	1	4.25	4.25
Rheumatology	22	22	198.30	198.30
Stroke Medicine	25	25	193.50	193.50
Trauma & Orthopaedics	39	39	375.50	375.50
Upper GI	15	15	123	123
Urology	46	20	254	145
Vascular Surgery	13	13	127.50	127.50
Total	**1538**	**1195**	**13884.30**	**10713.80**

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Annual leave	5	5	44.75	44.75
Compassionate Leave	2	2	16	16
Extra Cover	144	144	1165.25	1165.25
Maternity/Paternity Leave	2	2	24.75	24.75
Sickness	85	83	713.30	705.30
Study Leave	2	2	13	13

Vacancy	561	498	4856.25	4563.75
ED - Not Given Reason	737	459	7051	4181
Total	**1538**	**1195**	**13884.30**	**10713.80**

ii) Agency 1st October – 31st December 2022

Locum Bookings (Agency) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	40	2	316	24
F2	1632	603	16,505	5,699
CT/GPSTR/ST1-2	227	93	2,268	835
ST3+	420	102	4,412	1,013.09
Total	**2,319**	**800**	**23,500**	**7,57109**

Locum Bookings (Agency) by department				
Specialty	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
Acute Medicine	300	19	2,763	147
Cardiology	199	98	1895	857
Cardiothoracic Surgery	4	0	4	0
Elderly Medicine	35	8	346	96
Emergency Medicine	554	173	5,459	1,521
ENT	174	71	2,039	755
Gastroenterology	35	0	273	0

General Surgery	271	105	2,865	1,029
Infectious Diseases	2	0	18	0
Neonatal Medicine	16	4	198	48
Neurology	13	0	104	0
Neurosurgery	27	17	318	185
Obstetrics & Gynaecology	18	0	169	0
Oncology	85	52	887	485
Oral and Maxillofacial Surgery	54	0	815	0
Paediatrics	172	61	1630	539
Plastic Surgery	1	0	24	0
Renal Medicine	3	3	37	36
Rheumatology	39	3	317	28
Surgery	36	2	315	24
Trauma & Orthopaedics	217	144	2332	1435
Urology	62	40	605	375.84
Total	**2,319**	**800**	**23,500**	**7,571**

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	88	8	762	58
Annual Leave	65	0	657	0
Covid – Escalation rota	3	0	18	0
Covid-19 (pressures)	2	0	25	0
Escalation Beds	24	0	204	0
Exam Leave	14	0	175	0
Extra Activity / Escalation	125	62	1,367	0
Long Term Vacancy	8	0	54	0
LTFT Arrangement	14	0	134	0
Maternity / Paternity Leave	20	3	173	28
Occupational Health	1	0	13	0
Phased Return	8	0	64	0
Short Term Vacancy	10	0	80	0
Sickness	4	0	40	0

Sickness - Long Term	2	1	26	11.50
Sickness - Short term	128	1	1,229	12
Vacancy	1,803	725	18,481	6,891
Total	**2,319**	**800**	**23,500**	**7,571**

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. Increased use of the Trust's e-Rostering systems will be one of the ways that this would be captured which is being rolled out by the Medical Staffing team.

Locum work carried out by trainees 1st October – 31st December 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 and as above this will be easier to collate and analyse with the increased use of electronic rostering.

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
Cardiology	F2	135	47:30	Yes
Acute Medicine	F2	131	46	Yes
General Practice	GP	126	40	No
General Practice	GP	93.25	40	Yes
Neurology	ST4	88	44:30	Yes
Acute Medicine	ST3	87	44	Yes
Paediatric Surgery	GP/ST2	84.75	47:30	Yes
General Practice	GP	83.25	40	Yes
CT1	DME	80.90	46	No
ST2	Palliative Medicine	78.5	40:45	Yes

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.

The full establishment report is currently under review by Finance with the support of Medical Staffing to ensure that our records are accurate and up to date.

Hull University Teaching Hospitals NHS Trust - Junior Doctor Trainee Establishment effective December 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	7	28	0	114	0	149	6	27	0	99.3	0	132.3	88.8%
Acute Medicine	4	6	9	0	8	27	4	5	9	0	3.8	21.8	80.7%
Anaesthetics	5	4	20	0	27	56	5	4	14.3	0	28.1	51.4	91.8%
Breast Surgery	2	0	1	0	2	5	2	0	0	0	1	3	60.0%
Cardiology	2	1	3	1	10	17	2	1	2	1	8	14	82.4%
Cardiothroacic Surgery	0	3	0	0	4	7	0	3	0	0	3	6	85.7%
Chemical Pathology	0	0	0	0	1	1	0	0	0	0	1	1	100.0%
Colorectal Surgery	8	0	1	0	3	12	7	0	1	0	2.5	10.5	87.5%
Dermatology	1	0	0	1	0	2	1	0	0	1	0	2	100.0%
Elderly Medicine	5	3	5	8	6	27	4	3	4	5.6	5.8	22.4	83.0%
Emergency Medicine	0	12	12	6	16	46	0	12	10.4	4.8	16.2	43.4	94.3%
Endocrinology	3	0	2	0	4	9	3	0	2	0	3	8	88.9%
ENT	3	1	2	3	4	13	3	1	2	2	3.6	11.6	89.2%
Gastroenterology	3	0	2	0	6	11	1	0	1	0	5.8	7.8	70.9%
General Surgery	0	1	0	0	0	1	0	1	0	0	0	1	100.0%
Haematology	2	1	2	0	4	9	1	1	2	0	4.2	8.2	91.1%
Histopathology	0	0	0	0	4	4	0	0	0	0	3	3	75.0%
Immunology	0	0	0	0	1	1	0	0	0	0	0	0	0.0%
Infectious Diseases/Neuro-Rehab	2	0	1	2	5	10	2	0	0	2	5	9	90.0%
Neurology	2	2	3	0	5	12	2	2	3	0	5	12	100.0%
Neurosurgery	1	1	2	0	4	8	1	0	2	0	4	7	87.5%
Obstetrics & Gynaecology	0	2	5	4	13	24	0	2	5	4	12.8	23.8	99.2%
Oncology	2	0	2	4	9	17	2	0	1	4	8.2	15.2	89.4%
Ophthalmology	1	1	0	0	6	8	1	1	0	0	6	8	100.0%
Oral & Maxillofacial Surgery	0	0	10	0	2	12	0	0	5	0	2	7	58.3%
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	1.8	0	1.8	90.0%
Plastic Surgery	0	0	3	0	6	9	0	0	2.6	0	5.8	8.4	93.3%
Paediatrics	3	4	3	2	9	21	2	4	3	1.8	6.8	17.6	83.8%
Radiology	0	1	0	0	28	29	0	0	0	0	27.4	27.4	94.5%
Renal Medicine	2	1	2	0	7	12	2	1	2	0	6	11	91.7%
Respiratory Medicine	6	2	2	2	8	20	6	2	1	0	8	17	85.0%
Rheumatology	0	0	1	2	3	6	0	0	1	2	3	6	100.0%
Stroke Medicine	0	0	0	0	1	1	0	0	0	0	2	2	200.0%
Trauma & Orthopaedics	0	4	3	1	9	17	0	3	2	0	9	14	82.4%
Upper GI	7	0	3	0	4	14	7	0	3	0	3	13	92.9%
Urology	1	3	2	0	3	9	1	2	2	0	3.2	8.2	91.1%
Vascular Surgery	5	0	1	0	3	9	5	0	1	0	2	8	88.9%
TOTAL	**77**	**81**	**111**	**152**	**232**	**653**	**70**	**75**	**89.3**	**129.3**	**215.6**	**579.2**	**88.7%**

Appendix A: Exception reports episodes per specialty 1st October – 31st December 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	2	1	2	1
Acute Medicine	3	0	1	2
Anaesthetics	2	3	0	5
Cardiology	7	0	0	7
Cardio-thoracic surgery	15	3	4	14
Diabetes & Endocrinology	1	1	2	0
Gastroenterology	16	1	0	17
General Medicine	102	73	60	115
General Surgery	44	13	3	54
Medical oncology	16	7	8	15
Neonatology	1	0	1	0
Neurosurgery	2	0	0	0
Obstetrics and Gynaecology	7	0	0	7
Opthalmology	0	5	5	0
Paediatric Surgery	3	19	19	3
Paediatrics	6	0	1	5
Plastic Surgery	1	43	20	24
Surgical Specialties	21	27	27	21
Trauma & Orthopaedic Surgery	6	5	5	6
Urology	2	9	0	11
Vascular Surgery	14	7	6	15

Appendix B: Exception reports (episodes) by grade 1st October – 31st December 2022

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	153	78	73	158
F2	51	43	37	57
CT1	5	7	3	9
CT2	15	5	6	14
Specialty registrar in core training 1/2	14	0	1	13
ST1	17	7	3	21
ST2	3	4	5	2
ST3	4	33	8	29
ST4	1	21	14	8
ST5	2	9	9	2
ST6	6	6	5	7
ST7	0	1	1	0
ST8	0	3	0	3

Appendix C: Exception reports (episodes) by rota 1st October – 31st December 2022

Rota	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Rota 18b - Medicine F1 Endocrinology	10	4	6
Rota 134 – Orthopaedic/Orthogeriatric F2	3	2	1
Rota 40 – Plastic Surgery	36	19	17
Rota 29 - Vascular Surgery	2	2	0
Rota 23 - Surgery F1	5	5	0
Rota 124a - General Surgery, Acute & Elective	8	7	1
Rota 25 - Acute/Elective F1	7	3	4
Rota 14 - DME (Blp 431)	10	7	3
Rota 121 - CT Surgery & Cardiology	3	3	0
Rota 12 - Medical Oncology SpR	5	5	0
Rota 124b – General Surgery Urology	17	14	3
Rota 13 – Acute & General Medicine IMT	2	1	1
Rota 135 – Orthopaedic & Plastic Surgery CT	6	4	2
Rota 250 – AAU Academic F2	1	1	0
Rota 76 – Critical Care F2	1	0	1
Rota 83 – Anesthetics (HICU2)	2	0	2

Rota 30 – Orthopaedic SpR	1	1	0
Rota 4 – Gastro/DME/Acute Med/Neurology	39	35	4
Rota 42 – Urology SpR	9	0	9
Rota 8 – Oncology & Haematology	2	2	0
Rota 27 – Acute & Elective Surgery	4	0	4
Rota 36 – Opthalmology	5	5	0
Rota 130 – NCTR & General Medicine (F2+)	6	4	2
Rota 66 – Paediatric Surgery	15	15	0
Rota 131 – NCTR & General medicine (F1)	4	0	4

Appendix D: Exception reports (episodes) - response time 1st October – 31st December 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	17	6	33	19
F2	1	7	24	7
CT1	0	0	3	4
CT2	0	0	3	2
ST1	3	0	0	2
ST2	0	1	3	0
ST3	3	7	2	21
ST4	6	1	9	5
ST5	1	2	1	0
ST6	1	0	3	1

Agenda Item		**Meeting**	**Trust Board**	**Meeting Date**	**14th March 2023**
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 Committee 27th February 2023**				

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 asked to receive, discuss where appropriate and note this update on key performance issues.

