Hull University Teaching Hospitals
NHS Trust

TRUST BOARD

TRUST BOARD

9 May 2023

09:00 GMT+1 Europe/London

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

1 - Trust Board Agenda May 2023.pdf

Trust Board in Public
Tuesday 9 May 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 and 30 March and 24 April 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	09.20	Attached
	6.2 CQC Update Suzanne Rostron, Director of Quality Governance	Assurance	09.30	Attached
	6.3 Audit Committee Annual Report Tracey Zepherin, Audit Chair	Assurance	09.40	Attached
	6.4 Audit Committee Summary April 2023 Tracey Zepherin, Audit Chair	Assurance	09.50	Attached
	6.5 Trust Self-Certification Rebecca Thompson, Head of Corporate Affairs	Approval	10.05	Attached
	6.6 Fit and Proper Persons Rebecca Thompson, Head of Corporate Affairs	Approval	10.10	Attached
	6.7 Statement of Elimination of Mixed Sex Accommodation Jo Ledger, Interim Chief Nurse	Approval	10.15	Attached

	6.8 Board Assurance Framework – Q4 Suzanne Rostron, Director of Quality Governance	Approval	10.20	Attached
	6.9 Updated Code of Governance for Boards/Division of Responsibilities Rebecca Thompson, Head of Corporate Affairs	Information/Approval	10.25	Attached
	6.10 Standing Orders Rebecca Thompson, Head of Corporate Affairs	Approval	10.30	Attached
	Break		10.35	
	Strategy			
7	**7.1 Digital Strategy Update** Shauna McMahon, Group Chief Information Officer	Assurance	10.45	Attached
	7.2 Research and Innovation Annual Report Thozhukat Sathyapalan, Director of Research and Innovation	Information/Assurance	10.55	Attached
	Quality			
8	**8.1 Quality Report** Jo Ledger, Acting Chief Nurse/Makani Purva, Chief Medical Officer/Suzanne Rostron, Director of Quality Governance	Assurance	11.05	Attached
	8.2 Maternity Update Lorraine Cooper, Head of Midwifery	Assurance	11.15	Attached
	8.3 Learning from Deaths Report Makani Purva, Chief Medical Officer	Assurance	11.30	Attached
	8.4 Summary from the Quality Committee Una Macleod, Non-Executive Director	Assurance	11.40	Attached
	Workforce			
9	**9.1 Our People Report** Simon Nearney, Director of Workforce and OD	Assurance	11.45	Attached
	9.2 Summary from the Workforce, Education and Culture Committee	Assurance	11.50	Attached
	Performance			
10	**Performance Report** Ellen Ryabov, Chief Operating Officer **10.1 Finance Report** Lee Bond, Chief Financial Officer	Assurance Assurance	11.55 12.15	Attached Attached
	10.2 Summary from the Performance and Finance Committee Mike Robson, Chair of Performance and Finance	Assurance	12.30	Attached
11	**Questions from the public relating to today's agenda** Sean Lyons, Chair			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 11 July 2023, 9am – 12pm			

Attendance 2023/24

Name	09/05	21/06	11/07	12/09	14/11	13/02	12/03			Total
Sean Lyons										
S Hall										
T Zepherin										
T Curry										
U MacLeod										
M Robson										
L Jackson										
A Pathak										
D Hughes										
C Long										
L Bond										
M Purva										
J Ledger										
S Nearney										
E Ryabov										
M Cady										
S Rostron										
S McMahon										
R Thompson										

Attendance 2022/23

Name	10/5	16/06	12/07	03/08	13/09	11/10	08/11	14/2	14/03	30/03	Total
Sean Lyons	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
S Hall	✓	✓	✓	✓	✓	✓	✓	x	x	x	7/10
T Zepherin	✓	✓	✓	x	x	✓	✓	✓	x	x	6/10
T Curry	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	9/10
U MacLeod	x	✓	✓	✓	✓	✓	✓	✓	✓	x	8/10
M Robson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
L Jackson	x	x	x	✓	x	✓	✓	✓	✓	✓	6/10
A Pathak	x	✓	✓	✓	✓	x	✓	✓	✓	x	7/10
D Hughes	✓	✓	x	✓	✓	✓	✓	✓	-	-	7/8
C Long	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	9/10
L Bond	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	9/10
M Purva	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	9/10
J Ledger	✓	✓	✓	✓	x	✓	✓	✓	x	✓	8/10
S Nearney	✓	✓	✓	✓	✓	✓	✓	x	x	✓	8/10
E Ryabov	✓	✓	x	✓	✓	x	✓	✓	x	✓	7/10
M Cady	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	9/10
S Rostron	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	9/10
S McMahon	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	9/10
R Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10

APOLOGIES AND WELCOME

Verbal

DECLARATIONS OF INTEREST

Verbal

MINUTES OF THE MEETINGS

Minutes of the meeting held 14 and 30 March and 24 April 2023

REFERENCES

Only PDFs are attached

- 4 - Draft Minutes March 2023.pdf
- 4.1 - Draft Trust Board minutes 30 March 2023.pdf
- 4.1.1 - Draft Board Minutes 24 April 2023.pdf

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board
Held on 14 March 2023

Present:	Mr S Lyons	Chairman
	Mr M Robson	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Prof M Purva	Chief Medical Officer
	Mrs J Mizon	Deputy Chief Operating Officer
	Mrs M Cady	Director of Strategy and Planning
	Mrs S Rostron	Director of Quality Governance
In Attendance:	Mrs L Cooper	Head of Midwifery
	Mr M Howell	Director of Communications
	Mrs F Moverley	Head of Freedom to Speak Up
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies** Apologies were received from Mrs E Ryabov, Chief Operating Officer, Mrs J Ledger, Interim Chief Nurse, Mr S Nearney, Director of Workforce and OD, Mr S Hall, Vice Chair and Mrs T Christmas, Non-Executive Director	
2	**Chair's Opening Remarks** Mr Lyons welcomed everyone to the Board.	
3	**Declaration of Interests** **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 meeting held 14 February 2023** Mr Bond advised that in item 6.1 it mentioned a new ward block. This should be referred to as a step down facility rather than a ward. Mr Long added that discussions were ongoing with PLACE regarding an Urgent Treatment Centre on the hospital site. Mr Mizon advised that Item 10 paragraph 2 should read, "the trajectory reduces to 130 by March 2023. Following these changed the minutes were approved as an accurate record. **4.2 Board Work Programme** Mrs Thompson presented the work programme and advised that she was working with NLAG to ensure appropriate items were listed and mandatory items were aligned.	

4.3 Board Development Programme 2022/23
Mrs Thompson presented the Board Development Programme and advised there were no changes from last month.

4.4 Matters Arising
Mrs Cooper advised that the CQC inspection of maternity services was commencing 15/3/23.

4.5 Action Tracker
Mrs Rostron advised that Mrs McMahon had emailed her and the Human Factors Hub would ensure the points were covered.

Mrs Rostron also advised that the CQC Report would evolve as action plans were developed and implemented.

Mr Bond advised that only 4% of Trusts have used their full levy funding which equates to £4b of levy contribution lost nationally since 2019. The Trust itself was losing £500k and he suggested the Workforce, Education and Culture Committee took this as an action to review.

Action: Apprentice Levy to be discussed at the Workforce, Education and Culture Committee

5 Patient Story
Prof Purva presented a patient that had been treated in the TAVI Service and had received excellent care both before and after their procedure. Prof Purva advised that the procedure outcomes were as good as open hear surgery for some patients and patients on the cardiac waiting list were being considered for TAVI instead.

The Board discussed the ICS taking over the commissioning of the service in 2024 and the ICB would review the activity required.

Mr Lyons added that he had attended a presentation with NHS England regarding their re-organisation and how they are merging with NHS Digital. He agreed to circulate the slides.

Action: Mr Lyons to circulate the NHS England re-organisation slides.

6 CEO Report/Covid Update
Mr Long reported that the vast majority of Junior Doctors had gone on strike and the remaining doctors and consultants had been very responsive. The Emergency Department had not seen a reduction in patients and Mr Long thanked the doctors that had stepped up for their efforts. He added that some other hospitals had been hit very hard by the strike, so the situation at HUTH was as good as could be hoped for.

Mr Lyons asked about impact of having a consultant at the front door and Mr Long advised that some consultants were very good at turning patients around. He added that the availability of senior decision makers gets quicker and better decisions.
Mr Robson asked if the Trust would take a financial risk to increase

the skill levels and capacity and Mr Long advised that year on year investment had taken place which had increased the number of consultants from 7 to 20.

Ms Mizon advised that she was presenting to the ICB regarding ED and the updated governance and work streams, she suggested giving the same presentation to the Performance and Finance Committee in March.

Action: Performance and Finance Committee to receive ED presentation regarding updated governance and work streams.

6.2 CQC Update
Mrs Rostron advised that the CQC was not available yet but would be in the next week. She suggested a Board bitesize session once it had been received.

Senior Responsible Officers and Operational Leads had been appointed and work-streams agreed. Meetings with Surgery, Emergency Medicine and Medicine Health Groups were in the diary to discuss their improvement plans.

Once the report had been received, improvement plans linked to the Quality Strategy and Quality Improvement Programmes would be implemented and monitored through the relevant Board Committees.

Mrs Rostron advised that regarding the ED action plan 37 actions had been completed with evidence, and the actions remaining included the mental health area adjacent the ED which would open in April. Other actions included anti-ligature assessment which had now been completed and the digital work-stream work which had agreed timescales.

The Safety Oversight Group was meeting every 2 weeks to sign off actions plans and would carry on until the work-streams became business as usual. Mrs Rostron added that the assurance visits were ongoing and the findings were presented at the Quality Committee.

Dr Pathak asked about the mental health connections and Mrs Rostron advised that the Trust had seen good improvements and was working well with Humber Mental Health Trust.

There was also much work ongoing regarding Sepsis and a task and finish group had been established. Priority training was being rolled out in the Emergency Department.

The Board discussed the Quality Improvement Group and the importance of system partners being involved. Mr Long advised that he had discussed this with the PLACE directors.

Mr Curry expressed his concerns regarding his recent assurance visit to the Emergency Department. He stated that he felt there was a disconnect between the front and back doors which had led to issues with NEWS scores and that patients had been cohorted in the Atrium for 5 or 6 hours. Prof Purva explained that all Emergency Departments

are highly stressed areas and staff who choose to work in ED learn to cope with the pressures faced. She added that it was difficult to form a view of a department in a short space of time without speaking to the clinicians making the clinical decisions, so it is difficult to second guess what is going on.

6.3 Audit Committee Summary
Mr Robson presented the summary and advised that the item with limited assurance was a self-assessment undertaken by the Trust relating to processes and policies in Financial Management. Action plans were in place to address this.

Performance management also had management actions and plans in place to address.

6.4 Board Assurance Framework
Mrs Rostron presented the Q3 Board Assurance Framework and advised that the Quality Committee had reviewed risks 3.1 and 3.2 in light of the CQC investigation and although quality improvements were on track, results were not yet being seen.

BAF Risk 3.1 was reviewed and it was suggested that the current rating be uplifted to a rating of 16. It was also requested that the target risk rating be changed to 12.

BAF Risk 3.2 had been reviewed and the target risk rating proposal was an increase to 12.

Mr Bond advised that the in-year financial plan would be met and the current risk could be reduced to a risk rating of 4.

Resolved: The Board approved the 4 suggested risk rating changes detailed above.

7 **7.1 Operating Plan Update**
Mrs Cady presented the update and advised that it was still work in progress and a check and challenge review would be held before the final plan was presented to the Board for sign off. She added that a virtual Extra Ordinary Board would be required towards the end of the month to approve the plan.

Mr Lyons asked for clarity regarding the workforce numbers and Mrs Cady agreed to check them and report back to him.

Mr Bond advised that a further draft of the Income and Expenditure position had been submitted and the finance teams were working through the key assumptions of how much elective work was required. He added that the workforce element was the most challenging part.

8 **8.1 Quality Report**
Mrs Rostron presented the report and advised that the Quality Committee had reviewed it in detail.

She reported that there had been a Serious Incident reported in Emergency Medicine but a Business Case for a flat lift was being

developed. Mr Lyons asked why the equipment had not been in place and was the process of the business case getting in the way. He added that it might be an opportunity to use Charitable Funds.

There was a discussion around the SHMI/Stroke Peer Group and Prof Purva advised that the group was selected nationally.

8.2 Maternity Update
Mrs Cooper presented 4 reports the first relating to avoiding term admissions to neonatal units. 52 cases were reviewed the current position was 2.3% which was very positive. Other Trusts had asked that the team share their knowledge and learning.

The CNST standard relating to growth assessment in Q3 showed 1211 births, with 35 babies showing growth restrictions. Mrs Cooper added that there were only 5 true missed cases.

The Perinatal Surveillance Tool highlighted the midwifery staffing challenges with maternity leave being an issue. Mrs Cooper added that 22 students had been appointed from the University and the service had funding for 10 international recruits.

Mrs Cooper advised that the Trust was achieving all 5 MBRRACE standards and a team had carried out the 15 steps in maternity last week, with positive feedback. Medical workforce capacity was still an issue.

There was a discussion around the detail in the reports but Mrs Cooper advised that the specific reports were required by the regulators, but internal and external challenge was also received. Prof Purva added that post Ockenden the Trust was required to deliver a level of detail. Mrs Cooper added that since 2022 over 1000 recommendations had been presented and worked through.

Action: Mrs Cooper, Mrs Rostron and Mrs Ledger to review how the reports are presented to the Board.

Mr Lyons asked about the cultural work and Mrs Cooper advised that the teams were working with Trans2 Performance and an improvement in behaviours was being seen. Mr Long suggested using some case studies as part of the Staff Survey improvement plan.

8.3 Patient Safety Incident Response Plan
Mrs Rostron presented the report and advised that the PSIRF launch would take place on 1 April 2023 and that the ICB had signed the plan off at their Quality Committee.

Mrs Rostron spoke of South West London's plan and the support received by their ICB. She added that HUTHs plan was still to stop working to the Serious Incident process and move to PSIRF in April 2023. She added that the work is transformational and it would take 6-12 months to see the benefits.

Mr Robson asked if the new approach could allow some incidents to be missed and Mrs Rostron advised that all incidents would still be

recorded but would be reviewed within the new process, which would enhance learning and involve the families more.

Mr Lyons asked if it would be possible to have a Board Bitesize on PSIRF and whether risks around the new process should be on the risk register. Mrs Rostron advised that she was presenting to the ICB at the end of April so would work a Bitesize session around that presentation. She added that the progress would be included in the Quality Report and monitored by the Quality Committee.

Action: A Bitesize Board to be set up following the presentation to the ICB.

Resolved: The Board approved the Patient Safety Incident Response Plan.

8.4 Summary from the Quality Committee
Prof Macleod highlighted deep dives into VTE and Tissue Viability, the CQC Report and Hospital Mortality as issues discussed by the Committee.

9 **9.1 Our People Report**
Mr Howell advised that agreed rates had been paid to the consultants and SA Doctors during the Junior Doctors Strike. The Head of HR had confirmed this and was writing to them today.

9.2 Staff Survey 2022/23
Mr Howell advised that the survey was now live and would be benchmarked against Trusts in the Country. An action plan would be developed and approved by the Executive Team and reported to the Board.

Mr Howell advised that the Trust's position had deteriorated against the 10 themes and highlighted staff engagement and morale as the key issues.

All areas had seen a deterioration and the Trust was behind the national average. Mr Howell advised that the scores had declined in the last 2 years and was certain that this was due to the relentless pressures following the pandemic. A review of Trust values and behaviours would be carried out as well as health and wellbeing and this would form the revised People Strategy.

The Board discussed the current work loads for staff and whether there were particular areas of discontent. Mr Howell advised that a number of specialities and divisions had been highlighted. He added that the larger NHS Organisations were also struggling with their scores.

Mr Long advised that the relentless pressure and absence of hope in staff was the main issue. He stated that a plan was required so staff could do their jobs properly. The new step-down facility and plans for the 13th Floor would help as well as the new Day Surgery Unit at Castle Hill Hospital. Mr Lyons added that it was important to draw on what good looks like and have a robust action plan.

The Board also discussed the uptake and how this could be increased in the future as Prof Macleod stated usually disgruntled staff completed the survey and added that not all medical staff would have the time to complete it.

9.3 Gender Pay Gap Report
Mr Howell presented the report and advised that it was driven by what doctors get paid and there was a lot of male doctors working in the medical and dental services.

Prof Macleod advised that it would be useful to see what the gap was in non-medical areas.

Resolved: The Board approved the report.

9.4 Freedom to Speak Up
Ms Moverley presented the report and advised that the Freedom to Speak Up Champion network is now live. The network spans a number of roles including a junior doctor, consultants and nursing staff.

The Trust's Internal Auditors had reviewed the process and had given substantial assurance, with some minor actions to complete.

Concerns were increasing with an increase in nursing staff contacting the role for the first time.

Since the Board Bitesize discussion Ms Moverley had developed an improvement plan for the Board to approve.

Resolved: The Board thanked Ms Moverley for her hard work and approved the improvement/action plan.

9.5 Guardian of Safe Working Report
Prof Purva presented the report which was received for information.

The Board discussed Prof Loubani attending the Board to present the report and it was agreed that a video link could be set up due to clinical responsibilities.

Mr Curry asked about e-Rostering and Prof Purva advised that a Task and Finish Group was progressing the actions and significant progress was being made.

10 Performance Report
Ms Mizon clarified the number of patients with No Criterial to Reside and this was 193.

The number of 12 hour trolley waits had reduced in January 2023 following implementation of a Task and Finish Group.
C9A was still not open and the VRE infection was still causing delays in the system.

Over 63 day Cancer performance continued to improve and although

the 130 trajectory would not be achieved 170 would.

Ms Mizon was working with the Cancer Alliance Director reviewing the 104 day cohort of late into hospital transfers and how the Trust engages with the District Hospitals to improve the backlog.

Elective recovery 104 week was still good despite the ophthalmology issue and 78 week was hitting trajectory although there were still risks in gynaecology.

Mr Bond asked about the MRI backlog relating to the over 6 week cohort and Ms Mizon agreed to share the updated figures with him once received.

Mr Bond asked about the Theatre Utilisation and Ms Mizon reminded him that the Trust had Paused elective work in January so the figures would be reduced. She added that the Trust should see improvements when the new Day Surgery Unit opens at Castle Hill Hospital.

10.1 Finance Report Month 10
Mr Bond advised that he had the Month 11 figures which were showing the Trust with a £500k surplus which was an improved position on Month 10.

There was no risk to the year end as funding had been received for Capital charged and the 13th Floor beds. CRES was still forecasting 100% achievement although £4.5m was non-recurrent.