Performance and Activity Report

January 2023 Performance

December 2022 for Cancer data

Produced February 2023

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1. Executive Summary

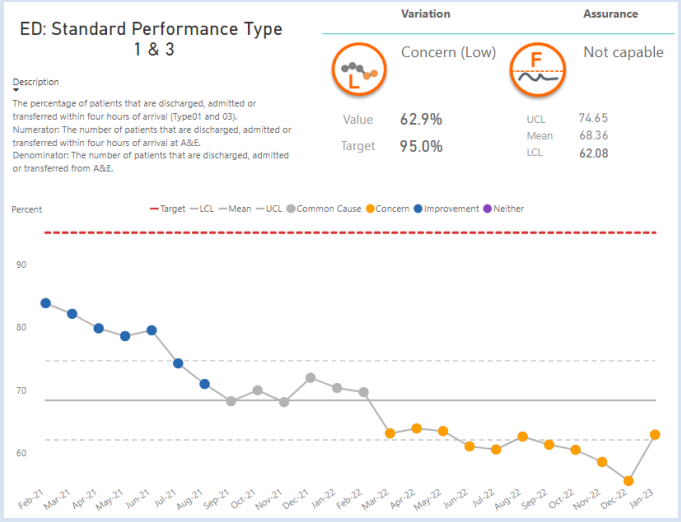
Areas requiring improvement	
Urgent Care performance – ED and Ambulance handovers	• For January 2023, the Ambulance handover position remained highly challenged due to the number of lodged patients within ED, however this has shown signs of improvement for two weeks in January 2023 when flow was improved by internal trust actions as well as working together with YAS, particularly on the impact of days with industrial action. • YAS and HUTH continue to work on improving ambulance handover times to enable the release of ambulance crews to support the community, albeit there continues to be significant challenges in this area. The use of cohorting has increased, there have been discussions and a risk assessment completed for continuing to use the Atrium or Fracture Clinic for cohorting; Fracture Clinic is not being used whilst identified risks are addressed. Reduction in cohorting in January 2023 linked to improved ED flow. • The number of patients in January 2023 with No Criteria to Reside continues to be the single largest factor affecting performance with a daily average of 132 (decrease 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 6.3% compared to the same period last year; there is no significant increase in confirmed cancers for any tumour site. • Only 1 of 9 cancer-waiting times' national standards were achieved (31-Day Drug). • The number of patients on the 62-day from 1st OPA to treatment Cancer PTL varies considerably from 1,300 – 1,600 and in itself is not monitored but used as the denominator when considering the +63 day backlog. From January 2023, the Trust began reporting patients on the 62-day PTL from referral to treatment, in line with the required Cancer Waiting Times guidance, which has increased the PTL by 500-700 patients on a weekly basis. • HUTH remains a Tier 1 provider for cancer performance and is the focus of the 2/52 NHSE assurance and recovery meetings – with particular emphasis on those patients +62 and +104 days, and the recovery trajectory to 31 March 2023.

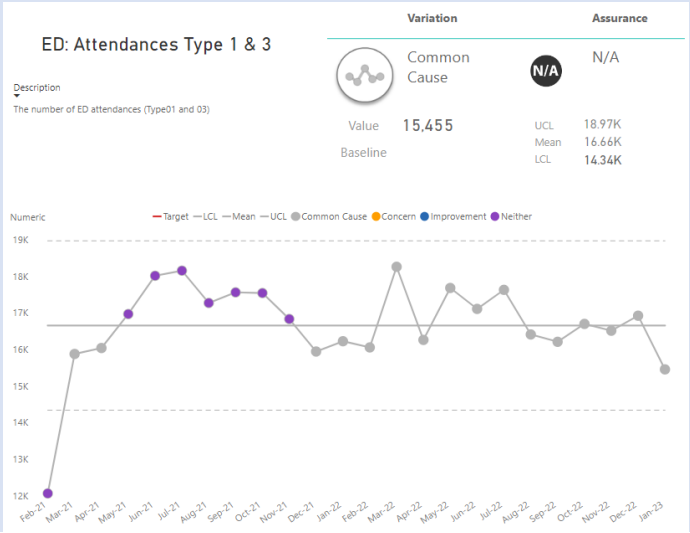
	The Trust did not achieve the recovery trajectory requirements in December 2022 – lost activity due to bank holidays and cancelled surgeries due to NCTR patients outlied to CHH. • Internally the 2/52 meetings with the top 4 tumour sites (colorectal, Gynae, urology and lung added, with skin stepped down in February 2023) are well established; chaired by the DCOO (Elective Recovery & Cancer) and attended by DGMs and the Trust Lead Cancer Manager to review all patients at +80 days in order to support achievement of the 62-day standard. • Following the Urology Service Improvement sessions in November 2022 & January 2023, an improvement action plan is in place and being actively progressed. Priorities are ensuring that there is sufficient prostate referral OPA capacity for key clinicians to accommodate referrals; this will ensure each patient is directed on the correct pathway first time therefore reducing delays at the beginning of the pathway and haematuria backlog clearance. • The Colorectal tumour site continues to improve following improvement in CT Colon waiting times/processes. Non-recurrent funding has been secured from the Cancer Alliance to increase the number of Cancer Nurse Specialists (CNS) to improve the front end of the pathways – this will required a recurrent funding source from the 23/24 and 24/25 cancer allocations. • A Gynae-oncology service improvement session in January 2023 identified several priority actions with the service focussing on the diagnostic part of the pathway, including a review of the impact on histology. • Late inter-hospital transfers (IHTs) from within the HNY ICS adversely affect urology and lung; discussions with referring Trusts are planned. • Histopathology delays impact on the Skin tumour site performance in particular – revised Cancer Waiting Times guidance has enabled removal from the Cancer PTL where an excision (treatment) is complete, and where the patient has been told of their expected diagnosis, prior to the histology result being reported which has improved +62 day and +104 day long waits. However, the delay in receipt of pathology results impacts on the overall performance upload – e.g. where results are not available the treatment (if cancer) is not captured and reflected in the national performance. Therefore further work is required to improve the skin pathology turnaround times (TAT) and this is underway.

Recovery of elective activity	• Recovery of elective activity in January 2023 did not achieve the plan in any POD. Ordinary elective activity was 64% of plan, which is a deterioration on previous months. This was due to challenges with NCTR, ICU bed capacity; ward bed capacity and infection outbreaks (VRE). The indicative activity requirement of 110% of 19/20 baseline was not delivered. • The operational plan also includes a reduction of outpatient follow-ups by 25% by March 2023. In January 2023, follow up activity was 90% of baseline and 99% of plan; further work is required to transform outpatient pathways to support this operational requirement. Focussed meetings with each Health Group commenced in November 2022 to drive performance improvement and/or under identify the reasons for any deviation, i.e. a number of clinic/activity types were previously excluded. • Outpatient new activity delivered 93% of plan and 9% of baseline. • Ward C9a is now vacant with oncology contained within the Queen's Centre for Cancer however Surgery Health Group are unable to staff C9a, therefore the recovery for orthopaedics and neurosurgery remains a risk. • Following the paediatric move to new accommodation on the 2nd floor of HRI, vacated wards H130 East and West have been converted to NCTR 31 bed capacity to support the increasing numbers of NCTR patients and reduce risk of impact on elective capacity; this will create a workforce pressure but is proving necessary while community/discharge capacity continues not to meet demand • Mutual aid continues albeit in limited numbers to improve waiting times and support the reduction of the overall size of the Trust's PTL.
Improving treatment times for long waiting patients	• There were 794 x 104 week wait patients to treat in 2022/23 Q1 and the Trust had been designated a Tier 1 organisation. The Trust was stepped down to a Tier 2 trust for long waits from November 2022 (regional oversight & assurance) for long waits. • At the end of January 2023, the Trust reported 26 x 104 week waits. The breaches reported were 2 x colorectal surgery (TCI dates displaced in January 2023 due to NCTR) and 24 Ophthalmology corneal transplants which were mandated by NHSE to move to a reportable RTT pathway.

	• 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. • 4,948 patients have waited more than one year for their appointment/procedure, this is below the trajectory of 5,431. • Mutual aid continues to be progressed in challenged specialties.
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 (NCTR) in an acute hospital". NCTR patients are medically fit from an acute perspective, but may still have other care needs, and are delayed in receiving that care, moving home either with care, or to a community or care home setting for their needs. • In January 2023, there were on average 132 patients per day with NCTR, decreased from last month. This is 13% of the total general & acute beds, and 19% of the beds at HRI (total G&A beds 680 HRI/347 CHH) occupied by NCTR patients who should be receiving appropriate care elsewhere with the support of other partner organisations or settings. • The Interim Deputy Chief Nurse leads a regular review of patients 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. • A system level plan has been agreed; increasing both bedded and care at home capacity, and continues to be enacted. ➢ In December, the system ran a discharge event with a target of reducing NCTR to 100 by the 31 December 2022. At the beginning of December, the number of NCTR patients in the Trust was at 222. During the first week of the event, NCTR had reduced to 176. However, due significant winter pressures, the figure rose to 197 at 31 December (25 less than the start point of 222). ➢ Next discharge initiative 27 February 2023, for 1 week, focusing on smaller number of initiatives in frailty.

2. Emergency Care Standards – 4 hour Performance





What the chart tells us

The 4-hour performance delivery has improved slightly, although is significantly below the required standard. In January 2023, performance was 62.9% for all Types. ED attendances are below the mean at 15,455 in January 2023.

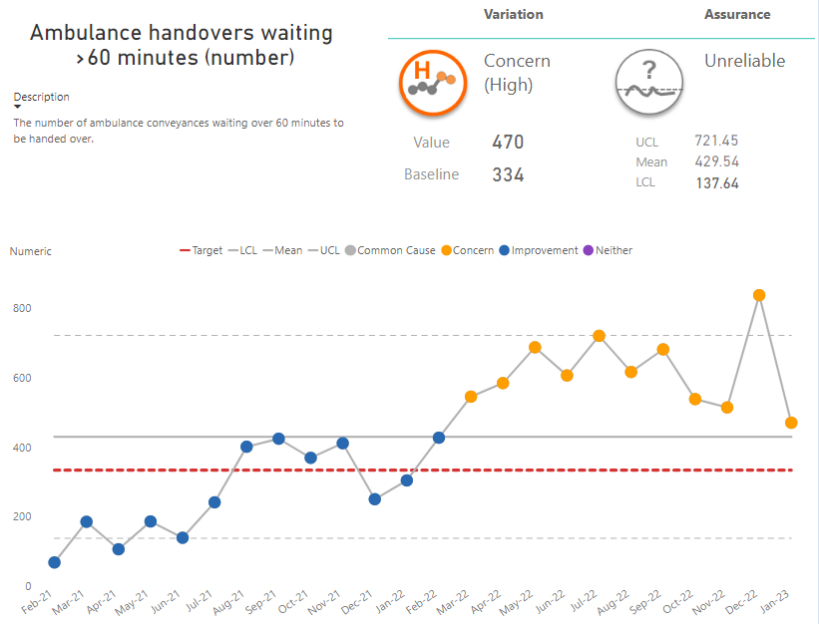
Intervention and Planned Impact

- The RAT model for the Emergency Care area has been in place since 4 November 2022, Monday to Friday, day and evening shift as times of greatest demand/potential impact
- Increased capacity at Storey Street commenced from 2 December 2022 to enable more patients to be directed to that service while urgent care capacity for Hull is assessed through a Place-led Task-and-Finish Group
- Use of National streaming tool to direct appropriate patients to primary or urgent care commenced 14 December 2022.
- Keeping SDEC free from bedded patients overnight, and able to function from 8am continues to be a priority. This was less possible at the start of January 2023 and varied throughout the rest of the month
- Patients with a NEWS score of 5+ on ambulances are brought through to ED as a priority – the right step for patient safety however this delays ECA lodged patients exiting to a bed or moving through to Majors
- A task and finish group is being established to review specialty referrals made via ED, and engage with specific specialties to agree pathways (direct to specialty or to appropriate assessment capacity) for any identified areas that the review identifies.
- The EMHG has agreed a governance structure of 3 x Task and Finish Groups to identify and implement patient safety improvements (which link to improving performance); these started w/c 13 February 2023 and will provide monthly updates to the Patient Safety Oversight (CQC) Group, the fortnightly Emergency Care Standards Delivery Group and the monthly Performance and Accountability meeting with the Exec team

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 as rooms are occupied for an extended period.
- Boarding (HUTH version of Bristol model) is in daily operation
- Increasing the number of support workers using overseas recruitment pool to provide care for lodged patients.

3. Ambulance Handovers waiting over 60 minutes



What the chart tells us

There were 470 (a reduction of 441 on previous month) over 60 minute ambulance handover delays in January 2023 that equated to 17.8%.

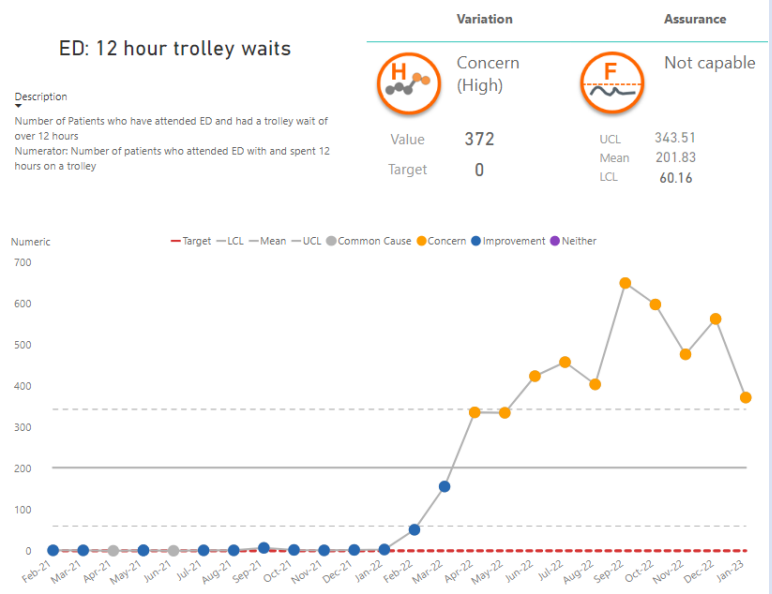
Intervention and Planned Impact

- HUTH Flow Model designed to reduce the number of lodged patients in ED by 10:30am daily, thereby creating space in majors to handover ambulances and reduce queuing in the morning. Flow model should also see a 15 further patients moved by 6 pm. Not always achieved consistently, which impacts on action below.
- Focusing on afternoon flow of patients into January 2023 to ensure that movement is maintained so that ambulances are available for the community – however, increase in NCTR patients, higher acuity of patient admissions and general discharge patterns particularly in the medicine bed base meant that performance is very variable and the delivery is variable.
- Cohorting of ambulances jointly with YAS enables a single crew to monitor a selected group of patients and enable the other crews to be available to respond to the community.

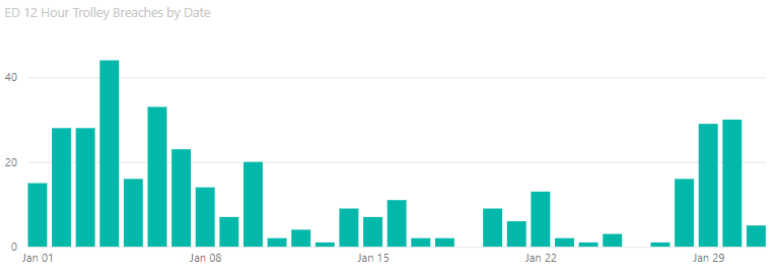
Risks / Mitigations

- Flow remains challenged as the number of patients with No Criteria to Reside, who are unable to be discharged, are occupying over 30% of the medical bed base.
- The number of morning lodged patients continues to be a barrier
- The additional wards remain open thereby placing additional pressure on Nurse and Medical Staffing
- The number of >60 minute Ambulance handover delays improved sharply in January 2023, compared with the previous month. This was seen in the two-week period when greater flow was achieved.
- Increasing IPC concerns/restrictions (e.g. Flu, Covid positive patients, VRE & Norovirus) reduce the ability to board patients

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



Day of Week Number	1 Mon	2 Tue	3 Wed	4 Thu	5 Fri	6 Sat	7 Sun	Total
ED Departures (Type 01)	1,581	1,713	1,179	1,221	1,185	1,118	1,434	**9,431**
ED 12 Hour Trolley Breaches	78	56	51	20	44	54	78	**381**
ED 4 Hour Standard Performance (Type 01)	44.7%	44.2%	49.5%	52.1%	54.3%	41.9%	45.9%	**47.2%**



What the chart tells us

There were 372 x12 hour trolley wait breaches in January 2023 with the longest wait from Decision to Admission (DTA) of 33 hours. In January 2023, Sunday and Monday 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 January 2023 was that 12.9% of patients (1,217 patients) waited over 12 hours against a national tolerance of 2%.

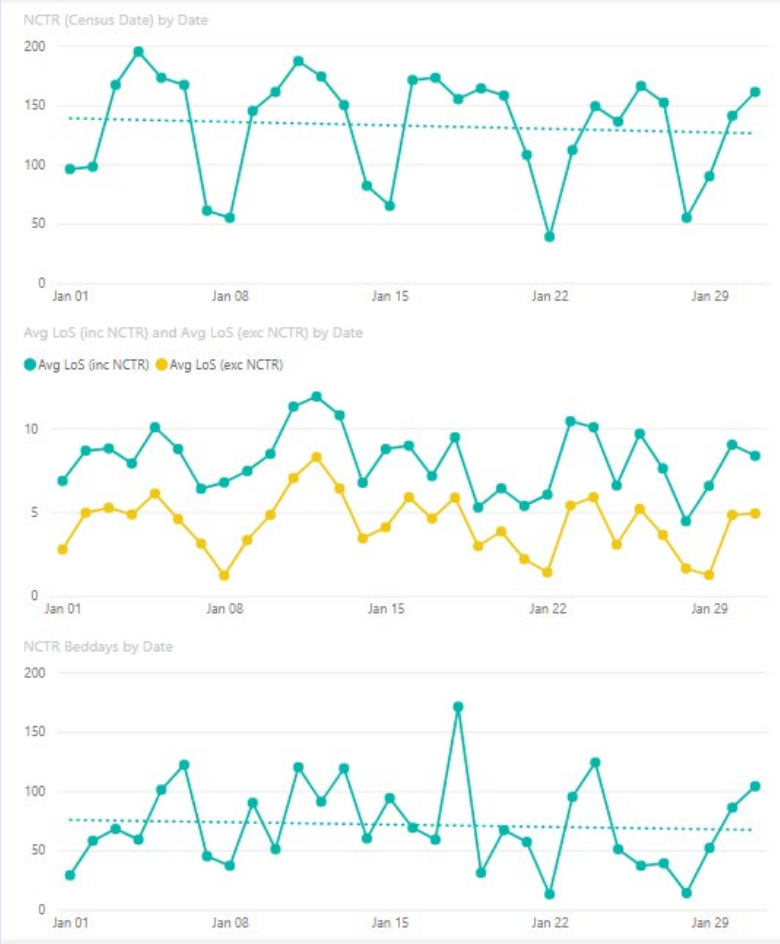
Intervention and Planned

- Implementation of HUTH flow model from mid-October 2022 initially reduced the number of 12hr trolley waits. The inability to undertake this model consistently as described above had a particular impact in December 2022.
- Board and Ward rounds in the Medicine Health Group implemented across HRI, auditing of compliance was undertaken in December 2022. There has been a 20% improvement in compliance in January 2023.

Risks / Mitigations

- High numbers of No Criteria to Reside patients, outside of the NCTR bed base are occupying acute beds reducing 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. This includes the 31 boarded patients in medical wards by 6pm, which does not happen consistently, nor boarding patients to surgical wards when necessary.
- Board round process will take time to embed, but have shown some improvement. An assessment of the data will now be carried out to assess whether the benefits of shorter lengths of stay to aid flow have been achieved.

5. No Criteria to Reside



What the chart tells us

On average, there were 132 patients per day with No Criteria to Reside in January 2023. There was an average impact of 4.0 days increase on Length of Stay due to the NCTR.

The NCTR accounted for 2,213 lost bed days in January 2023, which is a decrease on the previous month.

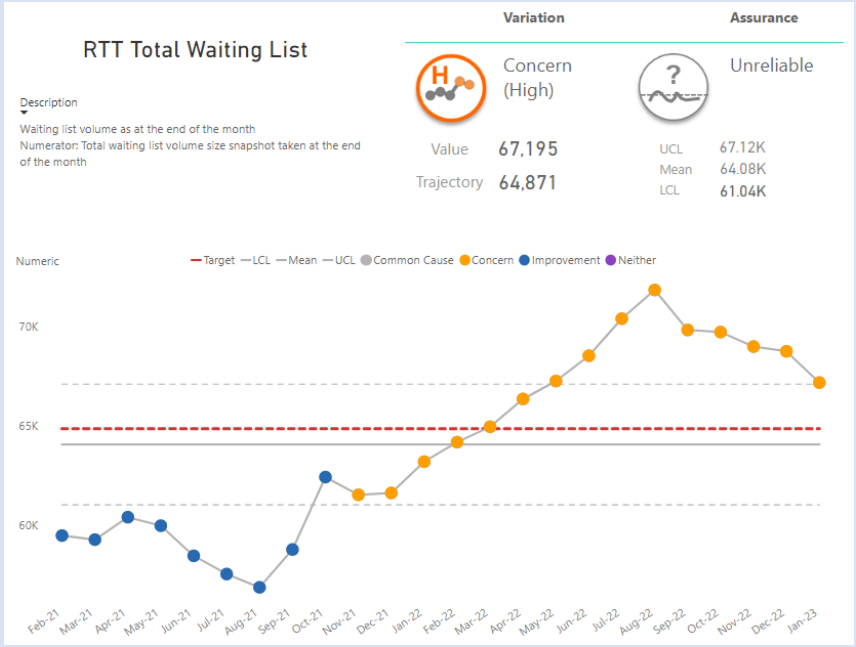
Intervention and Planned Impact

- System leaders are focused on reducing the number of NCTR patients to sub-100, with a further trajectory of 50 planned. This will be in part achieved by increasing both bedded and care at home capacity, including the additional 30 community beds which were originally planned for December 2022.
- The Fracture Neck of Femur community pathway began on the 4th December 2022, suspended 20 December 2022 due to the presence of Covid. Work continues to restart this pathway; the care home is taking risk assessed patients who have had Covid in the last 90 days.
- There was a marginal reduction in NCTR patents during the December 2022 discharge event. The marginal reduction has continued into January. The next discharge initiative begins on the 27 February 2022, for 1 week, focusing on smaller number of initiatives targeting frailty.

Risks / Mitigations

- Domiciliary capacity remains lower than demand.
- Recruitment challenges due to competition from retail
- Winter infections (Flu/D+V) closing care home capacity

6. Referral to Treatment – Total Waiting List Volume



What the chart tells us

The Trust's total waiting list volume (WLV) has reduced marginally. At the end of January 2023, the position was 67,195. The total WLV is above the trajectory of 64,871.

Referrals in January 2023 were the same as the same period last year. The operational plan for 2022/23 assumes no further increase in referrals.