Mr Bond added that the Health Group forecasts were consistent and there had been very few shocks throughout the year.

Mr Lyons asked if the surplus as a percentage of turnover was at an acceptable limit and Mr Bond advised that compared to other Trusts in the ICB HUTH was not the worst but there were risks around staffing, activity and CRES in the coming year as the Trust would not be investing money to increase staffing in services.

10.2 Summary from the Charitable Funds Committee
Mr Curry advised that a paper would be presented to a future Board to officially transfer the charitable funds from the Hospital funds to the WISHH Charity.

10.3 Summary from the Performance and Finance Committee
Mr Robson presented the summary and advised that ED performance had been separated out and had been given limited assurance, although lots of work was being carried out to address the issues.

Patients with no criteria to reside had been stable and targets had been set for improvements. All other items had received reasonable assurance, including the financial planning and underlying financial position.

11 Questions from the public relating to today's agenda
There were no members of the public present.

12 Chairman's Summary of the meeting

13 Any Other Business

Mr Lyons stated that it was Michelle Cady's last meeting and thanked her for her hard work and insightful and professional views on behalf of the Board.

14 Date and time of the next meeting:

Tuesday 9 May 2023, 9am -11am

Hull University Teaching Hospital NHS Trust
Minutes of the Extra Ordinary Trust Board
Held 30 March 2023

Present:	Mr S Lyons	Chair
	Mr M Robson	Non-Executive Director
	Mr T Curry	Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Chief Financial Officer
	Mrs J Ledger	Interim Chief Nurse
	Prof M Purva	Chief Medical Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr S Nearney	Director of Workforce and OD
	Mr I McConnell	Director of Strategic Development
In Attendance:	Mrs J Railton	Deputy Director of Strategy and Planning
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies** Apologies were received by Prof U Macleod, Non-Executive Director and Mrs T Christmas, Non-Executive Director, Mrs S Rostron, Director of Quality Governance, Dr A Pathak, Associate Non-Executive Director	
2	**Operational Plan 2023/24** Mrs Railton presented the plan which highlighted improvement trajectories for; increased day case activity, reduced length of stay, ambulance handover times and the 60 bedded step down unit. The plan aimed to reduce over-crowding in ED. The impact of a Urgent Treatment Centre at HRI was being considered but this was not included in the plan. The ED plan included improved patient flow by utilising staff more efficiently and mental health streaming to reduce lodged patients. A review of the Northumbria triage process was taking place and the Paragon Suite and 13th Floor discharge to assess unit were key to improved flow. The improvement trajectories for ED waiting times was 76% by February 2024 and category 2 handovers would be 100% by March 2024. Mrs Railton advised that there were fewer attendances to ED compared to 2019/20 and this acknowledged the work ongoing in the Community. Mr Lyons asked about the big improvement step in the June and July ambulance handover figures and Mrs Railton advised that it assumed the Paragon Suite impact. Mrs Ryabov added that the summer months also see a natural reduction in ambulances attending ED.	

Mrs Railton discussed Outpatients and Follow Ups and the shifts in reported figures due to coding changes.

There would be further confirm and challenge meetings with the Health Groups as the ICB wanted a further submission at the end of April 2023.

The Outpatient Transformation programme was ongoing to reduce DNAs and maximise PIFUs and SMS messaging.

The Trust could not make reductions in the shared care arrangements as the LNC had withdrawn GP involvement. This would increase the follow ups for patients with chronic illnesses. Mr Robson agreed to review this further at the Performance and Finance Committee.

Mrs Railton explained that the follow up figures in the plan were based on trends, forecasted outturn and the impact of Bank Holidays. The aim was to reduce follow ups and create new capacity.

Also included in the plan was the 52 week reduction, theatre utilisation, waiting list and diagnostics.

The Cancer waiting times for the 62 day pathway had been stretched to 170 for April 2023 and 148 by March 2024. Mrs Railton advised that the faster diagnosis standard was being achieved and further improvements were in the plan for 2023/24.

Work with the Independent Sector was included in the plan.

Key risks to delivery of the plan were; NCTR, ICU acuity, Independent Sector reliance and insufficient staff in some specialities.

Financial Plan 2023/24
Mr Bond presented the financial plan which was now showing a deficit of £28.5m deficit for 2023/24.

The plan was getting adverse attention both regionally and nationally as it was higher than neighbouring teaching trusts. Mr Bond advised that HUTHs costs were higher due to waiting list issues.

All non-recurrent funding had been removed, inflation was significant, there were cost pressures due to big contracts and the Trust's CNST bill had increased by £2.7m.

Mr Bond advised that the Trust had been asked to find a further £10m in efficiency savings on top of the planned amount of £28.4m.

The phasing of the plan would not be in equal 12th but would start from month 7 onwards. This would give time to review the cost base and length of stay impact, particularly in the Medicine Health Group.

Mr Bond stated that there would be a reliance on system flow and working closely with partners.

NHS England were anxious about the proposed growth in workforce to staff extra wards, the discharge to assess unit and the Paragon Suite, although minimum staffing levels were being sought.

There were a number of other investments including Obstetric and Gynae Consultant recruitment, CPE/VRE testing, transfer of oncology beds from NLAG and TAVI increased activity to sustain the service.

Elective activity will be paid/lost at 100% of tariff in 2023/24 and the Trust had £19m to support ERF delivery.

The plan was still working progress and a further submission would be required at the end of April 2023. Mr Bond advised that due to the risks within the plan it was likely that NHS England would commission a firm of consultants to check the submission and offer advice.

Mr Robson advised that the Performance and Finance Committee discussed the plan in detail at its meeting this week and the outcome was to recommend approval, noting the risks. Mr Bond added that cash flow could be an issue in 2023/24 so this would be monitored closely at the Performance and Finance Committee.

Mrs McMahon stated that transformation was key and the way the Trust managed care and services needed to change, particularly with the use of technology.

Mr McConnell suggested not limiting future discussions to 2023/24 but reviewing 24/25 and how the Trust could work differently.

Mr Long added that wider system changes and radically changing how elderly patients are managed was key.

Mr Lyons thanked the Board, Mrs Railton and Mr Bond for their hard work in submitting the 2023/24 plans.

Resolved: The Board approved the 2023/24 Operational and Financial plan.

3 Any Other Urgent Business

Mr Long expressed his concerns regarding the next Junior Doctors strike due to the length and dates it was taking place. As it was over the Easter holidays a number of consultants would be taking leave and cover would be more difficult than last time.

He advised that there would be a need for standing down elective activity and a catch up period would be required afterwards. Prof Purva added that it was acceptable to declare a major incident if necessary.

Mr Lyons thanked Mr Long for raising the issue and agreed that whatever needed to be done to keep patients safe would be agreed.

4 Date and time of the next meeting:

Tuesday 9 May 2023, 9am – 1pm

Hull University Teaching Hospitals NHS Trust
Minutes of the Extra-Ordinary Trust Board
Held on 24 April 2023

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice-Chair
	Mr T Curry	Non-Executive Director
	Mrs T Zepherin	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Mr L Bond	Joint Chief Financial Officer
	Mrs J Ledger	Interim Chief Nurse
	Prof M Purva	Chief Medical Officer
	Mrs S Rostron	Director of Quality Governance
	Mr S Nearney	Director of Workforce and OD
	Mr I McConnell	Director of Strategy
In Attendance:	Mrs J Mizon	Deputy Chief Operating Officer
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Welcome and apologies** Apologies were received from Mr C Long, Chief Executive Officer, Mrs E Ryabov, Chief Operating Officer and Prof U Macleod, Non-Executive Director. Mr Lyons welcomed Board members to the meeting to sign off the Financial and Capital 2023/24 plans.	
2	**Updated Financial Plan 2023/24** Mr Bond presented both the Revenue and the Capital plans for 2023/24. He advised that he would spend the time on the Revenue part of the plan and that Performance and Finance would have change to review the Capital part that afternoon. The Board was asked to approve both the Revenue and Capital Plan. Mr Bond advised that the financial position at 17 April 2023 was a £32m deficit, within an overall Humber and North Yorkshire (HNY) ICB deficit of £118m. Subsequent to the Board agreement, the ICB allocated the Trust another £3.6m of income, reducing the reported deficit to £28.4m. The £28.4m includes a £10m 'stretch savings target' that does not yet have detailed plans to support it. The Trust was visited by a Financial Director working with the Centre to review the Trust's plan. The ICB and NHSE will review the revised planned deficit of £60m and it is expected there may be some additional income to follow, currently forecasted at £27m. This would reduce the ICB deficit to £33m. HUTH's share of the £27m Provider reduction is £11.7m. This would reduce the planned deficit to £16.7m. There may be further reductions if the Trust received a share of the additional £27m. Mr Bond expressed his concern regarding the £54m efficiency target which equated to 6.9%.	

There was a number of actions in place to deliver the reduction of the of the additional £11.7m, the biggest item being the Paragon Suite which would be run by CHCP at no extra cost.

Mr Bond advised that there was a large amount of risk in the plan and it relied heavily on partnership working, reducing length of stay in medicine and the opening and staffing of the 13th Floor discharge to assess unit. He added that there was a lot of non-recurrent funds which meant that the underlying position remained challenged and it was important to focus on the opportunities which included the re-focus on outpatients, theatre utilisation and flow through the hospital.

Mr Robson asked about the governance around the new Paragon Suite and how it would be run. Mr Bond was keen to ensure that this was CHCP and Executive led. Ms Mizon added that there was ongoing work through the Operational Planning Group as well as confirm and challenge meetings with the Health Groups looking at outpatients, data quality and good clinical discharge.

Mrs Ledger advised that the Project Group working to ensure the Paragon Suite was managed efficiently included herself as Chair and the CEO of CHCP. Dr Pathak expressed his concern regarding the Communities abilities to provide the staff, funding and how they would be held to account.

Mr Nearney suggested that a vacancy gap monitoring process be put into place but Mr Bond was nervous regarding clinical posts due to the large vacancy gaps currently being carried by the Health Groups. A review of non-clinical staff would be reviewed.

Mr McConnell advised that oversight of the increase of efficiencies from 2 – 6.9% was important and would require a change in behaviour and more radical thinking.

There was a discussion around achieving 106% of activity and not having the workforce to achieve it. Mr Bond was also concerned about the future overtime rates.

Mr Lyons thanked the Board and wanted oversight of progress against the plan regularly reviewed by the Board. He added that there would be opportunities through the Group model but it was the priority to ensure patients were being cared for safely.

Resolved: The Board approved the Financial and Capital Plan for 2023/24.

3 Any Other Urgent Business

There was no other business discussed.

4 Date and time of the next meeting:

Tuesday 9 May 2023, 9am – 1pm

BOARD WORK PROGRAMME

REFERENCES

Only PDFs are attached

4.2 - Trust Board Work Programme 2023.xlsx

BOARD DEVELOPMENT FRAMEWORK

REFERENCES

Only PDFs are attached

4.3 - Board Development Framework 2023.pdf

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

MATTERS ARISING

Verbal

ACTION TRACKER

REFERENCES

Only PDFs are attached

4.5 - Action Tracker May 2023.pdf

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
March 2023						
03/03	Maternity Update	Maternity reports to be reviewed and presented differently to the Board	LC	May 2023		
04/03	PSIRP	Bitesize Board to be set up to review the PSIRP	RT/SR	July 2023		
COMPLETED						
01/03	Patient Story	Mr Lyons to share the NHS England re-organisation slides	SL	March 2023		Completed
02/03	CEO/Covid Update	Performance and Finance Committee received ED presentation relating to updated governance and workstreams	JM	March 2023		Completed
01/02	Patient Story	Mrs McMahon to share details of the service excellence programme used in Canada	SMc	March 2023		Completed
02/02	CQC Update	CQC assurance reports to be received at the Board – format to be agreed	SR	March 2023		Completed
03/02	Our People Report	Clarity regarding the £2.6m apprentice levy and whether it is lost if not used	HK/SN	March 2023		Discussed at WECC

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

PATIENT STORY

REFERENCES

Only PDFs are attached

5 - Patient Story 1.MP4

5 - Patient Story 2.MP4

CEO REPORT/COVID UPDATE

REFERENCES

Only PDFs are attached

6.1 - Chief Exec report May 23.pdf

Hull University Teaching Hospitals NHS Trust

Trust Board

9th May 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:	CQC response, medical physics apprenticeships and excellence in RDI	

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 9th May 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 MARCH AND APRIL 2023

COMPASSIONATE CARE

Trust responds to CQC Report

Following its inspection in November 2022 the CQC published its report into services at our hospitals. The CQC inspected Emergency and Urgent Care, Medicine and Surgery and looked at the 'well-led' key question for the Trust. The overall rating for Hull University Teaching Hospitals NHS Trust was Requires Improvement, which is the same as the rating we received in 2020.

We were pleased that the CQC acknowledged the compassion and kindness, which our staff and teams demonstrate in the treatment of their patients. For 'Care' we received a rating of 'Good' from inspectors.

Inspectors rated the key domain of 'Safe' as 'Inadequate' and they highlighted a number of issues in emergency care and surgery at the Trust, which required urgent action. Many of the areas they highlighted for improvement have already been addressed.

Like many other Trusts up and down the country we have experienced a sustained period of extreme pressure on our emergency services. Despite the best efforts of our staff we have seen long delays for patients in our Emergency Department and we apologise to anyone who has not received the quality of care we always aim to provide.

We know that staff have already delivered against many of the urgent actions we set ourselves after we received the CQC feedback. Our goal now is to ensure that the improvements we are making will be sustained. We have a plan to open an intermediate care centre at Hull Royal Infirmary for patients who are medically fit to leave. This will increase capacity in our hospitals making it easier to discharge and admit patients and therefore reduce delays.

I would like to thank our staff for the amazing care and support they give to our patients, while acknowledging that they have been working in an incredibly challenging and busy environment.

HUTH launches innovative Medical Physics programme for apprentices

Our Trust has secured £250,000 funding from Health Education England to be able to offer apprenticeships with degree-level training in the highly specialised fields of Nuclear

Medicine, Radiation Protection and Diagnostic Imaging Services and Radiotherapy Engineering.

Three apprentices recruited to the project will join the Medical Physics teams on competitive salaries in September and will study for their three-year BSc (Hons) courses at the University of West of England (Bristol).

The Medical Physics department opened its doors on Saturday, April 22, to offer a "behind the scenes" glimpse of its work to showcase how it benefits patient care at both Hull Royal Infirmary and Castle Hill Hospital as they seek recruit local apprentices for the posts.

The event gave the chance for potential future Medical Physics technicians and their families to see the Queen's Centre facilities at Castle Hill Hospital and meet some of the trust's Medical Physics experts to find out more about career opportunities.

This year marks the 10th anniversary of the relaunch of the trust's apprenticeship programme and, since then, more than 900 apprentices have been recruited.

Apprenticeships are offered in more than 30 career pathways in the NHS from finance to customer service and horticulture to health care sciences. It also offers nursing apprenticeships, with the first registered nurse degree apprentices graduating last year.

The new apprenticeships with the Medical Physics team follows the success of a pilot project last year when the trust recruited two Nuclear Medicine degree apprentices and one apprentice in Radiation Physics Treatment Planning.

The trust has also recruited four degree apprentices in Radiotherapy Services, offering courses in conjunction with Sheffield Hallam University.

Project offering easier access to maternity advice shortlisted for national award

A team of midwives whose work to support those expecting a baby has been recognised by the Royal College of Midwives.

'Ask a Midwife', the online service which responds to questions and requests for help through social media, has been shortlisted in the 'Excellence in Midwifery for Public Health" category of the 2023 RCM Awards.

The service responds to over 500 contacts from people expecting a baby every month, including partners and family members, and is accessible via the 'direct message' function of the Hull Women and Children's Hospital facebook page. There are also daily posts to social media covering health promotion advice, safety alerts, and key issues or concerns which are trending within the antenatal day unit, such as winter bugs or summertime swollen ankles.

The idea for Ask a Midwife was conceived in Hull in 2020, due the amount of questions received about the COVID-19 pandemic. The service has continued to evolve ever since; not only does the team now have an Instagram account to further extend its reach, but the midwives are starting to work with local employers with high numbers of non-English speakers to promote early access to antenatal care.

The service has been so successful, in fact, that the blueprint has been taken and used to help families in other parts of the region, including York, Harrogate, Scunthorpe and Grimsby, as part of the Humber and North Yorkshire Local Maternity System.

The Ask a Midwife team will make a presentation on their service to a panel of RCM judges later this month, before finding out if their project has been successful at the RCM Awards ceremony which takes place on 19 May.

Visiting rules relaxed as hospitals 'learn to live with Covid'
Our Trust has removed the need for ward visitors to pre-book slots in advance, and now openly encourages loved ones to attend at mealtimes.

The move reflects a changing, more relaxed approach to Covid-19 as the impact from the virus reduces and a higher number of people carry the protection of vaccination.

Key changes include:

- General ward visiting no longer needs to be pre-booked and can take place any time between 11am and 7pm
- Patients can receive multiple visits during the day from different people, as long as there are no more than two people at a patient's bedside at any one time
- Visitors are actively encouraged to attend at mealtimes to help/encourage patients with eating and drinking

The ward sister or charge nurse still reserves the right to limit visiting where this is felt to be in a patient's best interests or where, for example, there is an infection outbreak on a particular ward. In these instances, visiting will still be facilitated in exceptional circumstances.

RESEARCH, DEVELOPMENT AND INNOVATION

Research into rehabilitation for people who have been hospitalised with Covid-19

A research trial has been completed by the University of Hull, Hull York Medical School and our Trust to determine rehabilitation practices for those who have shown ongoing effects of Covid-19, including fatigue, dyspnoea, joint pain, chest pain and cough, amongst others.

Researchers at the University of Hull and HUTH conducted the first randomised, wait-list controlled trial of group-based pulmonary telerehabilitation during recovery from Covid-19. Pulmonary telerehabilitation is an exercise and education programme, which is delivered remotely, primarily used by people with lung disease who experience symptoms of breathlessness.

Forty people, who were recently discharged from the hospital, were asked to complete six weeks of online pulmonary rehabilitation, consisting of twice weekly online exercises in a group of three to five people.

The exercise sessions were curated by a strength and conditioning lecturer and delivered by a physiotherapist. They included a structured warm-up, cardio, flexibility, strength-based movements, balance work and a cool down.

The results of the six-week trial showed clear improvements in exercise capacity, respiratory symptoms, quality of life, fatigue and depression. These improvements were accelerated by early telerehabilitation, highlighting the need to offer this in a timely manner.

This has shown, for the first time, that group-based telerehabilitation is feasible, safe, beneficial and well-received with people recovering from Covid-19. Another success for our RDI teams.

Hull team leads rare cancer study thanks to the late Dr Assem Allam
Groundbreaking research into one of the most aggressive forms of cancer is being spearheaded in Hull, all thanks to one of the city's most ardent supporters.