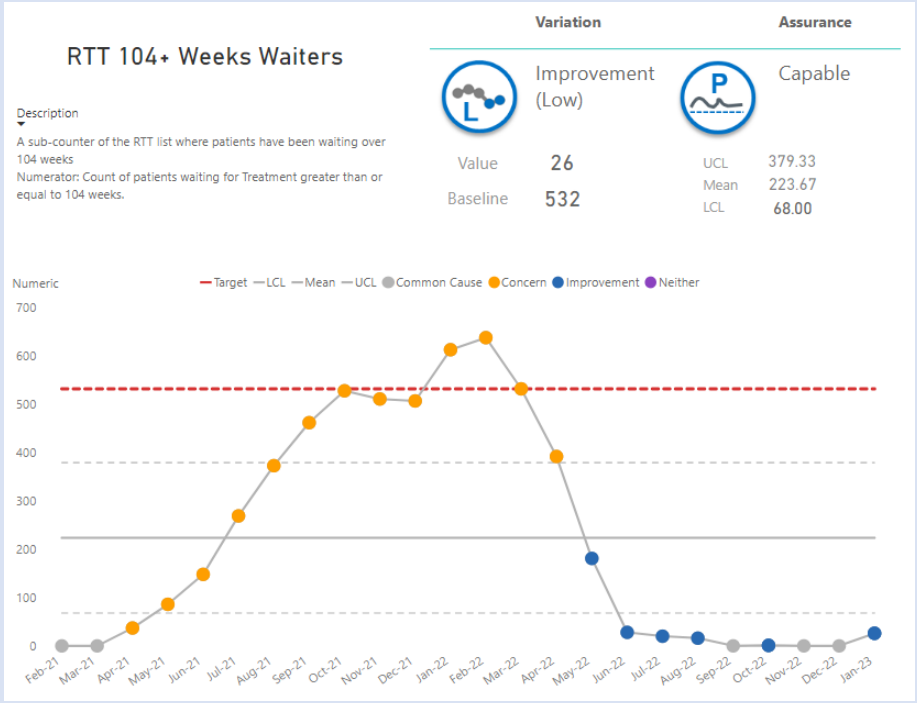
Intervention and Planned Impact

- 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 +52 week non-admitted waits at 31 March 2023. This initiative will progress reductions on the Total WLV
- Mutual aid/outsourcing is supporting the total WLV reduction overall.
- Capacity alerts in x6 pressured specialities are live – with monitoring arrangements to consider the effectiveness and impact (2x specialities – referrals have increased)
- Continuing insourcing arrangements to secure additional capacity. Additional support for Gynaecology is a priority.
- Text validation will be delivered as a business as usual validation process for the remainder of 2022/23 & into baseline from 2023/24.
- RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management has commenced through Learn RTT e-learning.
- Digital Mutual Aid System being used to find alternative providers in colorectal surgery, vascular surgery and Gynaecology.

Risks / Mitigations

- Further increase in GP referrals – referral triage and A&G in place to mitigate
- Orthopaedic bed base reduction (-12) – now available to orthopaedics, but cannot be staffed by Surgery Health Group
- Patients with No Criteria to Reside does not reduce
- Infections and the management of contacts reduces bed availability and/or affects staff availability
- Increase in non-elective demand displacing elective capacity
- Impact of any Industrial Action

7. 104 Week Waits & Planned Trajectory



What the chart tells us

At the end of January 2023, the Trust reported 26 x 104-week waits.

Colorectal patients x2 dated outside of breach date

- Severe capacity constraints in January 2022 due to NCTR displacing elective capacity at CHH resulted in complex cases x2 being cancelled (2 x surgeons & robotic theatre required) now re-dated February 2023)

Plus 24 unmatched corneal transplant breaches

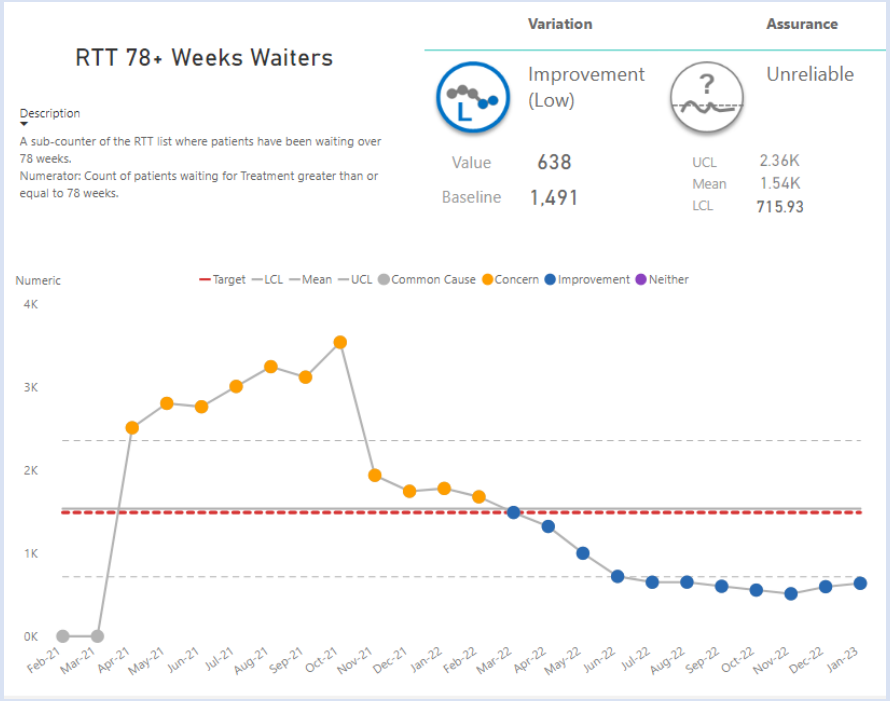
Intervention and Planned Impact

- Continued focus on zero 104-week breaches which are largely corneal transplant patients reliant on scarce donor material.
- Clinical Admin Service continue to proactively contact patients with confirmed 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 HNY 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
- Corneal transplant (unmatched) pathways previously managed by HUTH as planned were mandated to RTT ticking pathways by NHSE
- February 2023 (at 13/2/2023) risk of 104-week breaches currently x30 patients, of which 25 are corneal transplants.
- IPC risks including VRE affecting (staff absence & patient numbers
- NCTR and/or acute demand – 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

8. 78 Week Waits & Planned Trajectory



What the chart tells us

At the end of January 2023, the Trust reported 638 x breaches of the 78-week target, against a trajectory of 297.

The current position (at 16.2.23) is 1,195 total 78 week patients to treat by the end of March 2023. 80% of these have an appointment / TCI date booked before the end of March 2023.

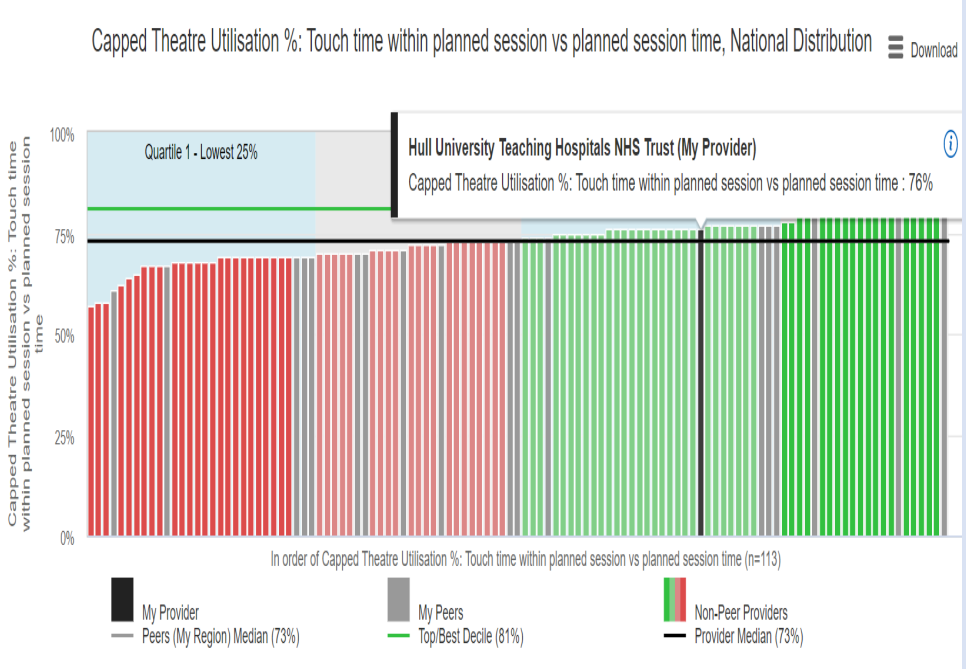
Intervention and Planned Impact

- Continued focus at speciality level of patients dated and/or risks now focussed to achieve zero 78-week waits by the end of March 2023.
- 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

- As above for 104 week risks / mitigations
- 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 – now staffing the 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)
  - Ophthalmology (corneal transplant donor material)

9. Capped Theatre Utilisation



What the chart tells us

This new metric was introduced as a response to the Elective Recovery Self-Assessment requirements. The elective recovery standard is a minimum of 85% capped theatre utilisation.

Data from Model Health for 2022/23 (up to 15.1.23) shows capped theatre utilisation at 76% and in Quartile 3 nationally, this is an improvement on the last reported position.

There is considerable variation in performance, with further work on-going with regards to data quality, theatre scheduling timings update, understanding the definitions and the Model Health outputs compared to the internal monitoring.

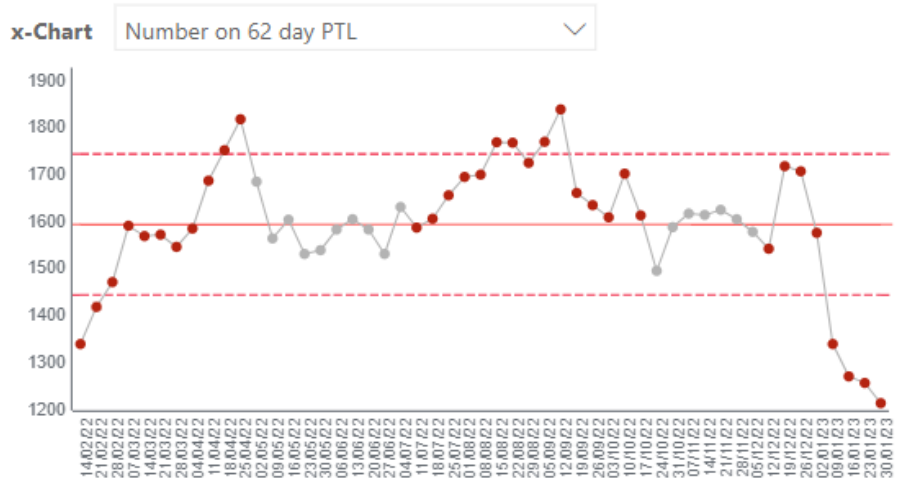
Intervention and Planned Impact

- Review of theatre timetable and configuration of ORMIS sessions. There are some theatres and sessions that need amending from elective to acute.
- Review of start and finish times of planned sessions in ORMIS; changes made to the sessions in ORMIS from 12 December 2022.
- Theatre timings being updated in the scheduler, and comparison to actual times underway
- Some changes to consultant job plans required to utilise the Trust standard 4-hour theatre session
- Model Health to share the reporting methodology so that the capped theatre utilisation can be replicated for internal reporting at Trust and specialty level.
- All BI dashboards to be aligned to capped theatre utilisation methodology.

Risks / Mitigations

- Late starts and/or cancellations on the day as a result of being unable to confirm beds
- Delay in confirming/lack of ICU beds
- Inaccurate theatre timings used in ORMIS
- Consultant job plans do not match theatre schedule

10. Cancer 62 day Waiting List Volume



What the chart tells us

The number of patients waiting to start treatment or benign diagnosis patients waiting to be removed, on a 62-day pathway increased 1,700 at the end of December 2022.

At week commencing 13 February 2023, the PTL size was **1,269**, demonstrating significant improvements. The focus nationally, and through the Tier 1 meetings remains on long waiting patients rather than PTL volume.

Colorectal and Skin continue to demonstrate good progress in reducing PTL volume and delivery of their respective cancer recovery backlog trajectories. During January 2023, Gynae-oncology has demonstrated good reductions in PTL volume; this can be attributed to improved histology turn-around times for diagnostic biopsies and, earlier production of clinical letters informing patients of benign diagnoses.

The Urology tumour site still requires significant attention, as delivery is significantly off-track.

Tumour site summary:

- Gynae-oncology – following the service improvement meeting on 13 January 2023, an improvement action plan has been developed. Pathways have been reviewed and in particular the PMB pathway has been revised for approval by the MDT membership and clinical director.
- Colorectal met the backlog trajectory at the end of December 2022 and in January 2023 the performance was only a small number of patients away from the trajectory.
- Skin continues to make progress, recovery has exceeded the backlog trajectory with sustain improvement through December 2022 and January 2023, with early signs of achievement of the final trajectory for 31 March 2023.
- The Urology tumour site still requires significant attention, as delivery is static but significantly off-track; and further input is required to deliver improvement by March 2023.
- Lung is now significantly off trajectory and will attend the additional Long Wait meeting with the Deputy COO and Trust Lead Cancer Manager for targeted support to improve performance from 23 February 2023. Late IHTs are a factor in regards to poor performance.

	The Subsequent Radiotherapy 31-day target of 94% has not been achieved since May 2022; a dip in achievement for the first time in the life of the Cancer Waiting Times targets. Performance is not expected to improve for the remainder of the calendar year and highly unlikely to significantly improve in Q4 2022/23. Performance for December 2022 was 44.3%, a decrease when compared to December 2022 (47.7%).
	Intervention and Planned Impact The capacity and/or pathway issues fall into 5 broad categories and remain so as follows: **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 waiting times now at 3-4 weeks compared to 10-weeks in June 2022; which has supported the improvement of the colorectal PTL. • CT backlog of reports continues to reduce which supports FDS performance and PTL volume **Histology capacity/delays** – whilst histology turn-around times remains a concern, there has been an improvement in both skin and Gynae-oncology which has resulted in PTL reductions for both tumour sites. 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 • New outsourced histopathologist capacity (Backlogs) with clinician attending the Gynae-oncology MDT commencing January 2023 • Longer to medium term related to workforce solutions through the NEY Regional Clinical Leads continues with monthly meetings however the impact is yet to be seen in the backlog • National cancer recovery funding for temporary administration support to reduce the reporting backlog agreed; post holder commenced 12 December 2022. Metrics developed to monitor improvement; good early signs from shorter turnaround times in availability of reports. Further funding from the HYN Cancer Alliance has allowed thus support to be extended into 2023/24.

Tracking capacity and decision making

- The PTL volume had reduced the ability for tracking staff to cross cover tumour sites for planned absences.
- Temporary funding has supported a floating tracker post for proof of concept for recurrent support. Post holder in post January 2023 and training underway.
- The introduction of this post is beginning to realise benefits; staff absence (planned or unplanned) s not resulting in PTL management variation.

Radiotherapy capacity/delays

- Staffing vacancies, long-term sickness and international recruitment processes continue to be a concern/risk.
- Recent recruitment drive for radiographers' – shortlisting complete; 50% of those shortlisted are 3rd year students who qualify summer 2023
- Senior radiographer vacancy – shortlist complete with one suitable applicant to interview
- Maternity leave due back to work in July and September 2023. One person will return January 2023 - requires full preceptorship as was newly qualified when maternity leave commenced
- Clinical Oncology workforce shortages remains a challenge with actions underway both regionally and nationally.

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 for May 2022. Performance will not improve for the remainder of the calendar year. December 2022 performance dipped further to 44.3%.; however, subsequent treatment with chemotherapy/drug (e.g. hormones) exceeded the standard (98%) with a 100% performance in December 2022.

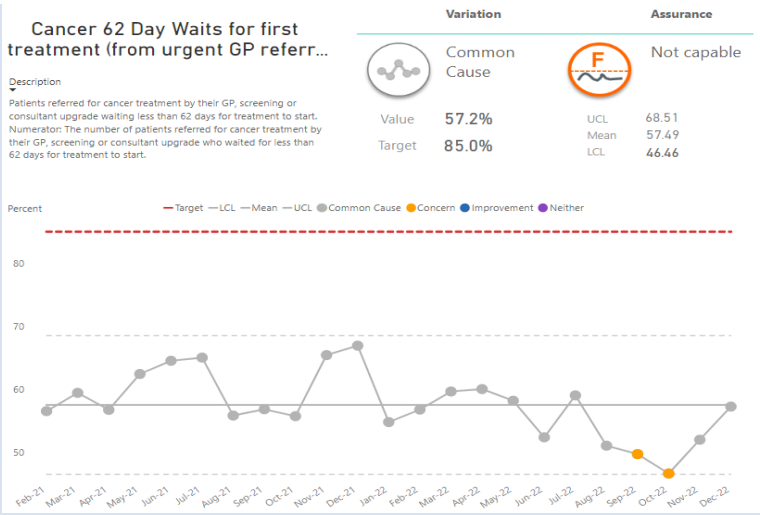
Mutual aid has been pursued across a range of providers to assist delivery improvement but without much success to date.

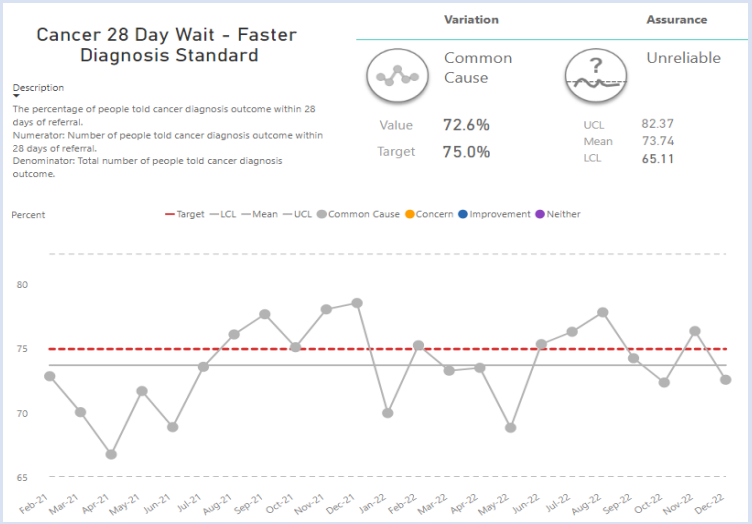
Transformation Opportunities

- Improvement in the Lower GI triage processes will shorten the pathway and lead to performance improvement – non-recurrent funding in place; will need recurrent support from the 23/24 & 24/25 growth for cancer

	• Increasing numbers of 2WW referrals received with a FIT test result will enable more patients to be effectively triaged; locally at +60% which continues to be monitored and on-going discussions with primary care planned to further improve uptake by GPs • Gynae-oncology – service improvement meeting (13.01.23) identified a programme of work that will support improvement in cancer pathways for patients and performance against Cancer Waiting Times • Urology action plan developed and agreed with the service and already gaining traction; improvement will be realised from April 2023 onwards • Upper GI – newly introduced steps at the beginning of the pathway to improve timeliness – enabling patients to have a CT scan on the same day as endoscopy if the results of the endoscopy indicates a likely cancer. This will also streamline the MDT process and improve compliance with the 62 day standard from March 2023. Results to date in this pilot are encouraging and provide patients with timely diagnosis. • Head and Neck – service improvement session in January 2023, with agreement to standardising clinical triage and test 'bundling' which will support a more efficient front end of the pathway. Work is underway to implement the new way of working These action plans form part of the overall Cancer Transformation programme of work
	Risks / Mitigations • Referral rate catch up impacts on the cancer PTL and waiting times • High profile patients and national cancer awareness media coverage result in an influx of referrals • Staff gaps (vacancies and absence) further impact on diagnostic capacity & waiting times • Histology tracking systems implemented locally to prioritise long-wait patients • Radiotherapy delivery continues to be a considerable challenge • Improvement plans fail to impact on performance metrics • Mutual aid for radiotherapy is not forthcoming • Cancer Transformation programme • Joint review (NLAG/HUTH) of late IPT referrals

11. Cancer 62 day Performance





What the chart tells us

Performance for December 2022 was 57.2%, which is higher than the previous month; performance has not been achieved for some time.

The Faster Diagnosis Standard (combined) December 2022 did not achieve the target with performance of 72.6%.

Intervention and Planned Impact

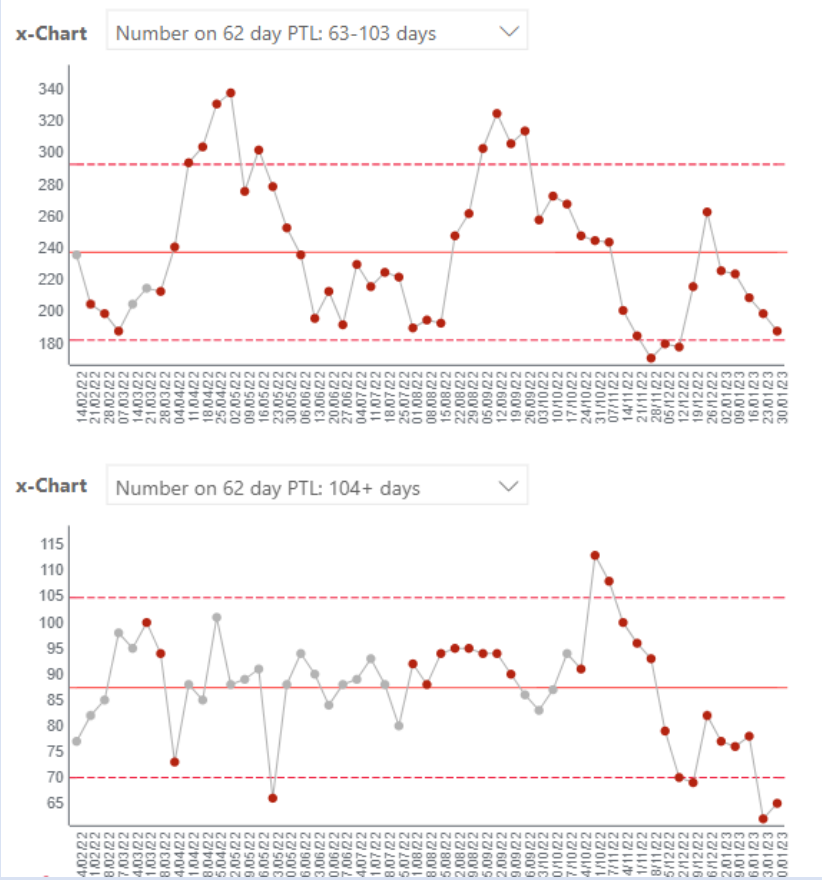
Largely the same as Section 8. Above.

- Administration processes continue to be reviewed and actions implemented
- Improved access to CT Colon internally should have a direct impact on FDS performance for colorectal; December 37.3%, November 35.8%, October 2022 at 39% which was an improvement on September 2022 30% and August 2022 at 23%.
- Radiotherapy capacity and patient prioritisation continues to adversely affect performance with no mutual aid available in the region to date
- Urology – prostate OPA capacity increased to meet weekly referral demand; key clinicians only seeing suspected prostate patients to ensure they are directed to the correct diagnostic pathway or discharged
- Head & Neck test bundling and clinical triage
- Gynae-oncology – pathway review and revisions
- FDS for tumour sites not achieving the target under review and process improvements being considered for implementation

Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times
- Staff gaps (vacancies and absence) further impact on diagnostic capacity, radiotherapy & waiting times)
- Additional internal CT Colon capacity continues through January 2023
- Mobile CT capacity continues to be provided by the IS

12. Cancer 63 day+ Performance – Lower GI, Urology, Skin



What the chart tells us

This metric has been added in response to the Elective Recovery Self-Assessment requirements.

The cancer PTL +62-day backlog is beginning to reduce in size, with Colorectal making good progress towards the planned recovery trajectory. In December 2022, there was an expected seasonal increase; patients cancel or DNA appointments, clinical and administration staff annual leave impacts on the efficient tracking of the PTL. In January 2023 the PTL reduced to 1256 demonstrating further improvement and recovered from the seasonal increase.

Skin is showing considerable improvements in the reduction of the backlog and the trajectory being met in December 2022.

Urology backlog continues to remain static. The December 2022 cancellations had a detrimental effect on the urology trajectory with worsened performance – 8 out of 10 operations in urology are for cancer.