In April 2018, Dr Assem Allam donated £402,000 to a local research team seeking to improve the diagnosis of pancreatic cancer and potentially prevent some patients from undergoing unnecessary or debilitating surgery.

The research team, which includes clinical, academic and research staff from Hull University Teaching Hospitals NHS Trust, Hull York Medical School and the University of Hull, devised a project, which stands unrivalled globally in both scope and ambition.

Part one of the TEM-PAC* research project has recently produced its first set of exciting results, which were presented for the first time at the prestigious ASCO-GI meeting in San Francisco last month. The findings have been so promising, in fact, that the team has received Cancer Research UK's Early Detection and Diagnosis Primer Award, a further £98,500 research grant to support phase two and ensure vital research into this field continues in the years ahead.

The team's research project has focused on the investigation of pancreatic lesions called 'cysts', in particular being able to spot changes in cells which would support a more accurate diagnosis of cancer and enable surgeons to operate accordingly.

The most commonly used diagnosis methods are still somewhat crude, making it difficult for a clinician to determine the exact nature of a lesion or cyst and, crucially, whether it is cancerous or likely to turn that way. As a result, many patients undergo major surgery on larger cysts, only for a surgeon to find the lesion was not cancerous, yet the patient can then be left with long term effects such as significant pain or difficulty absorbing food for the rest of their life.

The team has already recruited 168 patients to the study, with an overall target of 180 people across the lifetime of the project.

The innovative nature of the TEM-PAC study has attracted support from the National Institute for Health and Research, which has placed two academic clinical fellows (ACF) in the oncology department at Castle Hill Hospital, and a clinical lecturer post will also start in September 2023. This is the first time the oncology department has ever hosted such roles.

The second phase of the project will see the team recruit more participants and team up with other cancer research units across the UK on the next stage of research.

2. MEDIA/SOCIAL MEDIA ACTIVITY

In March there were 41 articles published/broadcast about the Trust, with a target of 80% positive coverage:

- 33 positive (81%)
- 1 neutral (2%)
- 7 negative (17%)

Social media
Facebook
Total "reach" for Facebook posts on all Trust pages in February – 269,472

- Hull Women and Children's Hospital – 55,871
- Castle Hill Hospital – 74,012
- Hull Royal Infirmary – 108,944
- Hull University Teaching Hospitals NHS Trust – 30,645

Twitter @HullHospitals

- 179,000 impressions in March 2023
- 10,810 followers

Tweets with highest number of impressions related to the junior doctors strike, International Women's Day and the 20th birthday of Hull Women and Children's Hospital.

In April there were 28 articles published/broadcast about the Trust, with a target of 80% positive coverage:

- 24 positive (86%)
- 0 neutral (0%)
- 4 negative (14%)

Social media
Facebook
Total "reach" for Facebook posts on all Trust pages in April – 275,800

- Hull Women and Children's Hospital – 49,041
- Castle Hill Hospital – 75,575
- Hull Royal Infirmary – 118,577
- Hull University Teaching Hospitals NHS Trust – 32,607

Twitter @HullHospitals

- 79,600 impressions in April 2023
- 10,822 followers

Tweets with highest number of impressions related to the search for a fruit and veg seller to set up a stall outside HRI and the 'Celebration of Research' conference at Hull University.

CQC UPDATE

REFERENCES

Only PDFs are attached

6.2 - CQC Update Report - May23 Board.pdf

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	9 May 2023
Title	Care Quality Commission (CQC) Update Report				
Lead Director	Director of Quality Governance				
Author	Head of Quality Compliance and Patient Experience				
Report previously considered by (date)	A previous version was considered by the Executive Team; however, the action plans have since been slightly amended and finalised. Therefore, this is an updated report.				

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:

- Acknowledge the urgent notice under Section 31 of the Health and Social Care Act 2008, to impose additional conditions on the Trust's registration against the Maternity and Midwifery regulated activity at Hull Royal Infirmary
- Support proposed assurance visit process (Section 4)
- Receive the updates in this report and decide if any further information and/ or assurance is required

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

1. PURPOSE

The purpose of this report is to provide the Trust Board with an update against the Trust's response to CQC inspections in November (ED, Medicine and Surgery) and December 2022 (Well led and ED) and March 2023 (maternity).

2. CQC UNANNOUNCED INSPECTION

2.1 Emergency Department

As previously reported the CQC undertook an unannounced inspection in November 2022 and completed the well-led element in December 2022. Following this inspection the CQC issued a letter of intent and highlighted urgent concerns in relation to the Emergency Department. Since this, the Emergency Department have been delivering the actions that were agreed as part of their urgent response to CQC, with weekly, fortnightly and monthly reporting to the Safety Oversight Group, Quality Committee and the Trust Board. These reports continue to be shared with the CQC.

The ED action plan includes 43 actions and is reviewed at the Safety Oversight Group and was last updated at the meeting held 17 April 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	39
Implemented with ongoing monitoring	2
Not yet due but on track	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. The Chief Operating Officer is leading this work, which has now commenced with Medicine and ED. A presentation detailing the arrangements and plans was due to be presented to the Executive Management Committee but it was stood down due to the first period of Junior Doctor Strikes. Work is now progressing against this action with a full EMC dedicated to this on the 19 April 2023.

The action not yet due, ED 4.3, is on track for its completion date of the end 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 two actions that have been implemented but require further monitoring prior to being signed off as completed are:

- ED3.2: This action was not completed as stated because the staff were moved to H130 as part of opening additional capacity for patients with no criteria to reside. This is remaining under review as part of the gold command meetings. Once the intermediate discharge unit is in place, this action will be reviewed.
- ED5.4: The task and finish group was up and running from December 2022 as per the action. It was decided to keep this action under review due to the vast amount of work being undertaken. Updates continue to be provided at SOG and an update report was presented to the February 2023 Quality Committee with a further update on progress reported in the CQC update report to the March 2023 Quality Committee.

The following action has been implemented and recorded on the action plan as completed since the last report:

- ED1.2: Sepsis training and competencies. Implementation commenced as planned in November 2022. The competency sign off and training started from a 0% position. At the time of writing, this has increased to 62% and is on trajectory for 90% by the end of May 2023. Therefore, it was agreed at SOG on 17.04.23 to close this action as completed and to continue to monitor the performance against the trajectory as part of the outcome measures.

The 'Urgent ED CQC Action Plan' has now been merged with the overall Emergency Department CQC Regulatory Action Plan. This overall plan for ED includes the four remaining urgent actions and the actions to address the must do actions in the final report.

2.2 Report and other areas for improvement

As reported in the February 2023 report to Quality Committee and to the Trust Board, the draft report was received 09 February 2023 with factual accuracy check to be completed by 16 February 2023, the Trust provided its factual accuracy response to the CQC on 15 February 2023.

The Trust received the final report on 16 March 2023, this remained embargoed until it was published in the public domain on Thursday 23 March 2023. The report can be accessed via https://www.cqc.org.uk/provider/RWA

The Trust retained its overall rating of 'Requires Improvement'. Safe is rated as 'Inadequate' (due to an inadequate rating in safe for Surgery and the Emergency Department), responsive and well-led have dropped to 'Requires Improvement'; however, caring remained 'Good'.

The Trust was required to provide its action plan in response to the final report by 20 April 2023. The regulatory action plans for the Emergency Department, Medicine and Trust-wide were submitted to the CQC on 19 April 2023, ahead of the deadline of 20 April 2023. The action plans are available for Board members to view in the Team's channel and were circulated to Board members as draft action plans, for comment, on the 14 April 2023.

An extension of 14 days has been provided by the CQC for the Surgery action plan in view of the timing of the Maternity inspection and volume of actions required. The Surgery action plan will be submitted to the CQC no later than 04 May 2023.

3. MATERNITY INSPECTION

The CQC National Maternity Team undertook the Maternity Inspection on 15 March 2023 and concluded with the interviews with the key service leads on 17 March 2023 and Board Safety Champions on the 30 March 2023.

A letter of intent was received late on the 17 March 2023, under Section 31 of the Health and Social Care Act, advising of potential enforcement action in relation to concerns around the triage process within the service. The Trust was required to provide an immediate response by 5:00pm on Friday 17 March 2023, this was achieved and the service was able to provide a

plan which explained how it would keep women attending ADU between Saturday 18 and Tuesday 21 March 2023 safe. The Trust was also required to provide a detailed action plan in response to the letter of intent by Tuesday 21 March 2023. The Maternity Service action plan was submitted to the CQC within the required timescales and has been presented to the Quality Committee in both March and April 2023. The letter of intent and full action plan is available on the shared Board Team's channel.

Maternity triage is only one element of the maternity service. Feedback for the remainder of the service was provided on the 5 April 2023. This was high level feedback only and is summarised below:

- The Maternity Services staff were very welcoming and receptive to the inspectors, the CQC thanked the staff for their friendly welcome during the inspection. The CQC also thanked the Senior Management team for their responsiveness to the information requests
- The environment in the maternity areas were clean, spacious and met the needs of the women
- The CQC received positive feedback from women and one patient descried the service as excellent

Further communication was received from the CQC on the 12 April 2023 requesting clarity around some of the information submitted and the opportunity to add to this. This related to NICE red flags data, PMRT management, specialist roles, consultant job plans and training data. The Trust responded within the prescribed timeframes. No feedback has been received to date.

The Maternity urgent action plan includes 41 actions. It is reviewed at the Safety Oversight Group and Quality Committee and was last updated at the meeting held 17 April 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	26
Implemented with ongoing monitoring	4
Not yet due but on track	11
Overdue	0

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

- MAT1.7: Plan from IT / Digital teams to map and confirm full service requirements - The Maternity Service continue to meet with the Hdigital, IT and telecoms teams to progress this work. Telephone triage via one number (with a menu, narrative and re-routing when busy) has been developed and will be tested W/C 17.04.23, CDC forms have been developed and awaiting 'Go-live', developing a BI dashboard to monitor KPIs and a quote has been requested for call recording facility to be added to a designated telephone on Maple, Labour and ADU
- MAT2.5: Explore the potential to increase of the ward clerk cover for Labour Ward, ADU, Antenatal and Postnatal Wards to 24/7. Action has been completed as planned. There is a need for additional recruitment to support weekend ward clerk cover on ADU. Recruitment process commenced 29/03/2023.
- MAT5.5: Introduction of weekly audit of triage times (including medical response times) in ADU (interim until IT solution is fully functional) - implemented, weekly audit underway as planned
- MAT5.6: Assurance mechanism - Implementation of a monthly assurance MDT visit to ADU (the MDT will be external to Maternity) - Assurance visits planned monthly with the first visit scheduled for 20 April 2023

The first monthly assurance visit to Maternity took place on 20 April 2023. This was too close to the Quality Committee for a full report to be provided. However, concerns were escalated to the Quality Committee in terms of the effectiveness and embedding of some actions. The Interim Chief Nurse, as the Board Maternity Safety Champion, convened a meeting for the 26 April 2023 to agree additional actions. Weekly meetings with the service, the Interim Chief Nurse and the Director of Quality Governance have been arranged for the next 6 weeks to closely monitor the implementation of the actions. This will be supplemented by the continuation of the monthly assurance visits and the monthly maternity safety champions meeting.

The National Maternity inspection team undertook an unannounced follow up visit to the Maternity Service on Monday 24 and Tuesday 25 April 2023. Feedback from this visit wasn't received until Friday 28 April 2023. The CQC highlighted that they were not assured the service had effective systems and processes in place for managing and responding to patient risk to ensure all mothers and babies who attend the unit are cared for in a safe and effective manner and in line with national guidance. In response to this, the CQC issued an urgent notice under Section 31 of the Health and Social Care Act 2008, to impose additional conditions on the Trust's registration against the Maternity and Midwifery regulated activity at Hull Royal Infirmary. The Trust is required to submit an action plan by 4.00pm, Friday 26 May 2023 to address the issues raised in the letter and then a monthly report from 4.00pm, Friday 30 June and thereafter.

4. TRUST-WIDE ACTIONS

There were 4 Trust-wide actions in relation to regulatory breaches within the report. Whilst the Board is ultimately responsible for all regulatory breaches, these are the actions arising specifically from the Well-led inspection. It is of note that none of these actions are in relation to Regulation 17 in terms of governance, which is usually the output of a Well-led inspection.

The focus of the CQC with regards to HUTH in terms of the narrative and some service level actions was the lack of 'decisive action' being taken in a timely way as opposed to a lack of awareness of the issues raised. There was also commentary on 'ward to board' arrangements. These should still be considered and addressed but were not of sufficient concern to result in a must or should do action.

The 4 'must do' actions are:

TW1: The trust must ensure care and treatment of service users must only be provided with the consent of the relevant person. (Regulation 11 (1) (2) (3) (4)).

Lead Executive:	Makani Purva
Work-stream Lead:	Surgery Medical Director
Reporting:	Safety Oversight Group
Update:	An audit was undertaken prior to receiving the draft CQC report. This supported the CQC findings and started work focusing consent form 4, which related to adults who may lack capacity. Membership for the task and finish group has been confirmed with dates currently being confirmed to progress and monitor this work.

TW2: The trust must ensure that mandatory training compliance, including training, meets the trust target. (Regulation 12 (1) (2) (c)).

Lead Executive:	Simon Nearney

Work-stream Lead:	Head of Learning and Organisational Development
Reporting:	Workforce Transformation
Update:	WECC approved a change in the requirement for mandatory training compliance, with the exception of IG training, to be 85% as opposed to 90%. This is in line with other trusts in the system. The Trust's target was aspirational but has been used within the CQC report as a standard to measure against. It was agreed that 85% still provided assurance on safety aspects and the risks mandatory training is intended to manage. The current trust performance is 84% overall. There is focussed work required on areas of mandatory training that are more challenging such as resuscitation training and safeguarding training. This will be picked up via existing structures. This action is unlikely to require actions over and above targeting the known areas of lower compliance, as it will be monitored via the performance and accountability meetings with the Health Groups and will provide assurance to WECC on behalf of the Board.

TW3: The trust must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (Regulation 12 (2) (c)).

Lead Executive:	Simon Nearney
Work-stream Lead:	Head of Learning and Organisational Development
Reporting:	Workforce Transformation
Update:	WECC approved a change in the requirement for appraisal compliance to be 85% as opposed to 90%. As per the mandatory training, this action is unlikely to require additional actions as it will be monitored via the performance and accountability meetings with the Health Groups and will provide assurance to WECC on behalf of the Board.

TW4: The trust must ensure where responsibility for the care and treatment of service users is shared with, transferred to other persons, or working with such other persons, service users and other appropriate persons that timely care planning takes place to ensure the health, safety and welfare of the service users. (Regulation 12 (2) (i)).

Lead Executive:	Jo Ledger and Ellen Ryabov
Work-stream Lead:	Deputy Chief Operating Officer – Unplanned Care
Reporting:	In-house Delivery Group and Emergency Care Board
Update:	The Trust will continue to work towards the system wide discharge to assess model. Other work alongside this will include the development and implementation of the step down facility (Paragon Suite) and the pathway 0 reviews and actions especially those where they have failed.

In addition to the oversight and assurance processes detailed in Section 6, the Board asked the Executive team to consider further actions, particularly around strengthening governance and assurance.

In response, the following are being progressed by the Executive team:

- Increase the assurance visit programme. This was planned to recommence in Quarter 2 and continue at the one core service per month. The increase would be to bring the start date forward and take a more detailed look at specialty level rather than core service alone (for example instead of Medicine overall, review cardiology, stroke, DME, diabetes etc.). The plan would be to undertake 2 new assurance visits per month in addition to the monthly visits in ED and maternity.
- Board members were asked to redirect the time they currently use for the Board to ward visits to support these assurance visits until October 2023. After this time, the normal programme of assurance visits April to December will commence with focus on corporate areas January to March.
- Create a core inspection team for data analysis, leadership and support with rotating clinical staff. Also consider including bank staff and recently retired staff as an option. These inspection teams, like the CQC inspections, do not have patients in the inspection team but absolutely engage with patients using our services at the time of the inspection and incorporate information from complaints, PALS, surveys and PROMS where appropriate.
- Allocate a budget for the inspection programme and backfill for posts needing to prioritise the inspections and service level check and challenge. The teams need to include medical, nursing, non-registered, AHPs, governance, Board members and external representation.
- Director of Quality Governance to write the programme plan, submit the draft to the April 2023 Quality Committee and provide training for those involved in the inspections. (This was approved by Quality Committee at its meeting on the 23 April 2023)
- Introduce check and challenge meetings for Surgery and Medicine and Safety Champion meetings for ED and Maternity to look at all plans in detail – Director of Quality Governance and Interim Chief Nurse. This to ensure the hour available to the Safety Oversight Group focuses on escalation and risks, as opposed to trying to go through every service and work-stream in detail.
- Provide training to medical clinical governance leads to strengthen specialty governance and escalation.
- Additional senior nursing support to be provided in ED, particularly in majors. (site matron on a temporary basis)
- Dedicated sepsis nurse educator within the department 2-3 days per week for 3 months.

In addition to the actions above, the internal audit programme for 23/24 includes learning from incidents (Q1) and an audit to check compliance with and the process for monitoring delivery of the CQC action plan (Q3).

5. SAFETY OVERSIGHT GROUP

The Safety Oversight Group has been established since the 14 November 2022 and has been led by the Director of Quality Governance, continues to meet fortnightly. The group receives updates on the ED action plan and the assurance reports on compliance with the agreed actions and improvements. This is then reported to the Quality Committee, Board members via our internal Board Team channel, the CQC and the HUTH Quality Improvement Group that includes all providers, NHSE and CQC to support with the delivery of actions across the system and within HUTH. The Quality Committee receives a monthly assurance report from the Safety Oversight Group.

These oversight and assurance processes will remain in place and will now include updates and assurance reports following visits to Maternity and the other work-stream progress which are to address all regulatory and should do actions identified by the CQC for Medicine, Trust-wide and Surgery. It was agreed that a Safety Champions meeting will be set up for ED chaired by the Interim Chief Nurse and that check and challenge meetings would be set up for the Surgery/FWHG action plan and the Medicine action plan chaired by the Director of Quality

Governance. This is where the detailed discussion will take place with cross Health-Group matters and escalation reported to the Safety Oversight Group.

To demonstrate the importance of this and for good governance in terms of accountability, the Quality Committee approved a change in the terms of reference from May 2023 for the Chief Executive to chair the Safety Oversight Group.

In addition to these oversight and assurance processes, the following section highlights the actions that has been suggested to strengthen governance and assurance.