The Gynae-oncology backlog is beginning to reduce and although still off track is heading in the right direction for both 63+ and 104+ PTL. Pathway review and revisions are being agreed for implementation in Q1 2023/24

The recovery trajectory for January and February 2023 will not be achieved; there is a renewed expectation that the 130 target at 31 March 2023 is more likely to deliver at 170, with late IHTs a factor.

The number of 104+ days, although making slow progress is reducing; in December 2022 the number was 72. Patients are constantly progressing and moving off the PTL and new patients take the place from the 63+ day's backlog. The improvement trajectory to 31 March 2023 remains a challenge, which is affected by late IHTs received at day 80+.

Intervention and Planned Impact

- Additional tracking resource for LGI, funded by the Cancer Alliance, has demonstrated benefits as the primary PTL continues to reduce; further reductions are expected to ensure the Trust backlog does not exceed 170 by 31 March 2023. The recovery

	trajectory is demonstrating good progress in this tumour site. Further funding into 23/24 has been secured to continue to support this pathway • CTC capacity and demand improvements has had a positive impact for patients waiting for diagnostic tests. Further improvements are required to reach the planned sustainable list of no more than two weeks; the deadline of November 2022 was not achieved with waiting times remaining static at ~3-4 weeks. • LGI Nurse led triage, currently in development, is intended to shave off up to 7 days at the front end of the pathway (removes a two-step triage process). Further discussions with the MDT lead clinician are on-going to agree an implementation plan; the recruitment process sits within the service and is being progressed • The front end of the Prostate cancer pathway has been identified for transformation intervention to ensure the right patient is on the right prostate pathway (there are 3 distinct treatment pathways); improvement in backlog numbers and Faster Diagnosis Standard is the expected impact • Understand reasons for and proactive actions to reduce late IHTs – reviews are in progress
	Risks / Mitigations • Urology service improvement action plan has been developed and agreed to address gaps and delays • Gynae-oncology diagnostic pathways are of concern and being addressed • Upper GI pathway 8-week pilot (endoscopy indicative of cancer are escorted to radiology to have a CT scan on the same day)

13. Elective Recovery Fund

	Target	104%	104%	104%	104%	104%	104%	104%	104%	104%	104%	
POD	DATA	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Grand Total
01 Day Case	2019-20 M10 FOT Baseline	4,044,191	4,230,361	4,014,832	4,402,456	3,913,770	4,165,038	4,412,862	4,115,086	3,670,549	4,375,557	41,344,703
	22-23 Baseline Plan	3,886,720	4,212,249	4,344,252	4,380,168	4,263,009	4,657,413	4,156,644	4,488,322	3,917,096	5,522,246	43,828,119
	Actuals	3,617,775	4,536,981	4,183,067	4,396,718	3,900,946	4,403,844	4,517,074	4,877,322	3,928,435	4,409,621	42,771,783
	Baseline 19/20 %	89%	107.2%	104%	100%	100%	106%	102%	119%	107%	101%	103%
	Plan %	93%	108%	96%	100%	92%	95%	109%	109%	100%	80%	98%
	Indicative Gain/Loss	(441,138)	103,054	5,731	(136,377)	(127,031)	54,154	(54,228)	448,224	83,298	(105,719)	(170,031)
02 Elective	2019-20 M10 FOT Baseline	5,360,427	5,489,596	5,843,159	5,773,436	5,236,041	5,704,305	6,127,880	6,099,478	5,758,620	5,476,207	56,869,150
	22-23 Baseline Plan	5,702,897	6,110,717	5,990,456	6,217,486	6,286,858	6,352,712	6,297,363	6,376,087	6,025,671	6,174,543	61,534,790
	Actuals	4,159,135	5,031,179	5,117,440	5,016,301	4,655,601	4,945,029	4,900,694	5,599,525	4,797,137	4,011,994	48,234,035
	Baseline 19/20 %	78%	92%	88%	87%	89%	87%	80%	92%	83%	73%	85%
	Plan %	73%	82.3%	85%	81%	74%	78%	78%	88%	80%	65%	78%
	Indicative Gain/Loss	(1,061,782)	(508,501)	(719,584)	(741,054)	(592,411)	(740,586)	(1,104,226)	(557,949)	(893,871)	(1,262,446)	(8,182,411)
05 Outpatient Firsts	2019-20 M10 FOT Baseline	2,640,750	2,759,378	2,662,984	2,955,371	2,380,527	2,777,070	3,014,479	2,750,214	2,435,809	2,794,632	27,171,213
	22-23 Baseline Plan	2,603,906	2,846,753	2,802,015	2,888,876	2,856,419	3,028,043	2,970,465	3,131,591	2,872,928	2,964,453	28,965,450
	Actuals	2,653,862	3,119,167	2,830,208	2,864,128	2,750,510	2,774,697	2,887,656	3,311,498	2,504,265	2,874,336	28,570,325
	Baseline 19/20 %	100%	113%	106%	97%	116%	100%	96%	120%	103%	103%	105%
	Plan %	102%	109.6%	101%	99%	96%	92%	97%	106%	87%	97%	99%
	Indicative Gain/Loss	(69,388)	187,060	45,528	(157,094)	206,071	(85,092)	(185,551)	338,457	(21,732)	(24,061)	234,198
06 Outpatient Followups	2019-20 M10 FOT Baseline	2,555,279	2,764,825	2,600,678	2,932,571	2,407,671	2,748,114	3,033,729	2,795,192	2,439,755	2,956,278	27,234,094
	22-23 Baseline Plan	2,718,188	3,011,828	2,950,842	3,000,947	3,029,555	3,187,902	3,036,939	3,200,108	2,976,863	3,034,242	30,147,413
	Actuals	2,863,690	3,203,441	3,011,158	2,948,237	3,019,800	3,059,024	3,044,088	3,499,676	2,787,892	3,388,638	30,825,643
	Baseline 19/20 %	112%	116%	116%	101%	125%	111%	100%	125%	114%	115%	113%
	Plan %	105%	106%	102%	98%	100%	96%	100%	109%	94%	112%	102%
	Indicative Gain/Loss	-	-	-	-	-	-	-	-	-	-	-
Outpatient Procedures	2019-20 M10 FOT Baseline	1,205,211	1,312,244	1,183,512	1,406,665	1,212,842	1,278,148	1,416,215	1,310,520	1,161,571	1,359,926	12,846,854
	22-23 Baseline Plan	977,002	1,079,583	1,045,209	1,048,279	1,054,034	1,129,927	1,135,024	1,180,063	1,074,673	1,113,951	10,837,744
	Actuals	1,018,405	1,213,055	1,077,196	1,096,219	1,118,283	1,181,536	1,157,743	1,303,535	1,038,506	1,168,273	11,372,749
	Baseline 19/20 %	85%	92%	91%	78%	92%	92%	82%	99%	89%	86%	89%
	Plan %	104%	112%	103%	105%	106%	105%	102%	110%	97%	105%	105%
	Indicative Gain/Loss	(176,261)	(113,759)	(115,243)	(275,035)	(107,305)	(110,804)	(236,340)	(44,554)	(127,146)	(184,538)	(1,490,984)
	2019-20 M10 FOT Baseline	15,805,858	16,556,404	16,305,166	17,470,500	15,150,851	16,672,676	18,005,165	17,070,490	15,466,304	16,962,600	165,466,014
	22-23 Baseline Plan	15,888,713	17,261,130	17,132,773	17,535,756	17,489,875	18,355,997	17,596,435	18,376,171	16,867,230	18,809,435	175,313,517
	Actuals	14,312,867	17,103,822	16,219,069	16,321,602	15,445,140	16,364,130	16,507,255	18,591,555	15,056,234	15,852,861	161,774,535
	Baseline 19/20 %	91%	103%	99%	93%	102%	98%	92%	109%	97%	93%	98%
	Plan %	90%	99%	95%	93%	88%	89%	94%	101%	89%	84%	92%
	Inicative Gain/Loss	(1,748,569)	(332,146)	(783,567)	(1,309,560)	(620,675)	(882,328)	(1,580,345)	184,177	(959,451)	(1,576,764)	(10,384,503)

31/01/2023		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
		*Actual activity for current month is projected using working days; actual activity is based on data submitted to SUS									
		Plan activity is from health group submissions with corporate adjustments for a small number of specialties									
t (% of baseline):		104%	104%	104%	104%	104%	104%	104%	104%	104%	104%
vity (% of baseline):		75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
New	Baseline	17,637	17,096	16,632	18,386	14,792	17,746	18,482	17,249	15,263	16,653
	Plan	14,229	16,146	15,726	16,348	16,183	17,259	17,044	18,072	16,388	17,022
	Actual*	14,276	16,994	15,526	15,573	15,412	15,955	16,466	18,424	14,129	15,863
	Plan %	100%	105%	99%	95%	95%	92%	97%	102%	86%	93%
	19/20 Baseline %	81%	99%	93%	85%	104%	90%	89%	107%	93%	95%
Follow Up	Baseline	33,158	37,048	34,967	38,951	32,800	35,396	40,453	36,572	31,595	38,860
	Plan	30,529	35,206	34,395	34,371	34,910	37,462	35,973	37,893	34,517	35,376
	Actual*	34,128	38,202	36,070	35,654	36,728	37,087	37,131	41,702	33,721	35,029
(minimise)	Plan %	112%	109%	105%	104%	105%	99%	103%	110%	98%	99%
(minimise)	19/20 Baseline %	103%	103%	103%	92%	112%	105%	92%	114%	107%	90%
Day Case	Baseline	6,080	6,198	5,817	6,488	5,948	6,167	6,688	6,244	5,702	6,600
	Plan	5,800	6,369	6,594	6,741	6,505	7,118	6,175	6,775	5,888	7,268
	Actual*	5,596	6,820	6,273	6,633	6,183	6,590	6,697	7,098	5,906	6,347
	Plan %	96%	107%	95%	98%	95%	93%	108%	105%	100%	87%
	19/20 Baseline %	92%	110%	108%	102%	104%	107%	100%	114%	104%	96%
Ord Elect	Baseline	1,203	1,276	1,296	1,341	1,177	1,275	1,403	1,383	1,244	1,300
	Plan	1,175	1,266	1,244	1,296	1,314	1,326	1,316	1,338	1,259	1,294
	Actual*	888	1,049	1,072	1,067	973	1059	1,008	1,209	1,022	830
	Plan %	76%	83%	86%	82%	74%	80%	77%	90%	81%	64%
	19/20 Baseline %	74%	82%	83%	80%	83%	83%	72%	87%	82%	64%

What the chart tells us

Recovery of elective activity in January 2023 against the operational plan delivered:

- New Activity 93%
- Follow up Activity 99%
- Day Case Activity 87%
- Ordinary Elective Activity 64%

The indicative activity requirement of 110% of 19/20 baseline was not delivered in any POD.

Overall financial position delivered 84% of the plan and 93% of baseline in January 2023.

Intervention and Planned Impact

Access to HOB and ICU capacity remain the limiting factor in relation to IP elective recovery; as is the use of C9A – now vacated by oncology for orthopaedics, however Surgery HG do not have sufficient staffing to open this capacity.

Further affected by NCTR patients in the CHH bed base during December 2022 and January 2023.

Additional funding to support HOB expansion at HRI and 8 beds on C15 provided however, physical space and workforce is limiting the delivery respectively.

Day case delivered 104% of plan (activity) in December 2022 (104% of 19/20). The December 2022 theatre sessions were reduced by bank holidays and actual delivery further reduced due to the NCTR patients in the CHH bed base. Anaesthetic shortfalls continue which has affected the cardiac surgery theatre provision (also impacted by ICU capacity issues).

OP 1st attendances (activity) achieved 86% of the plan in December 2022 and 93% of 19/20 baseline.

OPFU (activity) continue to over-perform at 98% of the plan and 107% of the 19/20 baseline, 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 Health Group speciality level. Many procedures are counted/coded in the HUTH follow-ups – work is underway to understand if this activity should be excluded from the reduction in follow up rates.