6. RECOMMENDATIONS

The Trust Board is recommended to:

- Acknowledge the urgent notice under Section 31 of the Health and Social Care Act 2008, to impose additional conditions on the Trust's registration against the Maternity and Midwifery regulated activity at Hull Royal Infirmary
- Support proposed assurance visit process (Section 4)
- Receive the updates in this report and decide if any further information and/ or assurance is required

Head of Quality Compliance and Patient Experience
May 2023

AUDIT COMMITTEE ANNUAL REPORT

REFERENCES

Only PDFs are attached

6.3 - Audit Committee Annual Report 202223.pdf

Agenda Item		Meeting	Trust Board	Meeting Date	09.05.23
Title	Audit Committee Annual Report				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report has not been considered at any other Board Committee				

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

Key Recommendations to be considered:

The Trust Board is asked to:

- Review the information to be added to the Trust's Annual Report relating to the Audit Committee
- Decide if any further assurance is required

Audit Committee Annual Report

1 Purpose of the Report

The purpose of the report is to inform the Trust Board of the work carried out by the Audit Committee in 2022/23. This information will form the Audit Committee section of the Trust Annual Report.

2 Audit Committee

The Audit Committee comprises of 3 Non-Executive Directors. Other individuals attend the meeting but are not members of the Committee. These are Internal Audit (RSM), External Audit (Mazars), the Chief Financial Officer, the Deputy Director of Finance and the Director of Quality Governance.

The Audit Committee provides assurance on the Trust's systems of internal control, integrated governance and risk management. A tracking system of agreed actions is in place and the internal auditors follow up recommendations to provide assurance to the Audit Committee that the issues raised have been addressed. There were 5 meetings of the Audit Committee in 2022/23 which included 1 extraordinary meeting to consider the Annual Accounts and Report. All meetings were quorate.

Members	Attendance
T Christmas (Chair)	**4/5**
M Robson	**5/5**
T Curry	**4/5**

The Committee reviewed relevant disclosure statements in particular the draft Governance Statement, financial Accounts and the Quality Accounts.

The internal audit programme for 2022/23 was informed by the Trust's own risk and assurance framework, discussion with a wide range of officers and the broader context of the NHS. It was developed around the Trust's strategic objectives and its business-critical systems and was risk based.

The Trust has RSM as its internal auditors and Mazars as its external auditors.

The Director of Audit Opinion and Annual Report 2022/23 from RSM gave an overall opinion of positive assurance with an amber/green rating. This means that the Trust has an adequate and effective framework for risk management, governance and internal control and that the internal auditors' work has identified further enhancements that can be made.

The Trust's internal auditors issued the following audits with positive assurance opinions in 2022/23:

- Quality and Safety Improvement (Substantial Assurance)
- Freedom to Speak Up (Substantial Assurance)
- Performance Management Framework – Deep Dive (Reasonable Assurance)
- Learning from Deaths and Mortality (Reasonable Assurance)

Two partial assurance opinions were also issued in 2022/23:

- Safeguarding (Partial/Minimal)
- Cyber Security (Partial/Minimal)

Minutes and other updates from the work of the Quality Committee and Remuneration

Committees were considered by the Audit Committee, as well as routine receipt of the minutes from all other Trust Board Committees, which contributed to the overall view of governance and internal control. No concerns of gaps in the Trust's internal control framework were identified through this review work.

Work to prevent or counter fraud continued and reports were received throughout the year. The Committee reviewed the Board Assurance Framework processes as well as other documents in respect of risk. These included losses and special payments, debts, the Trust's Registers of Declared Interests and for Gifts, Hospitality and Sponsorship, legal fees, credit card expenditure and Trust Board expenses. The Audit Committee also regularly reviewed the Trust's Speaking Up arrangements, including whistleblowing and the Freedom to Speak Up Guardian, as well as other ways the Trust supports staff to raise concerns.

3 Recommendations

The Trust Board is asked to:

- Review the information to be added to the Trust's Annual Report relating to the Audit Committee
- Decide if any further assurance is required

Rebecca Thompson
Head of Corporate Affairs
May 2023

AUDIT COMMITTEE SUMMARY

REFERENCES

Only PDFs are attached

6.4 - Audit Committee Summary to the Board - April 2023 - Public.pdf

Report to the Board in Public
Audit Committee April 2023

Item: Going Concern Report 2022/23	Assurance: Good
The Going Concern Report was received and accepted by the Committee and endorsed the recommendation that the Board can assume the 2022/23 statutory accounts are prepared on a 'Going Concern' basis.	
Item: Draft Annual Accounts 2022/23	Assurance: Good
The draft Annual Accounts were presented with the key points and changes in year highlighted to the Committee and discussed as necessary. The draft Accounts will be submitted to NHSE on 27 April 2023, following which the Trust's External Auditors (Mazars) will commence their audit work.	
Item: Draft Annual Governance Statement 2022/23	Assurance: Good
The draft Annual Governance Statement was presented for review and comments by the Committee. A number of suggestions relating to elective recovery, ED and cancer waiting times were made and the document updated. Any further comments are to be supplied to the Head of Corporate Affairs for inclusion. The final version will be presented to the Audit Committee on 21 June 2023.	
Item: Counter Fraud Reports (RSM)	Assurance: Good
The results of Local Proactive Exercises on Asset Disposal and Conflicts of Interest were presented and discussed. The Counter Fraud Annual Report for 2022/23 was also presented by RSM. The Counter Fraud function transferred to the in-house collaborative hosted by NLAG on 1 April 2023, and the Counter Fraud Operational Plan for 2023/24 was presented to the Committee.	
Item: Draft Head of Internal Audit Opinion 2022/23	Assurance: Good
The draft Head of Internal Audit Opinion (HOIAO) was a positive opinion (adequate and effective framework for risk management, governance and internal control, with further enhancements identified to ensure it remains so). The HOIAO will be finalised for the June Audit Committee once all reviews are complete.	
Item: External Audit Strategy Memorandum	Assurance: Good
The report set out the External Auditors responsibilities to the audit of the Trust's draft 2022/23 Accounts in order to provide their overall opinion on the financial statements and their VFM conclusion, areas of potential significant risk which must be considered, key milestones for the audit, etc. Mazars confirmed there were no issues in relation to their independence for the forthcoming audit.	
Item: Freedom to Speak Up Guardian	Assurance: Good
The Committee received its annual update from the Trust's Freedom to Speak Up Guardian. A comprehensive and positive report was received and the Committee noted increased reporting by individuals likely resulting from increased communications and growing awareness of the FTSUG role. The Internal Audit review at the end of 2022 also received 'Substantial Assurance'.	
Item: Internal Audit Reports – Learning from Deaths and Mortality, and Risk Maturity	Assurance: Good
The review of Learning from Deaths and Mortality received a positive assurance rating of 'Reasonable Assurance'. The Risk Maturity review, although only advisory, concluded that the Trust has a well-designed framework and the report gave suggestions for potential further enhancements.	
Item: Internal Audit Report – Pre CQC Maternity Review	Assurance: Reasonable
This was an advisory piece of work, resulting in 11 recommended areas for improvement agreed with management. These actions relate to the maternity Safe Standard and the maternity Well-led Standard.	

Item: Internal Audit Plan 2022/23	Assurance: Good
The plan of Internal Audit work for the year ahead was received, considered and approved by the Committee.	
Item: Risk Management Strategy	Assurance: Good
A report was received to show the progress against the Risk Management Strategy in year 1. The Risk Maturity Assessment was discussed and actions are in place for continuous improvement.	

Reports received for assurance by the Audit Committee were:

- Trust Annual Report 2022/23 status update – verbal;
- Quality Accounts 2022/23 update;
- Losses, Special Payments and Write-Offs for 2022/23;
- Single Source Waivers;
- Committee Minutes: Performance and Finance, Quality, Workforce Education and Culture and Charitable Funds;
- Six month review of the Remuneration and Quality Committees.

Items received for approval by the Audit Committee were:

- Declarations of Business Interests Policy – minor amendments - approved by the Committee;
- Audit Committee Terms of Reference – annual review – amendments approved by the Committee;
- Audit Committee Work Plan 2023/24 – refreshed – approved by the Committee;
- Policy for External Auditor Non-Audit Services – new policy - approved by the Committee;

TRUST SELF-CERTIFICATE

REFERENCES

Only PDFs are attached

6.5 - 2019-20 self assessment v1.pdf

6.5.1 - App 2 self assessment G6 and CoS7.xls

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	09.05.23
Title	2022/23 Self Assessment against Standards G6 and FT4				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report is received by the Trust Board annually				

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

Key Recommendations to be considered:

Each year, The Trust Board is required to provide two self-assessment declarations covering 2022/23; this is a requirement from NHS Improvement and mirrors the self-assessment process and standards that applied previously to NHS Foundation Trusts. With the merger of NHS regulators, these self-assessments apply the same requirements across the acute provider sector. These require Trust Board review and approval.

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

The Trust Board is asked to approve the two attached self-assessments covering 2022/23.

Hull University Teaching Hospitals NHS Trust

NHS Improvement Self-Assessments 2022/23

1. Purpose of this report

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

2. Background

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

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

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

3. Self-Assessments Requirements

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

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

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

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

3.1 Condition G6

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

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

The Trust meets all the requirements of the licence.

NHS Acts

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

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

NHS Constitution

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

The NHS Constitution consists of two rights and a number of pledges around NHS care. The Trust has published its performance data with every set of Board papers during 2022/23 against these rights and pledges and the Board holds the Trust to account during the year on delivery.

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

As reported to the Board and Performance and Finance Committee, the NHS Priorities and Operational Planning Guidance data 2022/23 show that Trust has not consistently met some of the waiting time standards that are included as rights to NHS patients in the NHS Constitution, specifically the 18-weeks Referral to Treatment standard, the ED four-hour standard, the diagnostic waiting times standard and the cancer 31- and 62 day standards.. The reasons for this have been detailed during Trust Board and Performance and Finance Committee meetings during the year.

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

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

Condition FT4

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

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

4. Recommendation

The Trust Board is recommended to review and approve the self-certification for GC6 and FT4 and to approve publication of the same by 30 June 2023.

Rebecca Thompson
Head of Corporate Affairs
May 2023

Appendix 1 - Actions to ensure compliance with the Monitor licence

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

Condition	Action	Evidence	Completed	Party responsible
G4 Fit and proper person	All those with the title of Director or equivalent shall complete the fit and proper person test and a register will be kept. This includes the Governors. This will be updated on an annual basis as part of the year end process.	Fit and Proper Persons Test updated and presented to the Trust Board May 2023 – no issues raised As a non-FT, the Trust does not have any Governors	May 2023	Director of Quality Governance/ Trust Board
G4 Fit and proper person	Term to be added to all Directors' employment contracts to state that a Director will have their employment as a Director summary terminated in the event of not being able to satisfy the fit and proper person test. This should be extended to those considered to be equivalent to a director, but not using the title.	Clause included in the updated Very Senior Manager contracts, agreed by the Remuneration Committee in April 2016; contract applicable to the most senior tier of trust management (not just Executive Directors)	April 2016	Director of Workforce and Organisational Development
G5 NHS E/I guidance	When NHS E/I releases guidance, the Trust is required to comply with that guidance or explain why it cannot comply. On the release of guidance a review will be undertaken and if there are any areas where the Trust cannot comply they will be reported to the Board. Where necessary a statement will be sent from the Board to NHS E/I to explain why the Trust is not complying with the guidance.	The Trust has applied this to NHS Improvement guidance and, before this, to Trust Development Authority guidance No issues raised with compliance to date; most recent changes have been use of the NHS Priorities and Operational Planning Guidance, which form the basis of the Trust's Integrated Performance Report, reviewed and published at each Trust Board meeting, and used on a monthly basis by Performance and Finance Committee	As per any new guidance	Director of Quality Governance/ Trust Board

Condition	Action	Evidence	Completed	Party responsible
G6 System for compliance	The Trust is required to take reasonable precautions against the risk of failure to complying with the licence and the conditions imposed under the NHS acts and required to have regard to the NHS Constitution No later than 2 months from the end of the financial year, the Trust must prepare and submit to Monitor a certificate to the effect that the Trust during the previous financial year has complied with the conditions in the licence. Trust must publish each certificate within 1 month of submission to Monitor in such a manner as would bring to the attention of anyone who may be interested.	The Trust's Annual Governance Statement identifies risks to compliance with the NHS Contracts it has in place and to NHS Constitution rights The Trust will complete and publish its annual report including annual financial statements by 30 June 2023	30 June 2023	Director of Quality Governance
G7 Registration with the CQC	Trust must at all times be registered with the CQC	The Trust has remained registered with the CQC at all times	In place	Director of Quality Governance
G7 Registration with the CQC	Trust to advise Monitor if the Trust does not maintain the CQC registration - the Trust must notify Monitor within 7 days	Not applicable – Trust has retained registration		
G8 Patient eligibility and selection criteria	Set transparent eligibility and section criteria and apply those criteria in a transparent way to persons who, having a choice of person from whom to receive health care services. Publish the criteria in such a manner as will make them accessible to those that are interested.	The Trust has the standard NHS Contract in place for all NHS services; patient choice arrangements are managed via local commissioners. The Trust provides a service to all patients referred under the NHS Contracts in place with commissioners. The Trust makes appointments available via Choose and Book at the point of choice and referral.	In place	Chief Operating Officer

Condition	Action	Evidence	Completed	Party responsible
G9 Application of Continuity of Services	Condition applies whenever the trust is subject to a contractual or other legally enforceable obligation to provide a service which is a Commissioner Requested Service	The Trust has Commissioner Requested Services included in contracts with local commissioners	In place	Chief Financial Officer
G9 Application of Continuity of Services	The Trust shall give NHS E/I not less than 28 days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to which no extension or renewal has been agreed.	The Trust would inform NHS Improvement if this were enacted – no such action taken for 22/23 contracts	If required	Chief Financial Officer
G9 Application of Continuity of Services	The Trust shall make available free of charge to any person a statement in writing setting out the description and quality of service which it is under a contractual or other legally enforceable obligation to provide as a Commissioner Requested Service (CRS).	The Trust publishes bi-monthly such statements through its Trust Board papers, and also through publications such as the Quality Accounts, all of which are available free of charge on line. The Trust has in place the NHS Standard Contract, including description of service and quality standards, in place for all NHS services provided	In place	Executive Directors
G9 Application of Continuity of Services	Within 28 days of a change to the description or quantity of services which the Trust is under a contractual obligation to provide as Commissioner Requested Services, the Trust shall provide to NHS E/I in writing a notice setting out the description and quantity of all services it is obliged to provide as CRS.	The Trust would inform NHS Improvement if this were enacted	In place	Chief Financial Officer

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

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

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

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

Condition	Action	Evidence	Completed	Party responsible
CoS3 Standards of corporate governance and financial management	Trust is required at all times to maintain, adopt and apply systems and standards of corporate governance and of risk management which reasonably would be regarded as: Suitable for a provider of the CRS provided by the Trust Providing reasonable safeguards against the risk of the Trust being able to carry on as a going concern	Audit Committee and Trust Board have oversight of governance. Audit Committee and Trust Board signed off preparation of accounts on a going concern basis Trust Board has oversight and sign-off of Annual Governance Statement, confirming adequate governance arrangements are in place Head of Internal Audit Opinion gave a positive assurance opinion for 22/23 year-end position	April 2023	Chief Executive
CoS3 Standards of corporate governance and financial management	The Trust shall have regard to: Guidance from NHS E/I Trust rating using risk rating methodology Desirability of that rating being not less than the level regarded by NHS E/I as acceptable	The Trust has regard for NHS Improvement requirements and publishes its risk rating based on this methodology with each set of Trust Board papers, including explanatory notes	Bi-monthly	Chief Financial Officer
CoS4 Undertaking from the ultimate controller	The Trust shall procure from each company or other person which the trust knows or reasonably ought to know is at any time its ultimate controller	Not applicable	N/A	N/A

Condition	Action	Evidence	Completed	Party responsible
CoS5 Risk pool levy	The Trust shall pay to NHS E/I any sums required to be paid in consequence of any requirement imposed on providers, including sums payable by way of levy imposed and any interest payable. If no date given then within 28 days	Will be managed in line with the NHS standard contract, if applicable	N/A	Chief Financial Officer
CoS6 co-operation in the event of financial stress	If NHS E/I gives notice in writing to the Trust that it is concerned about the ability of the Trust to carry on as a going concern, The Trust shall: Provide information as NHS E/I my director to commissioners and to such other persons as Monitor may direct Allow such persons as NHS E/I may appoint to enter premises Cooperate with such persons	Such information exists and can be provided to NHS Improvement if such a concern was raised The Trust has a requirement under the NHS Standard contract to allow commissioners and regulators access to the Trust if significant concerns were formally raised	April 2023 In place	Chief Financial Officer Chief Executive
CoS7 Availability of resources	The Trust will at all times act in a manner calculated to secure the required resources Trust not later than 2 months after the year end shall submit to NHS E/I a certificate as to the availability of the required resources for the period of 12 months commencing on the date of the certificated using one of the following statements: After making enquires the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Going concern review submitted and accepted by the Audit Committee April 2023 Draft annual accounts shared with Audit Committee members in April 2023 and audited accounts shared June 2023 On track for review and acceptance by Trust Board members by 30 June 2023 deadline Annual report includes annual governance statement, including use of resources and anticipated risks to service delivery and resources	June 2023	Chief Executive / Trust Board

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

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

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

	• To generate and monitor delivery of business plans. • To ensure compliance with all applicable legal requirements • To obtain and disseminate accurate, comprehensive, timely and up to date info for BoD and Committee decision making • For effective financial decision-making, management and control The Trust shall submit to NHS E/I within 3 months of the year end: • A corporate governance statement by and on behalf of its Board confirming compliance with this condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this condition in the next financial year and any action it proposed to take to manage such risks. • If required by NHS E/I a statement from the External Auditors will be included.	The Trust updated its Risk Policy in April 2022 to include a more robust 'ward to board' process for the management or organisational risk. The Risk Management Strategy was approved by the Board in January 2022. The Trust has in place a process to generate and monitor business plans, whether these are the annual operational plan for the organisation, individual business cases for capital or revenue equipment, a rolling capital programme or Trust strategies. The Trust's monitoring of quality and finance includes compliance with legal and regulatory requirements The Board and Committee timings are set in advance to receive the most current data available The Trust will have completed and published its annual report, including its annual governance statement and assessment of risks for the coming financial year by the end of June 2023, and will publish this to be available to the public, stakeholders and regulators		

FIT AND PROPER PERSONS

REFERENCES

Only PDFs are attached

6.6 - Fit and Proper Report.pdf

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	09.05.23
Title	Declarations of Interest Fit and Proper Persons 2022/23				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebeca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report is considered annually by the Trust Board				

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

Key Recommendations to be considered:

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

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

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

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

Hull University Teaching Hospitals NHS Trust

Trust Board

Declarations of Interest and Fit and Proper Persons Declarations

1. Purpose

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

2. Background

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

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

3. Procedure

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

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

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

4. Recommendation

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

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

Rebecca Thompson
Head of Corporate Affairs
May 2023

Appendix A

Fit and Proper Person Declarations for Board Members and Trust Directors
Completed May 2023

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

Appendix B

Declarations of Board Members' Interests

Any declarations of interest made by Board members in 2022/23 and currently on the Trust's Register of Business Interests

Name	Role	Declared interest
Mr Sean Lyons	Chair	• Daughter is a Student Nurse at Sheffield Hallam University since September 2021 – May have placements at nearby Trusts • Trust Board member
Mr Stuart Hall	Vice Chair/Non-Executive Director	• Associative Non-Executive Director at Northern Lincolnshire and Goole NHS Foundation Trust • Partner Lay member of Yorkshire Clinical Senate
Mrs Tracey Christmas	Non-Executive Director	• Trust Board Member
Mr Tony Curry	Non-Executive Director	• Trust Board Member
Mr Mike Robson	Non-Executive Director	• Non-Executive Director and Trustee of Hull Truck Theatre(a registered Charity, Limited Company and Group of Companies) from September 2018 to present • Trust Board member
Prof. Una Macleod	Non-Executive Director	• Is a Dean at Hull York Medical School - employed by University of Hull • Holds grants from Yorkshire Cancer Research and NIHR
Ms Linda Jackson	Associate Non-Executive Director	• Vice Chair at Northern Lincolnshire and Goole Hospital
Mr Chris Long	Chief Executive Officer	Completed Nil Return
Dr Makani Purva	Chief Medical Officer	• Has ownership in SELF 2010 Success at Medical Interviews Training and Interview Practice / Counselling • Husband has a position at Trentcliffe Healthcare 2020 Secondary Care Work • Husband works for Northern Lincolnshire and Goole Hospital • Executive Committee member – Global Network for Simulation in Healthcare
Mrs J Ledger	Interim Chief Nurse	• Partner – Chief Financial Officer • Daughter – Registered Nurse • Niece – TNA • Niece - RDNA
Mr Lee Bond	Chief Financial Officer	• In a relationship with the Interim Chief Nurse HUTH • Joint Chief Financial Officer of Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust • President of HFMA • Trustee Wishh Charity
Mr Simon Nearney	Director of Workforce and Organisational Development	• Director of Cleethorpes Town FC /LHC • Daughter Ruby Nearney is an Apprentice Nurse at HUTH • Wife Lisa Nearney is an Auxiliary Nurse at NLAG • Son

		Willian Nearney is an Accountant (York) • Son Jacob Nearney works in HR at Lincolnshire Partnership
Mrs E Ryabov	Chief Operating Officer	• Budget holder and/or Trust Board Member
Mrs S Rostron	Director of Quality Governance	• Daughter works at HUTH as a HCA
Dr A Pathak	Associate Non-Executive Director	• Ambassador for Hymers College, Hull. Trustee for Cricket Beyond Boundaries (an organisation that helps and promotes disadvantaged cricketers in the field of sports). • Medical Member of HM Tribunal Services
Mrs S McMahon	Joint Chief Information Officer	• Is in cross appointment as Joint CIO for NLaG and HUTH, decisions will be made in the best interest of both Trusts, patients and staff • Trust Board Member
Mr David Haire	Project Director – Fundraising	• Chairman of VERTUAL Ltd (Trust Nominated) • Trustee of WISHH Charity (Trust Nominated), Osprey Charity and Hull and East Yorkshire Cardiac Charity • Son Damian Haire, Son Greg Haire and Daughter-in-Law Gemma Haire all work for HUTH • Is a budget holder
Mr Duncan Taylor	Director of Estates, Facilities and Development	• Director of Taywel Egineering Ltd, Hull Profile Cutting Ltd and Taywel Holdings Ltd • Taywell Engineering undertakes steel fabrication for the NHS Direct and a large number of construction companies in Hull and Yorkshire who work for the Trust (Work is tendered)
Mr Ed James	Joint Head of Procurement	• Wife works at Nottingham University Hospitals NHS Trust
Mr I McConnell	Joint Director of Strategy	• Trust Board Member

Appendix C

Fit and Proper Persons Declarations

Detail of what declarations must be made

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

STATEMENT OF ELIMINATION OF MIXED SEX ACCOMMODATION

REFERENCES

Only PDFs are attached

6.7 - HUTH EMSA Declaration of Compliance 202223.pdf

Agenda Item		Meeting	Trust Board	Meeting Date	09.05.23
Title	Eliminating Mixed Sex Accommodation				
Lead Director	Jo Ledger, Acting Chief Nurse				
Author	Head of Corporate Affairs				
Report previously considered by (date)	The Trust Board received this report annually				

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

Key Recommendations to be considered:

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

The situation remains the same as previous years:

- The Trust has declared 1 EMSA breach during 2022/23
- There have been no complaints or PALS issues raised by patients this year regarding sharing accommodation with someone of the opposite sex

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

ELIMINATING MIXED-SEX ACCOMMODATION (EMSA)

DECLARATION OF COMPLIANCE 2022/23

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

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

The Trust is able to confirm that mixed gender accommodation has been virtually eliminated in the Trust. There has been one breach in 2022/23, but on the whole patients who are admitted to any of our hospitals will only share the room where they sleep with people of the same gender. In addition, same gender toilets and bathing facilities will be as close to their bed area as possible.

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

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

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

The Trust is required to report any breaches of the Eliminating Mixed Sex Accommodation (EMSA) standards to its commissioners. The Trust can be subject to a financial penalty of £250 for each of these breaches. In 2022/23, there was one breach of the standards, this was on ward C27 due to unavailability of beds. The patient was moved the next day as a priority.

The Trust has not received any contacts through its Patient Advice and Liaison Service (PALS) or any formal complaints relating to mixed sex accommodation concerns during 2022/23.

INFORMATION FOR PATIENTS AND SERVICE USERS

'Same gender-accommodation' means:

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

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

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

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

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

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

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

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

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

Signed:

Sean Lyons
Chairman

Chris Long
Chief Executive

May 2023

BOARD ASSURANCE FRAMEWORK ? Q4

REFERENCES

Only PDFs are attached

6.8 - BAF Q4 2022 2023SR.pdf

Agenda Item		Meeting	Trust Board	Meeting Date	09.05.22
Title	Board Assurance Framework				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The Board Assurance Framework is received quarterly at the Board Committees and the Trust Board				

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

Key Recommendations to be considered:

The Board is asked to:

- Approve the Q4 risk ratings
- Approve the proposal to carry the existing risks for the first 6 months of 2023/24
- Decide if sufficient assurance has been provided

Hull University Teaching Hospitals NHS Trust
Trust Board
Board Assurance Framework Q4 2022/23

1. Purpose of the Report

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

2. Background

The Board held a development session in April 2022 to consider progress against the Trust Strategy and consider the risks to achieving the associated strategic objectives to inform the BAF for 22/23. Inherent (risks without any controls in place), current and target risk ratings were considered and risk appetite levels were set. The Board discussed and approved these at its meeting in May 2022.

3. Current Status of the Board Assurance Framework

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

Year-end risk rating proposals 2022/23

The table below shows all risks and risk ratings and whether the target risks have been met for year-end. Appendix 1 shows the movement throughout the year in graph format. Section 5 in this report gives a brief overview of how the targets have been met and gives reasons why they have not.

Table 1

Risk	Inherent Risk (L x I)	Current Risk (L x I)				Target Risk Achieved
BAF 1 - The Trust does not make progress towards further improving a positive working culture this year	5x4=20	Q1 4x4=16	Q2 4x4=16	Q3 4x4=16	Q4 4x4=16	Target risk rating of 3x4=12 not acheived
BAF 2 - The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust	4x5=20	4x4=16	4x4=16	4x4=16	4x4=16	Target risk rating of 3x4=12 not achieved
BAF 3.1 – 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	3x4=12	4x4=16	4x4=16	Target risk of 3x4=12 not achieved
BAF Risk 3.2 – 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	4x4=16	4x4=16	4x4=16	Target risk of 3x4=12 not achieved
BAF 4 - There is a risk to access to Trust Services following the residual impact of Covid	5x5=25	4x5=20	4x5=20	4x5=20	4x5=20	Target risk rating of 4x4=16 not achieved
BAF 5 - 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	3x4=12	3x3=9	3x3=9	Target risk rating of 2x3 not achieved

BAF 6 – There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment	4x4=16	3x4=12	3x4=12	3x4=12	3x4=12	Target risk rating of 2x4=8 not achieved
BAF 7.1 - There is a risk that the Trust does not achieve its financial plan for 2022/23	5x4=20	5x4=20	5x4=20	1x4=4	1x4=4	Yes target achieved Now 1x4=4
BAF 7.2 - There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year	4x5=20	4x5=20	4x5=20	4x5=20	4x5=20	Target risk rating of 3x5=15 not achieved
BAF 7.3 - There is a risk over the next 3 years of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability	4x5=20	3x5=15	3x5=15	3x5=15	2x5=10	Yes target of 2x5=10 achieved

4. Actions Update

A number of actions have been taken in Quarter 4 and these are shown in the Appendices.

5. Risk ratings

Generally target risks are set at the beginning of the year but due to the in-year CQC inspection and outcomes and the Staff Survey results a number of target risk ratings were changed in Q3. Despite this, the Board Committees did not consider there to be sufficient assurance at the end of Q4 to confirm achievement of the target risk ratings relating to workforce and quality.

There are currently ten risks on the Board Assurance Framework, two of these risks (7.1 and 7.3) achieved the target risk rating in 2022/23. Eight risks (BAF1, 2, 3.1, 3.2, 4, 5, 6 and 7.2) did not achieve the target risk ratings. A summary of each risk rating throughout the year is included in the table.

The risks that did not achieve the target risk rating (80%) have been impacted by extreme clinical pressures, staff morale, staff absence, social care, mental health staffing capacity and patients with no criteria to reside. The sources of assurance that were used by the Committees included management reports, performance, finance and quality data, internal audit reports aligned to the BAF, the CQC inspection findings and the staff survey.

The Board should be aiming for a higher proportion of risks to achieve the target risk ratings and this should be taken into consideration when agreeing plans and target risk ratings for 2023/24.

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

BAF 1 – Honest, caring and accountable culture

The target risk rating was challenged at the Workforce, Education and Culture Committee and it was proposed that the current risk remained at 16. Due to the staff survey results and what staff are reporting, redeployment and high sickness levels, the opinion is that the risk has not been mitigated. However, there are a number of support services available for staff to help with a wide range of mental and physical challenges faced whilst at work.

The risk will be carried over to 2023/24, subject to Board approval.

BAF 2 – Valued, skilled and sufficient staff

The Workforce, Education and Culture Committee discussed the risk and highlighted the Trust's vacancy rates are in a good position but pressures in the hospital are still causing capacity issues and staff sickness.

The Committee proposed leaving the risk at its current rating, 16.

The risk will be carried over to 2023/24, subject to Board approval.

BAF 3.1 – High Quality Care
The proposed target risk rating has not been met due to a number of concerns raised in the CQC Report in relation to patient safety. Action plans are in place to address the concerns. The Quality Committee and the Board are receiving updates against the action plans.

The Committee propose to increase the year-end rating to 16 as the impact of the actions relating to the CQC action plan are not yet fully seen.

The risk will be carried over to 2023/24, subject to Board approval.

BAF 3.2 – Harm Free Care
The Quality Committee propose that the Q4 risk rating be increased to 16. This is due to the ongoing operational pressures and the number of patients with no criteria to reside.

However a number of actions including a 60 bedded step down facility being built, the Bristol Model and discussions with partners to improve Community Care are being implemented.

The risk will be carried over to 2023/24, subject to Board approval.

BAF 4 – Great Clinical Services
The Performance and Finance Committee discussed performance and the measures in place to mitigate this risk. It was felt that despite the amount of actions in place, issues outside of the Trust's control would prevent the risk from achieving its target in Q4. The Committee proposed a Q4 risk rating of 20.

Issues that remain include patients with no criteria to reside, ambulance handovers and flow through the hospital meaning that the 4 hour target is still not at the required standard.

The risk will be carried over to 2023/24, subject to Board approval.

BAF 5 – Partnerships
The Trust is fully engaged with the ICS and the Committees in Common and Joint Development Board are overseeing the Humber Acute Services Review programmes. It has been agreed that the HASR Committees in Common will become the Integrated Committees in Common as part of the future group model work between HUTH and NLAG.

The HASR is currently being reviewed and the learning from the services already working together captured.

However there are still recovery issues being impacted by Primary Care and Social Care constraints.

The risk will be carried over to 2023/24, subject to Board approval.

BAF 6 – Research and Innovation
It is proposed that the year-end risk remains at 12. There has not yet been a definitive change to secure recurrent investment/funding from the Trust to underwrite research and innovation activities. This is compounded further by anticipated financial pressures for the Trust in 2023/24 and the likely continuation of clinical pressures stretching the already limited resources and associated delivery and support services.

The risk will be carried over to 2023/24, subject to Board approval.

BAF 7.1 – Finance
The risk has been mitigated and the target risk rating achieved in line with the financial plan.

The risk will be carried over to 2023/24, subject to Board approval.

BAF 7.2 – Underlying Financial Position
It is proposed that the Q4 risk rating remains at 20. This is due to the underlying deficit and the need to increase in-house productivity, the level of non-recurrent CRES and in-year pressures.

The risk will be carried over to 2023/24, subject to Board approval.

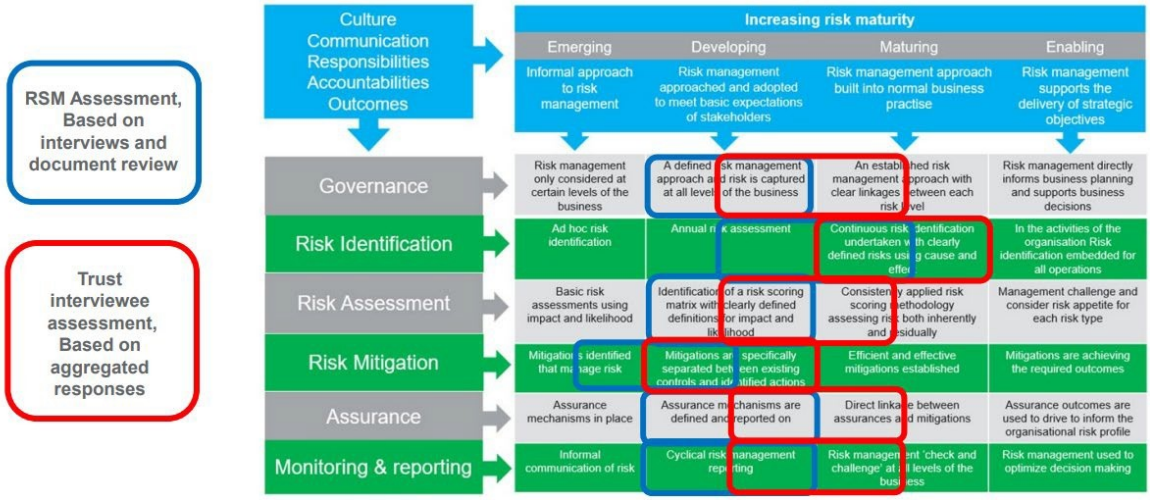
BAF 7.3 – Capital and Infrastructure
The risk has been mitigated and the target risk rating achieved for 2022/23 (this is subject to year-end audit).

The risk will be carried over to 2023/24, subject to Board approval.

6. Internal Audit Risk Maturity Report

During Q4 the Risk Management process was assessed by the Trust's internal auditors RSM. The findings showed that the Trust was a developing organisation on the Risk Maturity matrix.

Risk Maturity Assessment



The Full report will be received by the Audit Committee for review and scrutiny and the actions will be managed operationally at the Operational Risk and Compliance Sub-Committee.

7. Timetable

The Trust Board is asked to consider a proposal to extend each of the current risks for 6 months, so that any work relating to the Group Model and Strategy can be aligned.

The Committees will be asked to review the risks and the risk ratings (current and target) during Q1 in the usual way. These will be presented to the July 2023 Board meeting, along with any proposals for new risks, for discussion and approval.