Risks / Mitigations

- On-going anaesthetic staff shortfalls – rolling recruitment in place and development of Anaesthetic Assistant roles
- 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

14. Non-Elective Activity

31/01/2023		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
		*Actual activity for current month is projected using calendar days; actual activity is based on data submitted to SUS									
		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Non-elective	Baseline	4,735	4,952	4,603	4,765	4,531	4,537	4,850	4,745	4,790	4,772
	Plan	3,934	5,059	4,897	5,249	5,439	5,447	5,818	5,631	5,818	5,818
	Actual*	3,678	5,028	4,715	5,139	4,766	4,674	4,995	5,152	5,115	5,009
	Plan %	93%	99%	96%	98%	88%	86%	86%	91%	88%	86%
	19/20 Baseline %	78%	102%	102%	108%	105%	103%	103%	109%	107%	105%

What the chart tells us

Non-elective activity in January 2023 was higher than the baseline of 19/20.

Intervention and Planned Impact

-

Risks / Mitigations

-

Agenda Item	7.1	**Meeting**	Performance and Finance Committee	**Meeting Date**	27.2.23
Title	Finance Report – 2022/23 - Month 10				
Lead Director	Lee Bond, Chief Finance Officer				
Author	Stephen Evans, Operational Finance Director				
Report previously considered by (date)					

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

Key Recommendations to be considered:

a) The reported position of a surplus of £0.1m at month 10, which is £0.2m away from plan.

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 initially reported uncovered risk of £1.2m in the year-end forecast. This is now covered by additional income from the ICB.

d) The underlying position of £55m deficit.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE COMMITTEE: MONDAY 27th FEBRUARY 2023

FINANCIAL UPDATE 2022/23 – MONTH 10

1. Purpose of Paper

To update the Performance and Finance Committee on the financial position at month 10 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 10

The table in appendix 1 shows the month 10 reported position against the revised NHSI plan, at health group level. The Trust is reporting a surplus of £0.1m, which is £0.2m worse than the plan. This is £0.3m improvement from month 9.

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 to be confirmed but ICBs have been told to assume no clawback. ICBs may still enact clawbacks and redistribution within systems but HNY ICB has not said that it is expecting to do this.

The Trust position includes the receipt of capacity funding for additional NCTR beds in the period Months 7 - 10 (£1.5m).

The Trust has received an additional £1.2m from NHSE specialist commissioning and £1.0m has been included in the position at month 10.

Additional income for lung health check, virtual ward and community diagnostics has also been included in the position.

Education income is also above plan (£0.7m), which is being utilised to pay for additional accommodation costs for Junior Doctors, clinical nurse educators and additional medical posts in Medicine health group.

The Trust has received and additional £0.7m of income from the ICB to offset the shortfall in the cost of the 2022/23 pay award. The pay award has now been fully funded for 2022/23, although £1m of this has only been provided non-recurrently.

The Trust is £0.9m above plan on interest receivable, an increase of £0.2m in month. This reflects the high cash balances the Trust holds and the increased level of interest rates in year

The Trust plan assumed receipt of Salix grant income but this will not 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 £5.4m at month 10. This is an increase of £1.2m in month.

The CRES position is £0.1m short of plan at month 10, a slight deterioration in month, within the Surgery health group. The year-end forecast is for 100% delivery of the CRES plan in 2022/23. Over delivery in Estates, Facilities and Development due to a non-recurrent rates rebate is offsetting shortfalls in the Health Groups. £4.7m of this is non-recurrent, unchanged from previous month. Health Groups need to continue focusing on identifying recurrent schemes. The breakdown by Health Group is as per the following table:

	YEAR TO DATE				YEAR-END FORECAST				RECURRENT		
	YTD CRES Plan £'k	YTD CRES Actual £'k	YTD CRES Variance £'k	% Achieved YTD	Annual CRES Target £'k	Forecast CRES Achievement £'k	Forecast CRES Variance £'k	% Achieved Forecast	Recurring CRES achievement £'k	Recurring CRES Variance £'k	% Achieved Recurring
Medicine	1,521	1,521	0	100%	1,825	1,764	-61	97%	**622**	-1,203	34%
Emergency Medicine	326	243	-83	75%	397	297	-100	75%	167	-230	42%
Surgery	2,500	2,205	-295	88%	3,070	2,767	-303	90%	2,563	-507	83%
Family & Womens Health	1,525	1,284	-241	84%	1,814	1,533	-281	85%	873	-941	48%
Clinical Support Services	1,791	1,653	-138	92%	2,150	2,052	-98	95%	1,346	-804	63%
Corporate	1,440	1,440	0	100%	1,709	1,709	0	100%	1,039	-670	61%
Estates, Facilities & Development	717	1,238	521	173%	865	1,680	815	194%	**552**	-313	64%
Energy	4,291	4,291	0	100%	5,149	5,149	0	100%	5,149	0	100%
Central	298	298	0	100%	357	357	0	100%	357	0	100%
TOTAL	**14,409**	**14,173**	**-236**	98%	**17,336**	**17,308**	**-28**	100%	**12,668**	**-4,668**	73%

Excluding CRES the overall HG position deteriorated by £1.1m.

Surgery Health Group overspent by £0.3m in month, excluding CRES, mainly in non-pay and reflecting increased levels of inflation in year.

High cost drugs within the block contract increased by £0.2m to £1.0m overspent.

Corporate position deteriorated by £0.3m in month due to pressures on clinical admin pay expenditure (£0.1m), cost of posts in supporting Acute Collaborative (£0.1m) and Interim Clinical Plan (£0.1m) and legal fees (£0.1m). These have been offset by vacancies in other corporate areas.

Estates, Facilities and Development overspent by £0.3m with the main area being the costs of security cover at CHH.

Other health groups remained close to plan in month.

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 10 was £8.7m with year-end forecast of £10.5m. This would be £1.0m above the revised target but is £0.5m 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. At reporting stage, this included two major risks.

a) £1.2m of uncovered risk within Health Group expenditure plans.
b) Shortfall on delivery of ERF target of 104% activity value is not clawed-back in year.

Since the position was finalised the Trust has been notified of £1.2m of additional income to be received from the ICB to cover depreciation and the cost of the additional beds on the 13th floor. This removes the remaining risk to delivering the financial position and the Trust expects to deliver its financial plan.

6. Underlying Position

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 (£4.7m) and additional in-year pressures has moved this to a position of £55m. Further update on this is given in the financial planning paper later on the agenda.

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

The SOFP and SOCF for month 10 are reported in appendices 2 and 3.

Capital

The reported capital position at month 10 shows gross capital expenditure of £16.8m against a plan of £25.1m. The main areas of expenditure relate to the Digestive Disease Scheme; Theatres; Day Surgery Scheme and PFI lifecycle costs. The main variance from plan relates to the Salix Grant scheme (£8m), which has now slipped to 2023/24.

The planned capital expenditure for 2022/23 (incl PFI/IFRIC12 impact) is £45.0m; this has changed from plan due to the slippage on the Salix Grant scheme (£10m) mentioned above. The revised total also now includes confirmed PDC schemes including NCTR ward (£3.8m); CDC (£3.4m); EPR (£2.9m); Lung Health Check (£1.2m) and early drawdown Phase 2 Day Surgery (£5.4m).

The planned capital spend is £0.7m above the Trust CDEL limit. This is to support slippage across the ICS. The Trust has brought forward planned expenditure from 23/24 into this year to offset undershoots in other Trust in the ICS.

Stocks

Stock levels are at £18.1m, a decrease of £0.6m in month but £2.3m higher than year-end. Pharmacy stock levels increased in the run up to Christmas but has fallen since and will reduce by £1.5m next month.

Health Group	Mar 22 £000	Dec 22 £000	Jan 23 £000	Change from March 22 £000
Clinical Support	7,178	9,099	9,045	1,867
Surgery	4,489	4,823	4,873	384
Medicine	2,326	2,935	2,316	(10)
F & WH	1,096	1,154	1,126	31
Other	434	441	441	7
PPE Stock	345	345	345	0
Total	15,867	18,797	18,146	2,279

All health groups have been tasked with reviewing stock levels and confirming that the levels held represent the appropriate level of risk compared to expected delivery times. Pharmacy currently holding 18 days of stock and are looking at ability to reduce this to closer to 15 days.

Debtors

The Trust currently has £3.7m of debt that is over 90 days, an increase of £0.3m from month 9. The main debtors are as follows:

Debtors over 90 Days	December 22	January 23	Change
	£	£	£
Northern Lincolnshire And Goole Nhs Ft	736,419	874,044	137,625
Humber Teaching Nhs Foundation Trust	255,911	253,006	-2,905
York & Scarborough Teaching Hospitals Nhs Ft	58,837	74,251	15,414
Harthill Pcn	14,330	65,330	51,000
Astrazeneca Ltd	61,225	61,225	0
Crawford & Company Adjusters (Uk) Ltd	60,720	60,720	0
East Riding Fertility Services Ltd	59,154	60,549	1,395
Nhs Humber And North Yorkshire Icb	26,287	55,623	29,336
Ge Healthcare	51,962	51,962	0
University Of Hull	51,574	46,015	-5,559
Other	2,088,783	2,136,262	47,479
Total	3,465,203	3,738,988	273,784

£286k of the NLAG debt relates to a recharge for the running of the ICS. It is expected that this will be paid shortly and other debts are being chased. A small credit note relating to Radiology services has been agreed and this should allow a large element of invoices to be cleared. £154k of the Humber FT value relates to the running of the ICS and this invoice was paid at the beginning of February 23.

Cash

The Trust's liquidity position remains healthy with a cash balance of £56.1m at the end of January. 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 95.2% by volume and 83.4 by value of non-NHS invoices within best practice terms. In January, the figures were 94.4% and 76.7% respectively

Recommendations

The Trust Board is asked to note the following:

e) The reported position of a surplus of £0.1m at month 10, which is £0.2m away from plan.

f) 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.

g) The initially reported uncovered risk of £1.2m in the year-end forecast. This is now covered by additional income from the ICB.