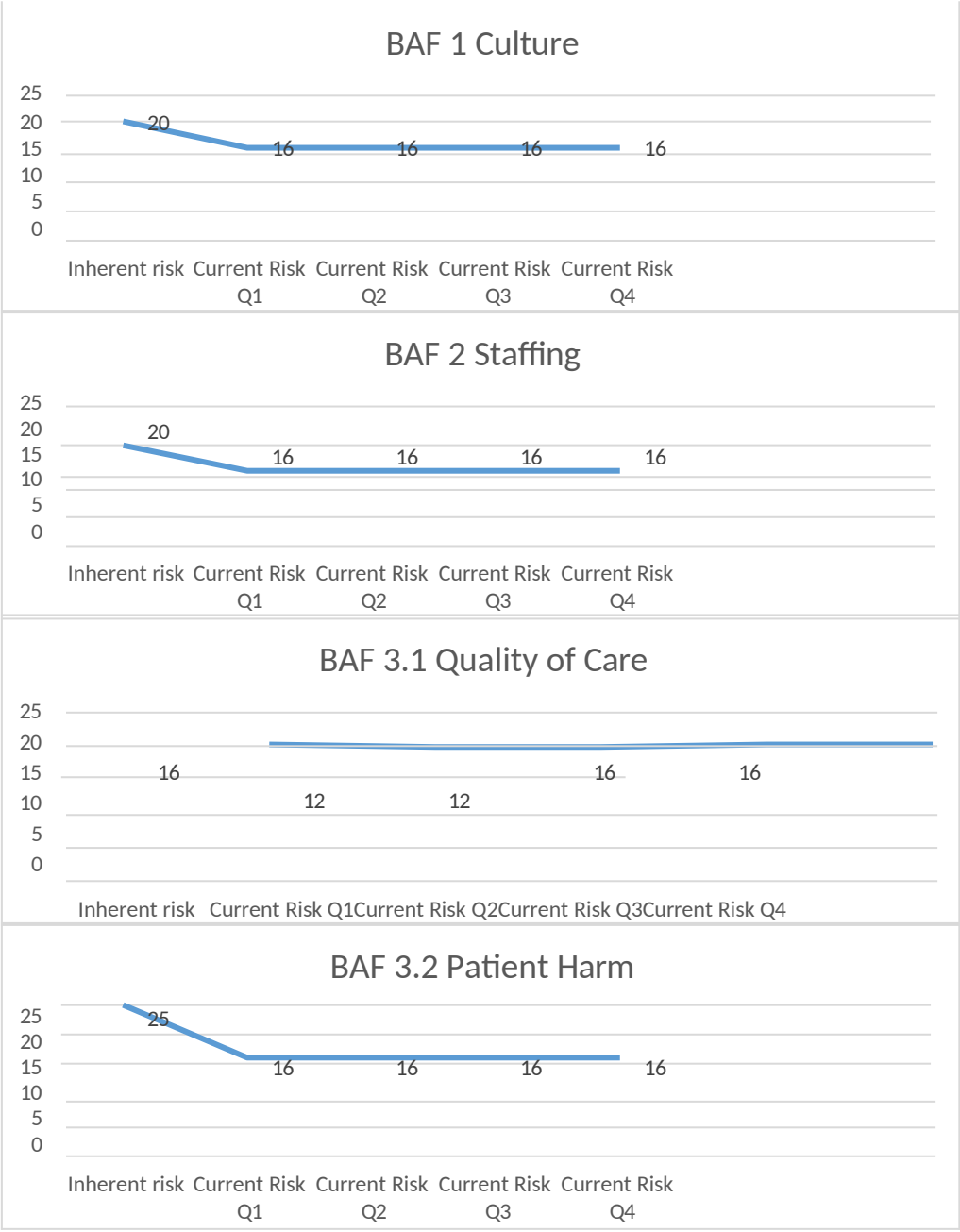
8. Recommendations

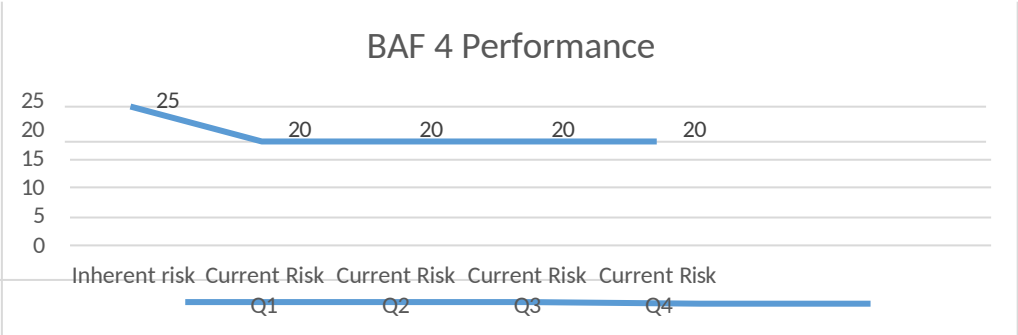
The Board is asked to:

- Approve the year-end risk ratings
- Approve the proposal to carry the existing risks for the first 6 months of 2023/24
- Consider whether any additional risks should be added.
- Decide if sufficient assurance has been provided

Rebecca Thompson
Head of Corporate Affairs
May 2023

BAF Risk movement throughout 2022/23




BAF 4 Performance
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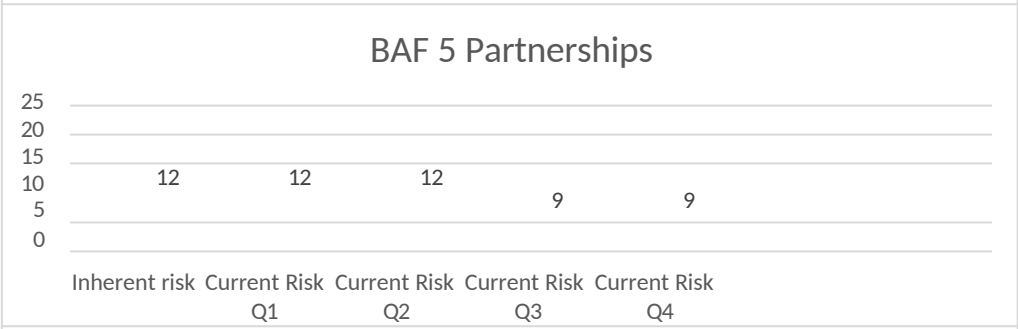
20
20
20
20
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Current Risk Q4


BAF 5 Partnerships
25
20
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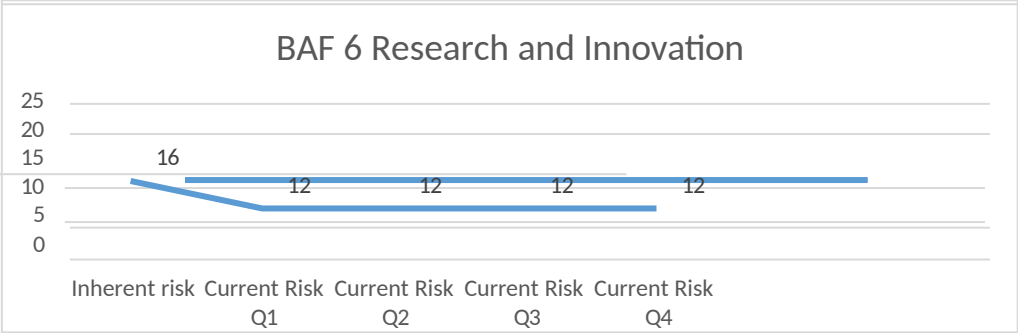
12
12
12
9
9
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Current Risk Q4


BAF 6 Research and Innovation
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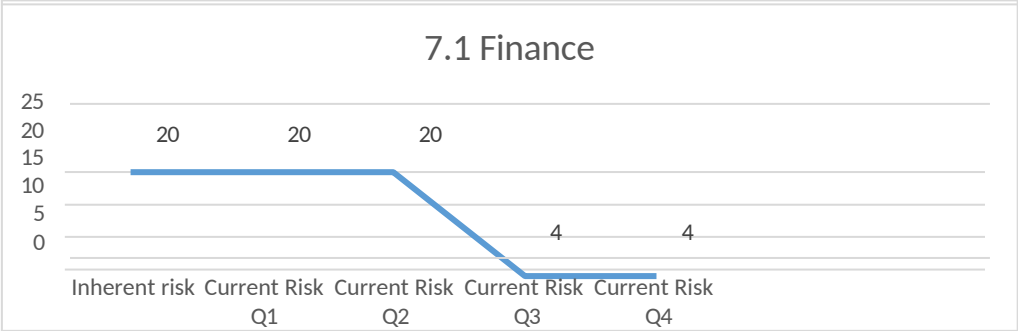
12
12
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Current Risk Q4


7.1 Finance
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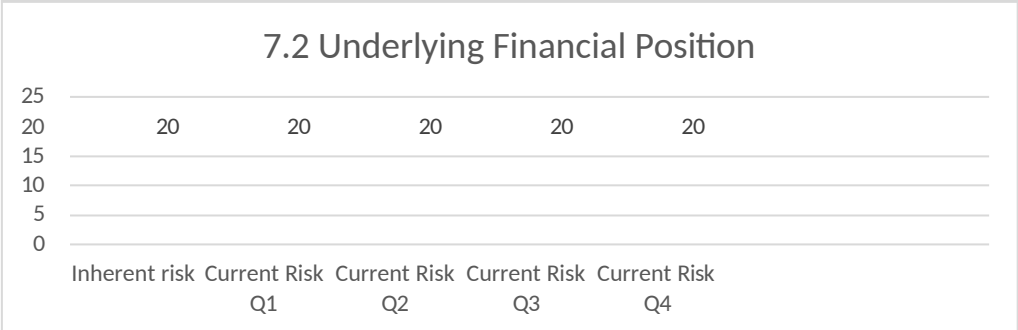
4
4
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Current Risk Q4


7.2 Underlying Financial Position
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20
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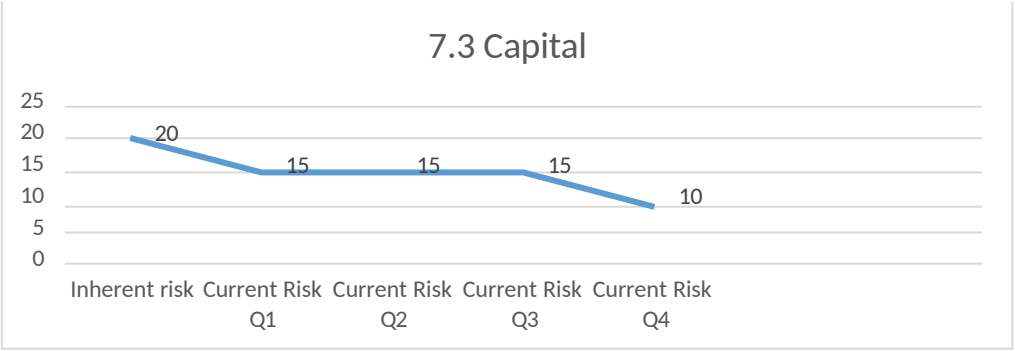
20
20
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Current Risk Q4


7.3 Capital
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20
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15
10
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Current Risk Q4

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 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	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

							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. Q4 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 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
	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:** 37% of staff (3160) completed the survey compared with 2021 (44%) The Trust is below the national average for all of the 9 key themes in the Staff Survey		

Inherent Risk			Risk position as at 31.03.23 (Q4)			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 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 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% Q4 Trust adjusted vacancy rate = 4% Turnover 11.9% against a target of 9.3%		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

					Less than 1 year leavers = 20.6% Consultant Job Plans = 81.2% Sickness = 4.4% Appraisals Medical = 92.5% Appraisals AFC staff = 67.4%		Explore electronic solutions for the processing of Pool and Pilot bank overtime to remove the need for paper timesheets. Q4 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.

Inherent Risk			Risk position as at 31.03.23 (Q4)			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 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 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'	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

						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 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	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 Q4 Transition to PSIRF planned from April 2023. PSIRF training has started. Targeted work with HGs regarding complaints is ongoing. Implementation of new PHSO complaints framework underway 2nd Celebration event held 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
	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			**Metrics:** National Audit Benchmarking Harm Free Care Patient Experience Survey	**Outcomes:** 1 Never Event reported in Q1 5 Never Events reported in Q2		

	reviewed & actioned by the requester 3450 - There is a risk of increased pressure damage to patients due to failing or lack of pressure relieving mattresses			**Independent / semi-independent:** CQC inspections Internal audits External reviews (e.g. NHSEI)	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 Q4 Regulation 28 = 0 Never Events reported in Q4 = 0 Open Serious Incidents = 32 PSIRF launched 1 April 2023 The Trust SHMI continues to remain within the “as expected” levels of death, with the latest SHMI figure of 1.10. Pneumonia SHMI is within the “expected” range, at 1.03, the lowest it has been post-pandemic. Sepsis SHMI is currently 1.29, showing a marginal reduction again.		
Inherent Risk			**Risk position as at 31.03.23 (Q4)**			**Planned target risk position by 31/03/2023**	

Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	4	4	16	3	4	12

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

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

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 Q4 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

						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	Test staff feedback following the full completion of the ED digital work 'Frosting' will be applied to glass to improve privacy and dignity.
	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:** **February 2023** 4 hour performance 59.6% all types Waiting list 66,672 104 week wait = 16 627 over 60 minute ambulance handovers 424 breaches - 12 hour trolley waits 206 patients per day with no criteria to reside 78 week breaches = 548 The number of patients waiting to start treatment on 62 pathway has reduced to 1256 from 1700 at the end of December 2022 2 of 9 cancer standards were met in February 2023 Faster diagnosis standard 79.8% (provisional)		

Inherent Risk			**Risk position as at 31.03.23 (Q4)**			**Planned target risk position by 31/03/2023**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
5	**5**	**25**	**4**	**4**	**16**	**3**	**4**	**12**

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 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.

						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	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 Q4 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
	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) 66,672 (February 2023) 104 week wait expected performance no worse than 127 (June 2022) 20 (July 2022), 16 (August 2022), zero (December 2022), 16 (February 2023) Patients with no criteria to reside = 169 July 2022, 179, August 2022, 234 December 2022, 206 February 2023 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 2 of 9 cancer standards were met in February 2023 Trust stepped down as a Tier 1 Organisation for 104 week waits November 2022 Ambulance handover position remains challenged		

					4 hour performance is 59.6% for all types 2 out of 9 cancer waiting times' national standards were achieved, cancer performance remains comparable with previous months Elective activity was 85% of plan which is an improved position 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 31.03.23 (Q4)			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 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

Strategic Theme: Strategy Appetite: Moderate
Risk: 5

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 Q4 **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
	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. Q4 Multiple programmes of change across the ICB, Place: Interim Clinical Plan/Humber Clinical collaborative Programme Community Diagnostic Centres Humber Acute Services Digital Transformation Planned Care Strategy Out of Hospital Programmes		

Inherent Risk	Risk position as at 31.03.23 (Q4)	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. Q4 Joint RDI working between HUTH and NLAG Joint strategy to be agreed
	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 31.03.23 (Q4)**			**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 Q4 Financial Plan achieved
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 Q4 Trust reported a surplus of £0.5m at month 11 and achieved its financial plan of break-even		

Inherent Risk			Risk position as at 31.03.23 (Q4)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	1	4	4	1	4	4

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 Q4 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 (£4.4m) and additional in-year pressures has moved this to a position of £54.1m. Draft income and expenditure plan presented to the Performance and Finance committee – March 2023

						are also pressures on junior doctors and paediatric devices. These are being offset by the high level of vacancies, especially in nursing staff. Plan Submitted to NHSE on 30th March 23 Indication of further submission in April 23 Assess ERF and activity position – The Trust must look to increase its core capacity closer to 19/20 baseline levels and reduce reliance on internal and IS premium capacity.	
	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:** Underlying deficit is £54.1m at month 11 The Trust delivered 100% of its CRES plan		

Inherent Risk			Risk position as at 31.03.23 (Q4)			Planned target risk position by 31/03/2023		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	4	5	20

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 Q4 The planned capital spend is £0.7m above the Trust CDEL limit. This is to support slippage across the ICS. Planned expenditure has been brought forward from 2023/24 into this year to offset undershoots in other Trusts in the ICS

						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 Trust has achieved its Capital Plan for 2022/23 (subject to audit)		

Inherent Risk			**Risk position as at 31.03.23 (Q4)**			**Planned target risk position by 31/03/2023**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	**5**	**20**	**2**	**5**	**10**	**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**			**3 x 4 = 12**	
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		**4 x 4 = 16**

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 4 x 5 = 20		Current Risk Rating 4 x 4 = 16			Target Risk Rating 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.		**4 x 4 = 16**

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 4 x 4 = 16		Current Risk Rating 4 x 4 = 16				Target Risk Rating 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		**Target risk rating increased to 3 x 4 = 12 in Q3** **Q4 Risk rating 4 x 4 = 16**	

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 3.2		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 4 = 12	
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.		**Target risk rating increased to 3 x 4 = 16** **Q4 Risk rating 4 x 4 = 16**	

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 4		**Great Clinical Services** There is a risk to access to Trust Services						
		Inherent Risk Rating **5 x 5 = 25**		**Current Risk Rating** **4 x 5 = 20**		**Target Risk Rating** **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		**Q4 position 4 x 5 = 20**

						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		

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 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		**Q4 position 3 x 3 = 9**

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 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		**Q4 position 3 x 4 = 12**

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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.

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				**Q4 position 1 x 4 = 4**

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 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		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 (£4.4m) and additional in-year pressures has moved this to a position of £54.1m.		**Q4 position 4 x 5 = 20**	

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Green	On track to achieve target risk rating
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.		The planned capital spend is £0.7m above the Trust CDEL limit. This is to support slippage across the ICS. Planned expenditure has been brought forward from 2023/24 into this year to offset undershoots in other Trusts in the ICS		**Q4 position 2 x 5 = 10 (subject to Audit)**	

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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	**Chris Richards**
Head of Corporate Affairs	**Risk Manager**
February 2023	**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	**<u>Links</u>** 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 **<u>Updates</u>** <u>November 2022 Update</u> 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						<u>December 2022</u> 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 <u>January 2023</u> Risk changed from Clinical Support to Trust Wide risk. <u>February 2023</u> 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	**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 – 4000, C3996, 2898, 4010, 2960, 4002, 2906, 3607, C3044, 3295, 3296, 3646, 3991, 3205, 4008 **Updates** 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

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 Negligible	2 Minor	3 Moderate	4 Major	5 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 Negligible	2 Minor	3 Moderate	4 Major	5 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

UPDATED CODE OF GOVERNANCE FOR BOARDS/DIVISION OF RESPONSIBILITIES

REFERENCES

Only PDFs are attached

- 6.9 - Updated Code of Governance May 2023.pdf
- 6.9.1 - NHS England » Code of governance for NHS provider trusts.pdf
- 6.9.2 - CEO Chair Division of Responsibilities 2023.pdf

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	09.05.23
Title	Draft Code of Governance				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Head of Corporate Affairs				
Report previously considered by (date)	This report has not been presented at any other 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 requested to:

- Receive the updated Code of Governance
- Approve the Division of the Chief Executive and Chairman Responsibilities
- Decide if any further assurance is required

Hull University Teaching Hospitals NHS Trust
Updated Code of Governance

1 Purpose of the Report

The purpose of the report is to inform the Board of the updated Code of Governance for NHS Provider Trusts.

2 Background

The draft Code of Governance for NHS Providers was issued by NHS England (NHSE) on 27 May 2022 and replaced the NHS Foundation trust code of governance. For the first time the code will apply to all Trusts. The new code applies from 1 April 2023.

3 New Draft Code of Governance

The code has been updated to reflect:

- its application to NHS trusts, following the extension of the NHS Provider licence to them
- changes to the UK Corporate Governance Code in 2018
- the legal establishment of integrated care systems (ICSs) under the Health and Care Act 2022
- the evolving NHS System Oversight Framework, under which trusts will be treated similarly regardless of their constitution as a trust or foundation trust.

In general, the provisions of the code do not greatly differ from the 2014 version since the Health and Care Act 2022 does not change the statutory role, responsibilities and liabilities of provider trust boards of directors. However, there are some themes underlying the key changes, most of which should come as no surprise to trusts but are now included in the code for the first time:

- Incorporation of the requirement for boards of directors to assess the trust's "contribution to the objectives of the Integrated Care Partnership (ICP) and Integrated Care Board (ICB), and place-based partnerships" as part of its assessment of its performance, and "system and place-based partners" are highlighted as key stakeholders throughout.

- The inclusion of the board's role in assessing and monitoring the culture of the organisation and taking corrective action as required, alongside "investing in, rewarding and promoting the wellbeing of its workforce". The previous code only mentioned wellbeing in the context of the finances of the organisation.

- A new focus on equality, diversity and inclusion, among board members but also training in EDI should be provided for those undertaking director-level recruitment. The board should have a plan in place for the board and senior management of the organisation to reflect the diversity of the local community or workforce, whichever is higher.

- For foundation trusts, potentially greater involvement for NHSE in recruitment and appointment processes, including utilising NHSE's Non-Executive (NED) Talent and Appointments team in preference to external recruitment consultancies and having representation from NHSE on NED recruitment panels. When setting remuneration for NEDs, including the chair, foundation trusts should use the Chair and non-executive director remuneration structure.

Terminology has been updated and there are links to other relevant frameworks, manuals, and guidance (such as the Well-led framework).

The Code is set out in 5 sections which include: Board leadership and purpose, division of responsibilities, composition, succession and evaluation, Audit, risk and internal control and disclosure of corporate governance arrangements.

4 Next Steps

The Head of Corporate Affairs will ensure that the Code of Governance is being adhered to and any issues will be escalated to the Trust Board. The Code of Governance is attached at Appendix 1 for review.

As part of the Code the Division of Chief Executive and Chairman Responsibilities is now a requirement. This is attached at Appendix 2 for Board approval.

5 Recommendations

The Board is requested to:

- Receive the updated Code of Governance
- Approve the Division of the Chief Executive and Chairman Responsibilities
- Decide if any further assurance is required

Rebecca Thompson
Head of Corporate Affairs
May 2023

Date published: 27 October, 2022
Date last updated: 23 February, 2023

Code of governance for NHS provider trusts

Publication (/publication)

Content

Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

About this document

This code sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems.

Key points

- Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered.
- In the NHS this means delivering high quality services in a caring and compassionate environment while collaborating through system and place-based partnerships and provider collaboratives to integrate care.
- Best practice is detailed in the following sections: board leadership and purpose, division of responsibilities, composition, succession and evaluation, audit, risk, internal control and remuneration.

Action required

- Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code.

Other guidance and resources

- Integrated care systems: design framework (https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/)
- Working together at scale: guidance on provider collaboratives (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf)
- The wider suite of Integrated care systems: guidance (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/)

Introduction

1. Why is there a Code of Governance?

1.1 NHS England has issued this Code of Governance (the code) to help NHS providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and ultimately discharge their duties in the best interests of patients, service users and the public.

1.2 The board of directors is a unitary board. This means that within the board of directors, the non-executive directors and executive directors make decisions as a single group and share the same responsibility and liability. All directors, executive and non-executive, have responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

1.3 In this code, we bring together the best practices of the NHS and private sector. We set out a common overarching framework for the corporate governance of trusts that complements the statutory and regulatory obligations they have (these are referenced throughout this document).

1.4 As with the UK Corporate Governance Code, each section of this code is built around a set of principles emphasising the value of good corporate governance to long-term sustainable success. Each section also incorporates a set of more detailed provisions to implement these, which can help trusts demonstrate the effectiveness of governance practices and their contribution to the long-term success of the organisation and its wider system.

2. What is new about this version of the code?

2.1 This version of the code applies from April 2023. A great deal has changed since we last updated the code in 2014. NHS England, Monitor and the NHS Trust Development Authority (TDA) started formally working together on 1 April 2019 to provide better support to delivery of the NHS Long Term Plan (https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/) (January 2019), which set the direction for greater integration of care with providers collaborating with partners in health and care systems. All systems had achieved integrated care system (ICS) status by April 2021. The Health and Care Act 2022 has merged Monitor and the TDA into NHS England and removed legal barriers to collaboration and integrated care, making it easier for providers to take on greater responsibility for service planning and putting ICSs on a statutory footing through establishing for each ICS:

- An integrated care partnership (ICP), a statutory joint committee of the integrated care board (ICB) and the upper tier local authorities in the ICS, that brings together organisations and representatives concerned with improving the care, health and wellbeing of the population. Each partnership has been established by the NHS and local government as equal partners and has a duty to develop an integrated care strategy proposing how the NHS and local government should exercise their functions to integrate health and care and address the needs of the population identified in the local joint strategic needs assessment(s).
- An ICB, which brings the NHS together locally, to improve population health and care; its unitary board allocates NHS budget and commissions services, and – having regard to the ICP's integrated care strategy – produces a five-year joint plan for health services and annual capital plan agreed with its partner NHS trusts and NHS foundation trusts.

2.2 The ICP and ICB, together with other key elements of the new arrangements including place-based partnerships and provider collaboratives, are tasked with bringing together all partners within an ICS.

2.3 At the heart of effective collaboration is the expectation that providers will work effectively on all issues, including those that may be contentious for the organisation and system partners, rather than focusing only on those issues for which there is already a clear way forward or which are perceived to benefit their organisation. The success of individual NHS trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver high quality care and effective use of resources (Integrated care systems: design framework (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf), p30).

2.4 To support this shift, we have put in place a new single framework for overseeing NHS systems and organisations, the NHS Oversight Framework (https://www.england.nhs.uk/nhs-oversight-framework/), which will evolve particularly for 2023/24. Under this new framework we intend to continue to treat providers in comparable circumstances similarly unless there is sound reason not to.

2.5 This updated code therefore applies to both NHS foundation trusts and, for the first time, NHS trusts. NHS foundation trusts and NHS trusts are constituted differently.

- NHS foundation trusts are public benefit corporations and their boards of directors have a framework of local accountability through members and a council of governors. The NHS foundation trust council of governors is responsible for holding the non-executive directors individually and collectively to account. In turn, NHS foundation trust governors are accountable to the members who elect them and must represent their interests and the interests of the public.

- NHS trusts were established by orders of the Secretary of State for Health and Social Care. Their chairs and non-executive directors are appointed by NHS England (chairs and non-executive directors hold a statutory office under the National Health Service Act 2006. The appointment and tenure of office are governed by the NHS Trusts (Membership and Procedure) Regulations 1990. NHS England makes NHS trust chair and non-executive director appointments using powers delegated by the Secretary of State for Health and Social Care. Board appointments are regulated by the Commissioner for Public Appointments to provide independent assurance that they are made in accordance with government's Principles of Public Appointments and Governance Code for public bodies) and they do not have a council of governors or members. Instead, we have a duty to hold the chair and non-executive directors of NHS trusts individually and collectively to account for the performance of the board.

2.6 Despite their different constitutions, there are overarching principles of corporate governance that apply to both NHS trusts and NHS foundation trusts. Where particular provisions of the code apply only to NHS foundation trusts or NHS trusts, we explicitly indicate this. Where we refer to 'trusts' in this code, we mean both NHS trusts and NHS foundation trusts. We use the term 'chief executive' to apply to the chief executives of NHS foundation trusts and the chief officers of NHS trusts, except in sections that are specific to NHS trusts, where we use 'chief officer'. References to 'directors' include the chair, executive and non-executive directors.

2.7 The UK Corporate Governance Code, on which the code has always been based, has also been updated a number of times since 2014. This code is modelled on the 2018 version of the UK Corporate Governance Code (https://www.frc.org.uk/directors/corporate-governance-and-stewardship/uk-corporate-governance-code).

3. What is corporate governance?

3.1 A trust board needs to be able to deliver entrepreneurial and effective leadership and prudent and effective oversight of the trust's operations, to ensure it is operating in the best interests of patients, service users and the public.

3.2 Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered. In the NHS this means delivering high quality services in a caring and compassionate environment, while collaborating within ICSs to integrate care and complying with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. Robust governance structures that support collaborative leadership and relationships with system partners and other stakeholders, and strong local accountability will help trusts maintain the trust and confidence of the people and communities they service. Good corporate governance is dynamic. Boards should be committed to improving governance on a continuing basis through evaluation and review.

3.3 Robust corporate and quality governance arrangements complement and reinforce one another. Quality governance is the combination of structures and processes at and below board level to lead on trust-wide quality performance, including (i) ensuring required standards are achieved and (ii) investigating and acting on sub-standard performance. Clinicians are at the frontline of ensuring patients receive quality care. However, the board of directors takes final and definitive responsibility for improvements, successful delivery and, equally, failures in the quality of care. Effective governance therefore requires boards to pay as much attention to quality of care and quality governance as they do to the financial health of their organisation. Boards also set the tone of their organisation by demonstrating shared values and behaviours, and recognising their organisation's role in an ICS and the wider NHS, and the risks and opportunities this may present for quality of care. Further guidance can be found in the Well-led framework for le (https://www.england.nhs.uk/well-led-framework/)adership and governance developmental reviews.

4. What should trusts do to fulfil the code's requirements of good governance?

4.1 We seek to support good governance by offering sound guidance. We are keen that trusts have the flexibility to ensure their structures and processes work well now and in the future, while making sure they meet the code's overall requirements for good governance, which are designed with the interests of patients, service users and the public in mind.

4.2 Ultimately only directors can demonstrate and promote the board behaviour needed to guarantee good corporate governance in practice. Good governance requires continuing and determined effort and boards have opportunities within the framework of the code to decide themselves how they should act.

Comply or explain

4.3 The provisions of the code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of Condition FT4 of the NHS provider licence (also known as the governance condition; NHS England has deemed it appropriate that Condition FT4 applies to NHS trusts as well as NHS foundation trusts under it's "shadow" licence regime). However, non-compliance may form part of a wider regulatory assessment on adherence to the provider licence.

4.4 Satisfactory engagement between the board of directors, the council of governors and members of foundation trusts, and patients, service users and the public is crucial to the effectiveness of trusts' corporate governance approach. Directors and, for foundation trusts, governors both have a responsibility for ensuring that 'comply or explain' remains an effective basis for this code.

Disclosure requirements

4.5 To meet the requirements of 'comply or explain' each trust must comply with each of the provisions of the code (which in some cases will require a statement or information in the annual report, or provision of information to the public or, for foundation trusts, governors or members) or, where appropriate, explain in each case why the trust has departed from the code.

4.6 We recognise that departure from the specific provisions of the code may be justified in particular circumstances. Reasons for non-compliance with the code should be explained, with the trust illustrating how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the trust should indicate when it expects to conform to the provision.

4.7 The form and content of this part of the statement are not prescribed, the intention being that trusts should have a free hand to explain their governance policies in the light of the principles, including any special circumstances applying to them which have led to a particular approach.

4.8 It is important to note that:

- Some provisions require a statement or information in the annual report. Where information would otherwise be duplicated, trusts need only provide a clear reference to the location of the information within their annual report.
- Other provisions require a trust to make information publicly available or, for foundation trusts, to provide information to their governors or members.
- The remaining provisions are those for which 'comply or explain' applies.
- Schedule A of the code sets out which provisions fall into which category.

5. How does the code fit with other NHS England requirements?

5.1 Although compliance with the provisions in this code is on a 'comply or explain' basis, we have included and clearly identified in the code any relevant statutory requirements. In the first instance, boards, directors and, for foundation trusts, governors should ensure they are meeting the specific governance requirements set out in the NHS provider licence (https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/licensing/#who-needs-a-licence).

5.2 The code sits alongside other NHS England reporting requirements which relate to governance but do not conflict or connect with the code. The code also includes references to other NHS England publications that focus on audit and internal control:

- NHS foundation trust annual reporting manual (https://www.england.nhs.uk/financial-accounting-and-reporting/nhs-foundation-trust-annual-reporting-manual/).

5.3 For clarity, we have provided a detailed explanation of how the different requirements sit together and the purpose of each in Appendix C.

6. Further information

6.1 Trusts may also find it useful to consult other guidance and sources of best practice about governance of public bodies and the NHS. In particular, the following publications are likely to be useful when considered alongside the code:

- Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (https://www.england.nhs.uk/well-led-framework/)
- Guidance on good governance and collaboration under the NHS provider licence (https://www.england.nhs.uk/long-read/guidance-on-good-governance-and-collaboration/)
- Your statutory duties: A reference guide for NHS foundation trust governors (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284473/Governors_g
- Foundation trust councils of governors and system working and collaboration: An addendum to your statutory duties – A reference guide for NHS foundation trust governors (https://www.england.nhs.uk/long-read/addendum-to-your-statutory-duties--reference-guide-for-nhs-foundation-trust-governors/)
- Director-governor interaction in NHS foundation trusts: A best practice guide for boards of directors (https://www.gov.uk/government/publications/nhs-foundation-trust-governors-and-directors-working-better-together)

- The Healthy NHS Board 2013 – Principles for good governance (https://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf)
- The seven principles of public life (https://www.gov.uk/government/publications/the-7-principles-of-public-life): covers the standards of behaviour in and principles of public
- Board governance essentials: a guide for chairs and boards of public bodies (https://www.cipfa.org/policy-and-guidance/publications/b/board-governance-essentials-a-guide-for-chairs-and-boards-of-public-bodies): developed by CIPFA (the Chartered Institute of Public Finance Accountants), this guide gives advice on the roles of chairs and board members.

Section A: Board leadership and purpose

1. Principles

1.1 Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust as part of the ICS and wider healthcare system in England, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public.

1.2 The board of directors should establish the trust's vision, values and strategy, ensuring alignment with the ICP's integrated care strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned. All directors must act with integrity, lead by example and promote the desired culture.

1.3 The board of directors should give particular attention to the trust's role in reducing health inequalities in access, experience and outcomes.

1.4 The board of directors should ensure that the necessary resources are in place for the trust to meet its objectives, including the trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners, and measure performance against them. The board of directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions.

1.5 For the trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners.

1.6 The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.

2. Provisions

2.1 The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.

2.2 The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.

2.3 The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.

2.4 The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk

is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.

2.5 In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.

2.6 The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.

2.7 The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.

2.8 The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.

2.9 The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.

2.10 The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement (directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations (https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf). In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests).

2.11 Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.

Section B: Division of responsibilities

1. Principles

1.1 The chair leads the board of directors and, for foundation trusts, the council of governors, and is responsible for its overall effectiveness in leading and directing the trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the chair facilitates constructive board relations and the effective contribution of all non-executive directors, and ensures that directors and, for foundation trusts, governors receive accurate, timely and clear information.

1.2 Responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision.

1.3 Non-executive directors should have sufficient time to meet their board responsibilities. They should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account.

1.4 The board of directors should ensure that it has the policies, processes, information, time and resources it needs to function effectively, efficiently and economically.

1.5 The board is collectively responsible for the performance of the trust.

1.6 The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust, and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.

1.7 All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.

2. Provisions

2.1 The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.

2.2 The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.

2.3 The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.

2.4 A foundation trust chair is responsible for ensuring that the board and council work together effectively.

2.5 The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.

2.6 The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:

- has been an employee of the trust within the last two years
- has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust
- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme
- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment (but note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval).
- is an appointed representative of the trust's university medical or dental school.

Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.

2.7 At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.

2.8 No individual should hold the positions of director and governor of any NHS foundation trust at the same time.

2.9 The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.

2.10 Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.

2.11 In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on

other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework (https://www.england.nhs.uk/non-executive-opportunities/chair-non-executives-support/framework-conducting-annual-appraisals-nhs-provider-chairs/).

2.12 Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.

2.13 The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.

2.14 When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

2.15 All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.

2.16 All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

2.17 The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.

Section C: Composition, succession and evaluation

1. Principles

1.1 Appointments to the board of directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths (for more information refer to the Equality Act 2010, The NHS' successive Equality Delivery Systems (EDS) and the NHS Workforce Race Equality Standard (WRES)). In particular, the board should have published plans for how it and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher.

1.2 The board of directors and its committees should have a diversity of skills, experience and knowledge. The board should be of sufficient size for the requirements of its duties, but should not be so large as to be unwieldy. Consideration should be given to the length of service of the board of directors as a whole and membership regularly refreshed.

1.3. Annual evaluation of the board of directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each director continues to contribute effectively.

2. Provisions for NHS foundation trusts board appointments

2.1 The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and

the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.

2.2 There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.

2.3 The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.

2.4 The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.

2.5 Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.

2.6 Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.

2.7 When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.

2.8 The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.

2.9 Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.

Relevant statutory requirements

2.10 A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.

2.11It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.

2.12 The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.

2.13 Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.

2.14 The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.

3. Provisions for NHS trust board appointments

3.1 NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.

4. Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts

4.1 Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors (https://www.cqc.org.uk/guidance-providers/regulations-enforcement/fit-proper-persons-directors).

4.2 The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.

4.3 Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.

4.4 Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.

4.5 There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.

4.6 The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.

4.7 All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework (https://www.england.nhs.uk/well-led-framework/) every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.

4.8 Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on:

- holding the non-executive directors individually and collectively to account for the performance of the board of directors
- communicating with their member constituencies and the public and transmitting their views to the board of directors
- contributing to the development of the foundation trust's forward plans.

The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors (https://www.gov.uk/government/publications/nhs-foundation-trust-governors-your-legal-obligations) and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors (https://www.england.nhs.uk/long-read/addendum-to-your-statutory-duties--reference-guide-for-nhs-foundation-trust-governors/).

4.9 The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.

4.10 In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.

4.11 The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.

4.12 The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.

4.13 The annual report should describe the work of the nominations committee(s), including:

- the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline
- how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition
- the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives
- the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard (https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/) and how far the board reflects the ethnic diversity of the trust's workforce and communities served
- the gender balance of senior management and their direct reports.

5. Development, information and support

5.1 All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.

5.2 The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.

5.3 To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.

5.4 The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.

5.5 The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.

5.6 A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.

5.7 The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors (https://www.gov.uk/government/publications/nhs-foundation-trust-governors-your-legal-obligations).

5.8 The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.

5.9 The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.

5.10 The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.

5.11 The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.

5.12 The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.

5.13 Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.

5.14 Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.

5.15 Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.

5.16 Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.

Relevant statutory requirements

5.16 The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.

Insurance cover

5.17 NHS Resolution's Liabilities to Third Parties Scheme (https://resolution.nhs.uk/wp-content/uploads/2018/09/LTPS-Rules.pdf) includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.

Section D: Audit, risk and internal control

1. Principles

1.1 The board of directors should establish formal and transparent policies and procedures to ensure the independence and effectiveness of internal and external audit functions, and satisfy itself on the integrity of financial and narrative statements.

1.2 The board of directors should present a fair, balanced and understandable assessment of the trust's position and prospects.

1.3 The board of directors should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the trust is willing to take to achieve its long-term strategic objectives.

1.4 Organisations should also refer to Audit and assurance: a guide to governance for providers and commissioners (https://www.england.nhs.uk/financial-accounting-and-reporting/audit-and-assurance-a-guide-to-governance/).

2. Provisions

2.1 The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.

2.2 The main roles and responsibilities of the audit committee should include:

- monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them
- providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy
- reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself
- monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors
- reviewing and monitoring the external auditor's independence and objectivity
- reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements
- reporting to the board of directors on how it has discharged its responsibilities.

2.3 A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.

2.4 The annual report should include:

- the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed
- an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans
- an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.

2.5 Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.

2.6 The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.

2.7 The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.

2.8 The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.

2.9 In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual (https://www.england.nhs.uk/financial-accounting-and-reporting/nhs-foundation-trust-annual-reporting-manual/), which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.