h) The underlying deficit of £55m

Stephen Evans
Operational Finance Director
February 2023

APPENDIX 1

Financial Year 2022/23 Month 10

	Annual Budget £000	Budget £000	Actual £000	Variance £000	Month 9 £000	Change In Month £000	Month 10 Forecast £000	Month 9 Forecast £000	Change In Month £000
Nhs Contract Income	651,689	543,265	546,736	3,471	2,708	763	4,470	3,941	529
ERF Income	19,589	16,324	16,324	0	0	0	0	0	0
Nhs Other Clinical Income	209	174	186	12	11	1	14	14	0
Education + Training Income	21,556	17,914	18,605	691	576	115	875	874	1
Other Income	2,320	1,933	1,862	(71)	(67)	(4)	(85)	(90)	5
Donated/Grant Income	10,460	8,360	28	(8,332)	(7,349)	(983)	(9,728)	(9,728)	0
Total Income	**705,823**	**587,970**	**583,741**	**(4,229)**	**(4,630)**	**(108)**	**(4,454)**	**(4,989)**	**535**
Surgery	(151,345)	(126,783)	(129,174)	(2,391)	(1,986)	(405)	(3,410)	(3,462)	52
Medicine	(94,553)	(78,805)	(79,720)	(915)	(903)	(12)	(1,389)	(1,623)	234
Clinical Support Services	(105,243)	(88,096)	(87,607)	489	483	6	573	408	165
Pass through drugs	(68,284)	(56,903)	(57,945)	(1,042)	(836)	(206)	(1,135)	(855)	(280)
Family + Womens Health	(91,946)	(77,002)	(77,933)	(931)	(838)	(93)	(1,206)	(1,085)	(121)
Corporate Directorates	(80,459)	(67,204)	(67,395)	(191)	92	(283)	33	353	(320)
Reserves	2,110	2,797	3,019	222	(171)	393	(852)	(948)	96
Pay Award	11,200	9,333	9,333	0	0	0	0	0	0
Other Operating Expenditure	(6,802)	(5,653)	(5,381)	272	214	58	309	258	51
Emergency Care Health Group	(19,169)	(15,934)	(15,949)	(15)	(2)	(13)	(100)	(129)	29
Estates Facilities & Developmt	(55,637)	(45,794)	(46,501)	(707)	(420)	(287)	(493)	(517)	24
Unaddressed Risk	0	0	0	0	0	0	1,249	1,837	(588)
Total Operating Expenditure	**(660,128)**	**(550,044)**	**(555,253)**	**(5,209)**	**(3,858)**	**(842)**	**(6,421)**	**(5,763)**	**(658)**
Donated Asset Income	(10,460)	(8,360)	(28)	8,332	6260	2,072	9,728	0	9,728
EBITDA	**35,235**	**29,566**	**28,460**	**(1,106)**	**(2,228)**	**1,122**	**(1,147)**	**(10,752)**	**9,605**
Depreciation	(22,161)	(18,474)	(18,474)	0	(65)	65	0	0	0
Interest Payable	(6,236)	(5,134)	(5,328)	(194)	(182)	(12)	(163)	(163)	0
Interest Receivable	217	180	1,072	892	711	181	1,070	947	123
Pdc Dividends	(8,195)	(6,829)	(6,829)	0	0	0	0	0	0
Total Non Operating Expenditure	**(36,375)**	**(30,257)**	**(29,559)**	**698**	**464**	**234**	**907**	**784**	**123**
Net Surplus/Deficit	**9,320**	**7,669**	**(1,071)**	**(8,740)**	**(8,024)**	**(716)**	**(9,968)**	**(9,968)**	**0**
Donated Asset Adjustment (NEW)	(9,320)	(7,410)	1,122	8,532	7,528	1,004	9,968	9,968	0
Adjusted Financial Performance before Profit/Loss Adjustment	**0**	**259**	**51**	**(208)**	**(496)**	**288**	**0**	**0**	**0**
Profit/Loss Disposal Assets Adjustment	0	0	0	0	0	0	0	0	0
Adjusted Financial Performance Surplus/Deficit	**0**	**259**	**51**	**(208)**	**(496)**	**288**	**0**	**0**	**0**

APPENDIX 2

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF FINANCIAL POSITION

	Accounts 31/03/2022 2021/22 £000	Actual 31/09/2022 YTD £000	Actual 30/12/2022 YTD £000	Actual 31/01/2023 YTD £000	Movement from 31/03/22 £000	Forecast 31/03/2023 £000
Non-current assets						
Intangible assets	8,790	9,213	8,884	8,847	57	8,671
Property, plant and equipment: on-SoFP IFRIC 12	63,165	62,369	61,986	61,853	(1,312)	64,368
Property, plant and equipment: other	322,078	317,919	320,594	320,962	(1,116)	355,691
Right of use assets - leased assets for lessee (exc	0	8,408	8,067	7,888	7,888	7,519
Investment property	100	100	100	100	0	100
Investments in joint ventures and associates	0	0	0	0	0	0
Other investments / financial assets	536	536	536	536	0	536
Receivables: due from NHS and DHSC group bodi	1,338	1,398	1,338	1,398	60	1,469
Receivables: due from non-NHS/DHSC group bod	1,953	1,887	1,946	1,887	(66)	2,253
Other assets	0	0	0	0	0	0
Total non-current assets	**397,960**	**401,830**	**403,451**	**403,471**	**5,511**	**440,607**
Current assets						
Inventories	15,867	16,347	18,795	18,146	2,279	15,897
Receivables: due from NHS and DHSC group bodi	17,732	13,618	19,859	12,685	(5,047)	12,124
Receivables: due from non-NHS/DHSC group bod	15,227	16,254	8,712	16,546	1,319	9,134
Other investments / financial assets	0	0	0	0	0	0
Other assets	0	0	0	0	0	0
Non-current assets for sale and assets in disposal	0	0	0	0	0	0
Cash and cash equivalents: GBS/NLF	79,415	72,272	61,455	56,048	(23,367)	55,000
Cash and cash equivalents: commercial / in hand	13	10	22	16	3	20
Total current assets	**128,254**	**118,501**	**108,843**	**103,441**	**(24,813)**	**92,175**
Current liabilities						
Trade and other payables: capital	(32,732)	(7,842)	(3,245)	(2,673)	30,059	(33,353)
Trade and other payables: non-capital	(108,479)	(115,806)	(107,311)	(114,292)	(5,813)	(94,220)
Borrowings	(2,989)	(5,115)	(5,425)	(5,479)	(2,490)	(5,434)
Other financial liabilities	0	0	0	0	0	0
Provisions	(3,997)	(3,949)	(490)	(462)	3,535	(215)
Other liabilities: deferred income including contr	(3,277)	(10,728)	(20,415)	(6,817)	(3,540)	(6,532)
Liabilities in disposal groups	0	0	0	0	0	0
Total current liabilities	**(151,474)**	**(143,440)**	**(136,886)**	**(129,723)**	**21,751**	**(139,754)**
Total assets less current liabilities	**374,740**	**376,892**	**375,408**	**377,189**	**2,449**	**393,028**
Non-current liabilities						
Trade and other payables	0	0	0	0	0	0
Borrowings	(51,377)	(54,370)	(53,390)	(53,041)	(1,664)	(51,702)
Other financial liabilities	0				0	
Provisions	(2,924)	(2,924)	(2,924)	(2,924)	0	(2,650)
Other liabilities	0	0	0	0	0	0
Total non-current liabilities	**(54,301)**	**(57,294)**	**(56,314)**	**(55,965)**	**(1,664)**	**(54,352)**
Total assets employed	**320,439**	**319,598**	**319,094**	**321,224**	**785**	**338,676**
Financed by						
Taxpayers' equity						
Public dividend capital	330,863	330,863	330,863	332,718	1,855	349,747
Revaluation reserve	26,537	26,538	26,537	26,538	1	26,537
Financial assets at FV through OCI reserve	536	536	536	536	0	536
Other reserves	0	0	0	0	0	0
Merger reserve	0	0	0	0	0	0
Income and expenditure reserve	(37,497)	(38,339)	(38,842)	(38,568)	(1,071)	(38,144)
Others' equity						
Non-controlling Interest	0	0	0	0	0	0
Charitable fund reserves	0	0	0	0	0	0
Total taxpayers' and others' equity	**320,439**	**319,598**	**319,094**	**321,224**	**785**	**338,676**

APPENDIX 3

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF CASH FLOWS

	Accounts 31/03/2022 £000	Actual 31/01/2023 YTD £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	14,669	9,996
Operating surplus/(deficit) of discontinued operations		
Operating surplus/(deficit)	**14,669**	**9,996**
Non-cash or non-operating income and expense:		
Depreciation and amortisation	18,210	18,473
Impairments and reversals	15,919	0
Income recognised in respect of capital donations (cash and non-cash)	(17,454)	(27)
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)	3,734
(Increase)/decrease in other assets	0	0
(Increase)/decrease in inventories	(885)	(2,280)
Increase/(decrease) in trade and other payables	38,392	(26,594)
Increase/(decrease) in other liabilities	2,547	3,540
Increase/(decrease) in provisions	1,031	(3,535)
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**	**3,308**
Cash flows from investing activities		
Interest received	41	1,072
Purchase of financial assets / investments		
Proceeds from sales / settlements of financial assets / investments		
Purchase of intangible assets	(3,062)	(1,198)
Proceeds from sales of intangible assets		
Purchase of property, plant and equipment and investment property	(71,910)	(15,642)
Proceeds from sales of property, plant and equipment and investment property	136	0
Receipt of cash donations to purchase capital assets	12,249	27
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)**	**(15,741)**
Cash flows from financing activities		
Public dividend capital received	38,616	1,855
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)	(1,754)
Capital element of PFI, LIFT and other service concession payments	(1,583)	(1,382)
Interest on DHSC loans	(395)	(184)
Interest on other loans		
Other interest (e.g. overdrafts)		
Interest element of finance lease	(4)	(48)
Interest element of PFI, LIFT and other service concession obligations	(5,520)	(4,992)
PDC dividend (paid)/refunded	(7,450)	(3,795)
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**	**(10,930)**
Increase/(decrease) in cash and cash equivalents	**20,500**	**(23,364)**
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**	**56,064**

Report to the Board in Public
Charitable Funds Committee February 2023

Item: Financial Report including Fund Balances	Level of assurance gained: Reasonable

The Committee agreed reasonable assurance. The committee received a comprehensive update on the charities funds including the balance sheet.

It was noted that there had not been a lot of changes since the previous committee, it was acknowledged that the £2m donation had now been received.

The lack of activity on the balances supported the previous discussions to transfer remaining balances to the WISHH Charity to manage.

Item: General Purpose Funds	Level of assurance gained: Reasonable

The Committee agreed reasonable assurance.

The paper shared with the committee provided the background in relation to WISHH Charity and the proposed actions to be taken in transferring to the balances. The committee was in agreement of the proposal the Board would be requested to endorse.

Item: Project Director's Report	Level of assurance gained: Reasonable

The Committee agreed reasonable assurance.

The committee received a comprehensive overview of the funding proposals, investment management arrangements and the development of working arrangements to provide a better understand the charity's purpose and the needs of the Trust.

The Project Director of Fundraising also provided an update on existing benefactor funded developments, which are

- Allam Diabetes Centre – Hull Royal Infirmary
- Endoscopy/Digestive Diseases Development – Castle Hill Hospital
- Twin Robotic Theatre – Castle Hill Hospital
- Molecular Imaging Research Centre And Radiopharmacy
- PET/CT Scanning Capacity
- Hospital Arts Strategy

Report to the Board in Public
Performance and Finance Committee
February 2023

Item: ED Performance Presentation	Level of assurance gained: Limited
Following the CQC Inspection the ED performance presentation was received for assurance. Lodged patients and over-crowding in the department were the key concerns, compounded by patients with no criteria to reside. Work was ongoing with YAS to improve handover times and a re-organisation of the ground floor was being developed with Acute Medicine and ED. The Committee discussed the issues outside of the Trust's control and that meetings are taking place with Community Partners in relation to next year's plan.	
Item: Financial Report Month 10	Level of assurance gained: Good
The Trust is currently reporting a surplus of £100k which is £200k away from plan. The full CRES plan would be delivered by the end of March 2023.	
Item: Medicine Health Group Bed Base	Level of assurance gained: Reasonable
The plan for 2022/23 had expected 470 beds and none of these had been delivered by the Community. The Trust was expecting to end the year with 100 extra beds. There would be additional funding for wards 1 and 5.	
Item: Financial Planning 2023/24	Level of assurance gained: Reasonable
The Trust was forecasting a deficit of £73.2m but with a target to get closer to £55m through inflation funding, growth funding and bed capacity funding. Included in the plan is a 2.2% efficiency target of £17.9m.	
Item: Capital Planning 2023/24	Level of assurance gained: Reasonable
The ICS capital funding was £78m and the Trust had been allocated £19.6m. The plan included medical equipment replacement, IT equipment and the theatre replacement programme.	
Item: Scan4Safety	Level of assurance gained: Good
An example of a product recall was shared which highlighted how quickly products can be flagged and quarantined, staff can be informed and affected patients contacted. RFID (wireless ID) programme was expected to be completed by the end of April 2023.	
The following reports were also shared: • Day Surgery Full Business Case – PAF approved release to NHS IE • Capital Resource Allocation Committee minutes – for assurance The following contracts were approved; • Contract recommendation paper – NCTR Ward – Modular Building • Contract recommendation paper – Keymed Scopes Maintenance Contract • Contract recommendation paper – SBS Software and Hardward adhoc purchases • Contract recommendation paper – CT/MRI for CDC • Contract recommendation paper – Supply of recombinant factor IX blood clotting factors products	