Section E: Remuneration

1. Principles

1.1 Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, with the skills and experience required to lead the trust successfully, and collaborate effectively with system partners. Trusts should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements. Trusts should follow NHS England's Guidance on pay for very senior managers in NHS trusts and foundation trusts (https://www.england.nhs.uk/publication/guidance-on-pay-for-very-senior-managers/) and NHS trusts should also follow Guidance on senior appointments in NHS trusts (https://www.england.nhs.uk/wp-content/uploads/2021/11/Guidance-on-senior-appointments-in-NHS-trusts.pdf).

1.2 Any performance-related elements of executive directors' remuneration should be transparent, stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any required competencies specified in the job description for the post.

1.3 The remuneration committee should decide if a proportion of executive directors' remuneration should be linked to corporate and individual performance. The remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration despite no corresponding improvement in performance.

1.4 The remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.

1.5 There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding their own remuneration.

1.6 The remuneration committee should take care to recognise and manage conflicts of interest when receiving views from executive directors or senior management, or consulting the chief executive about its proposals (for further information on conflicts of interest see Managing conflicts of interest in the NHS: Guidance for staff and organisations (https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf)).

1.7 The remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration.

1.8 Where executive directors or senior management are involved in advising or supporting the remuneration committee, care should be taken to recognise and avoid conflicts of interest.

1.9 NHS trusts should wait for notification and instruction from NHS England before implementing any cost of living increases.

2. Provisions

2.1 Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions.

- Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.
- Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate.

- Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary.
- For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors.
- The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.

2.2 Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure (https://www.england.nhs.uk/non-executive-opportunities/about-the-team/remuneration-structure-nhs-provider-chairs-and-non-executive-directors/).

2.3 Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.

2.4 The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.

2.5 Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity (severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements).

2.6 The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

2.7 The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.

Relevant statutory requirements

2.8 The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.

Schedule A: Disclosure of corporate governance arrangements

Trusts are required to provide a specific set of disclosures to meet the requirement of the Code of Governance. These should be submitted as part of the annual report (as set out for foundation trusts in the NHS foundation trust annual reporting manual (https://www.england.nhs.uk/financial-accounting-and-reporting/nhs-foundation-trust-annual-reporting-manual/) and for NHS trusts in DHSC group accounting manual.

The provisions listed below require a supporting explanation in a trust's annual report, even in the case that the trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

Section A, 2.1

The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.

Section A, 2.3

The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's

approach to investing in, rewarding and promoting the wellbeing of its workforce.

Section A, 2.8

The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.

Section B, 2.6

The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:

- has been an employee of the trust within the last two years
- has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust
- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme
- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment
- is an appointed representative of the trust's university medical or dental school.

Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.

Section B, 2.13

The annual report should give the number of times the board and its committees met, and individual director attendance.

Section B, 2.17 (NHS foundation trusts only)

For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.

Section C, 2.5 (NHS foundation trusts only)

If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.

Section C, 2.8 (NHS foundation trusts only)

The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.

Section C, 4.2

The board of directors should include in the annual report a description of each director's skills, expertise and experience.

Section C, 4.7

All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.

Section C, 4.13

The annual report should describe the work of the nominations committee(s), including:

- the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline
- how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition
- the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives
- the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served
- the gender balance of senior management and their direct reports.

Section C, 5.15 (NHS foundation trusts only)

Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.

Section D, 2.4

The annual report should include:

- the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed
- an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans
- where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit

an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.

Section D, 2.6

The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.

Section D, 2.7

The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.

Section D, 2.8

The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.

Section D, 2.9

In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the *DHSC group accounting manual* and *NHS foundation trust annual reporting manual* which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.

Section E, 2.3

Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.

For the provisions listed below, **the basic 'comply or explain' requirement applies**. The disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Section A, 2.2

The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.

Section A, 2.4

The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.

Section A, 2.5

The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.

Section A, 2.6

The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.

Section A, 2.7

The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.

Section A, 2.9

The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.

Section A, 2.10

The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.

Section A, 2.11

Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.

Section B, 2.1

The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.

Section B, 2.2

The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.

Section B, 2.3

The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.

Section B, 2.4 (NHS foundation trusts only)

A foundation trust chair is responsible for ensuring that the board and council work together effectively.

Section B, 2.5

The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.

Section B, 2.7

At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.

Section B, 2.8

No individual should hold the positions of director and governor of any NHS foundation trust at the same time.

Section B, 2.9

The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.

Section B, 2.10

Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.

Section B, 2.11

In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.

Section B, 2.12

Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.

Section B, 2.14

When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

Section B, 2.15

All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.

Section B, 2.16

The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.

Section B, 2.17

All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.

Section B, 2.16

All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

Section B, 2.17

The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.

Section C, 2.1 (NHS foundation trusts only)

The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.

Section C, 2.2 (NHS foundation trusts only)

There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.

Section C, 2.3 (NHS foundation trusts only)

The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.

Section C, 2.4 (NHS foundation trusts only)

The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.

Section C, 2.5 (NHS foundation trusts only)

Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.

Section C, 2.6 (NHS foundation trusts only)

Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.

Section C, 2.7 (NHS foundation trusts only)

When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.

Section C, 3.1 (NHS trusts only)

NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.

Section C, 4.1

Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation

to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.

Section C, 4.3

The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.

Section C, 4.4 (NHS foundation trusts only)

Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.

Section C, 4.5

There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.

Section C, 4.6

The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.

Section C, 4.8 (NHS foundation trusts only)

Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on:

- holding the non-executive directors individually and collectively to account for the performance of the board of directors
- communicating with their member constituencies and the public and transmitting their views to the board of directors
- contributing to the development of the foundation trust's forward plans.

The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.

Section C, 4.10 (NHS foundation trusts only)

In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.

Section C, 4.11

The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.

Section C, 4.12

The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.

Section C, 5.1

All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.

Section C, 5.2

The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.

Section C, 5.3

To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.

Section C, 5.4

The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.

Section C, 5.5

The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.

Section C, 5.6 (NHS foundation trusts only)

A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.

Section C, 5.8

The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.

Section C, 5.9

The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as

required.

Section C, 5.10

The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.

Section C, 5.11

The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.

Section C, 5.12

The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.

Section C, 5.13

Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.

Section C, 5.14

Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.

Section C, 5.16 (NHS foundation trusts only)

Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.

Section C, 5.17

The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.

Section D, 2.1

The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.

Section D, 2.2

The main roles and responsibilities of the audit committee should include:

- monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them
- providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy
- reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself
- monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors
- reviewing and monitoring the external auditor's independence and objectivity
- reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements
- reporting to the board of directors on how it has discharged its responsibilities.

Section D, 2.3

A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.

Section D, 2.5

Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.

Section E, 2.1

Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions.

- Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.
- Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate.
- Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary.
- The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement

Section E, 2.2

Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.

Section E, 2.4

The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.

Section E, 2.5

Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.

Section E, 2.7

The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.

The provisions listed below require information to be made **available to governors,** even in the case that the trust is compliant with the provision.

Section C, 4.9 (NHS foundation trusts only)

The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.

Section C, 5.7 (NHS foundation trusts only)

The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.

The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision.

Section C, 2.9 (NHS foundation trusts only)

Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.

The provisions listed below require information to be made **publicly available,** even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request.

Section B, 2.13

The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.

Section C, 4.2

Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.

Section E, 2.6

The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

Appendix A: Role of the trust secretary

The trust secretary has a significant role in the administration of corporate governance. In particular, the trust secretary would normally be expected to:

- ensure good information flows to the board of directors and its committees and between senior management, non-executive directors and the governors where relevant
- ensure that procedures of both the board of directors and the council of governors are complied with
- advise the board of directors and the council of governors (through the chair) on all governance matters
- be available to give advice and support to individual directors, particularly in relation to the induction of new directors and assistance with professional development.

Appendix B: Council of governors and role of the nominated lead governor

1. Principles

1.1 The powers and obligations of governors of NHS foundation trusts are set out in the 2006 Act, as amended by the 2012 Act. This appendix describes the relevant areas of the governors' role. In addition, *Your statutory duties: A reference guide for NHS foundation trust governors* (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/284473/Governors_guide_ (August 2013) examines how governors can deliver their duties and an addendum to this document, System working and collaboration: The role of foundation trust councils of governors (https://www.england.nhs.uk/long-read/addendum-to-your-statutory-duties--reference-guide-for-nhs-foundation-trust-governors/) (October 2022) clarifies how governors can continue to perform their duties within the context of system working.

1.2 The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.

1.3 The council of governors is responsible for representing the interests of NHS foundation trust members, the public at large, and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.

1.4 To discharge their duty to represent the public, councils of governors are required to take account of the interests of the public at large. This includes the population of the local system of which the trust is part and the whole population of England as served by the wider NHS.

1.5 Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members, the public at large, and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.

1.6 Governors should discuss and agree with the board of directors how they will undertake these and any additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the system and wider NHS and emerging best practice.

1.7 Governors should work closely with the board of directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The governors must be consulted on the development of forward plans for the trust and any significant changes to the delivery of the trust's business plan.

1.8 Governors should use their voting rights to hold the non-executive directors individually and collectively to account and act in the best interest of patients, members and the public at large. If the council of governors does withhold consent for a major decision, it must justify its reasons to the chair and the other non-executive directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust, the system and the wider NHS. The council of governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles.

2. Provisions

2.1 The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should make every effort to attend these meetings. The NHS foundation trust should take appropriate steps to facilitate attendance.

2.2 The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly.

2.3 The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.

2.4 The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.

2.5 The chair is responsible for leadership of both the board of directors and the council of governors but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive and other executives and non-executives, as appropriate, to their meetings. In these meetings other members of the council of governors may ask the chair or their deputy, or any other relevant director present at the meeting, questions about the affairs of the NHS foundation trust.

2.6 The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director.

2.7 The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.

2.8 The council of governors should only exercise its power to remove the chair or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chair with the senior independent director in the first instance.

2.9 The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, eg clinical statistical data and operational data.

2.10 The chair (and the senior independent director and other directors as appropriate) should maintain regular contact with the governors to understand their issues and concerns.

2.11 Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public at large regarding the trust, its vision, performance and material strategic proposals made by the trust board.

2.12 It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.

2.13 The chair should ensure that the views of governors and members are communicated to the board as a whole. The chair should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested to do so by governors. The senior independent director should attend sufficient meetings with governors to hear their views and develop a balanced understanding of their issues and concerns.

2.14 The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.

2.15 The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.

3. Additional statutory requirements

3.1 The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.

3.2 The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the NHS foundation trust annual reporting manual:

(a) the annual accounts

(b) any report of the auditor on them

(c) the annual report.

3.3 The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, eg for data protection or commercial reasons. Governors should respect the confidentiality of these documents.

3.4 The council of governors may require one or more of the directors to attend a meeting to obtain information about the trust's performance of its functions or the directors' performance of their duties, and to help the council of governors decide whether to propose a vote on the trust's or directors' performance.

3.5 Governors should use their rights and voting powers from the 2012 Act to represent the interests of members and the public at large on major decisions taken by the board of directors. These voting powers require:

- More than half the members of the board of directors who vote and more than half the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust.
- More than half the governors who vote to approve a significant transaction.
- More than half the governors to approve an application by a trust for a merger, acquisition, separation or dissolution.
- More than half the governors who vote to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's total income.
- Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions.

3.6 NHS foundation trusts are permitted to decide themselves what constitutes a 'significant transaction' and may choose to set out the definition(s) in the trust's constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition, but this would need to be stated in the constitution.

3.7 In taking decisions on significant transactions, mergers, acquisitions, separations or dissolutions, governors need to be assured that the process undertaken by the board was appropriate, and that the interests of the public at large were considered. A council may disagree with the merits of a particular decision of the board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the council of governors would need to provide evidence that due diligence was not undertaken.

3.8 The external auditors of a foundation trust must be appointed or removed by the council of governors at a general meeting of the council.

4. Lead governor

4.1 The lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chair or the trust secretary, if one is appointed.

4.2 It is not anticipated that there will be regular direct contact between NHS England and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to NHS England, and then updated as required. Any of the governors may be the lead governor.

4.3 The main circumstances where NHS England will contact a lead governor are where we have concerns about the board leadership provided to an NHS foundation trust, and those concerns may in time lead to our use of our formal powers to remove the chair or non-executive directors. The council of governors appoints the chair and non-executive directors, and it will usually be the case that we will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand our concerns.

4.4 NHS England does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, we will often wish to have direct contact with the NHS foundation trust's governors, but quickly and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand our role, the available guidance and the basis on which we may take regulatory action. The lead governor will then be able to communicate more widely with other governors. Similarly, where individual governors wish to contact us, this would be expected to be through the lead governor.

4.5 The other circumstance where NHS England may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chair or other members of the board, or elections for governors or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively,

while complying with the trust's constitution, may be inappropriate. In such circumstances, where the chair, other members of the board of directors or the trust secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide us with a point of contact.

Appendix C: The code and other regulatory requirements

Although compliance with the provisions in this guide is not necessarily mandatory, some of the provisions in this document are statutory requirements because they are enshrined elsewhere in legislation.

In the first instance, boards, directors and, for NHS foundation trusts, governors, should ensure that they are meeting the governance requirements for NHS foundation trusts as set out in the 2006 Act (as amended by the 2012 Act) and reflected in the NHS provider licence. This code sits alongside a number of other NHS England reporting requirements that relate to governance.

NHS England uses reasonable evidence, from disclosures made to us by NHS foundation trusts and NHS trusts, to determine if there is a risk of a breach of the licence condition 'Foundation Trust Condition 4: Governance in the NHS foundation trust' and to make a decision regarding intervention.

The information we receive includes: a **forward looking** disclosure on corporate governance (the corporate governance statement); a **backward looking** disclosure on corporate governance (the code of governance for NHS provider trusts); and a **backward looking statement on internal control, risk and quality governance** (the annual governance statement).

For clarity, here we have provided a brief explanation of how the different requirements sit together and the purpose of each.

Corporate governance statement – in the annual plan

To comply with the provider licence, the Annual Plan also includes a requirement for a corporate governance statement. This is a mandatory requirement. This is a forward looking statement of expectations regarding corporate governance arrangements over the next 12 months and trusts should be aware that **"issues not identified and subsequently arising can be used as evidence of self-certification failure"**. The requirement for the completion of the corporate governance statement is separate to the disclosure requirements of this code.

The code disclosure requirements – listed in this document and the NHS foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual

This document is designed to set out **standards of best practice for corporate governance.** It is not mandatory to comply with this guidance, however, the NHS foundation trust annual reporting manual and Department of Health and Social Care group accounting manual do require trusts to make some specific disclosures on a 'comply or explain' basis regarding the provisions listed in this document. (A detailed list of the disclosures required is provided in Schedule A of this.) This is a backward looking statement which should be submitted with the annual report.

Annual governance statement – in the NHS foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual

In addition to listing the code disclosure requirements, the NHS Foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual also require an annual governance statement. The annual governance statement is a backward looking statement which captures information on risk management and internal control, and includes some specific requirements on quality governance.

Completion of the Annual governance statement is a **mandatory requirement**. The annual governance statement does not relate to this code.

Date published: 27 October, 2022
Date last updated: 23 February, 2023

DIVISION OF RESPONSIBILITIES BETWEEN THE CHAIR AND THE CHIEF EXECUTIVE

1.0 Introduction

1.1 Within the NHS England (NHSE) Code of Governance for NHS Provider Trusts:

1.1.1 the chair leads the board of directors and, for foundation trusts, the council of governors, and is responsible for its overall effectiveness in leading and directing the trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the chair facilitates constructive board relations and the effective contribution of all non-executive directors, and ensures that directors and, for foundation trusts, governors receive accurate, timely and clear information.

1.1.2 responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision.

1.1.3 the responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.

1.2 The purpose of this document is to set out the division of responsibilities between the Chair and the Chief Executive. In doing so particular reference has been made to:

- NHS E Code of Governance for NHS Provider Trusts
- Standing Orders

2.0 Responsibilities of the Chair

2.1 The discrete responsibilities of the Chair can be summarised as follows:

2.1.1 The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers.

2.1.2 The Chairman must comply with the terms of appointment and with Standing Orders.

2.1.3 The Chairman shall work with NHS Improvement over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

2.1.4 The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.1.5 The effective running of the Trust Board.

2.1.6 Ensuring that the Trust Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

2.1.7 The guardian of the Trust Boards' decision making processes.

2.1.8 Offering counsel and advice on sensitive or complex issues raised by the Chief Executive or Other Executive or Non-Executive Directors.

2.1.9 General leadership of the Trust Board.

2.1.10 Ensuring compliance with the Trust Board's approved procedures.

2.1.11 Arranging informal meetings of the Directors, to ensure that sufficient time and consideration are given to complex, contentious or sensitive issues.

2.1.12 Facilitating the effective contribution of all members of the Trust Board to ensure that constructive relations exist between Executive and Non-Executive members.

2.1.13 Chairing, or nominating another independent Non-Executive Director to chair, the Remuneration Committee, and initiating change and succession planning in the Board and the appointment of effective and suitable members and Chairs of Board Committees.

2.1.14 Contributing to the agreement of the membership of Board Committees and proposing their Chairs.

2.1.15 Taking the lead in providing a properly constructed induction programme for new Non-Executive Directors.

2.1.16 Appraising the performance of Non-Executive Directors.

2.1.17 Taking the lead in identifying and seeking to continually update their skills and knowledge, and meet the ongoing development needs both of individual Non-Executive Directors and of the Board as a whole.

2.1.18 Ensuring periodic meetings take place with Non-Executive Directors in the absence of Executive Directors.

2.1.19 Promoting the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at Trust Board level.

2.1.20 Ensuring good information flows from and between the Trust Board and Non-Executive Directors.

3.0 Responsibilities of the Chief Executive

3.1 The discrete responsibilities of the Chief Executive can be summarised as follows:

3.1.1 The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

3.1.2 All members of the management structure report either directly or indirectly, to the Chief Executive.

3.1.3 Executive responsibility for running the Trust's business. **N.B.** The Chief Executive will be responsible for ensuring that in his / her absence, a designated Executive Director will deputise.

3.1.4 Ensuring that the Trust and its staff meets all relevant statutory requirements and service obligations including as set out in the NHS Provider Licence and making sure that the Trust's governance framework and associated structures and processes are 'fit for purpose'.

3.1.5 In conjunction with the Trust Board, responsible for creating, developing and promoting the Trust's strategy, taking account the needs of key stakeholders and enabled by a robust strategy for delivery of the Trust's overall objectives.

3.1.6 Ensuring the Chair is aware of the important issues facing the Trust and proposing agendas which reflect these.

3.1.7 Ensuring that the Executive Team provides reports to the Trust Board which contain accurate, timely and clear information.

3.1.8 Ensuring that the Chair is alerted to forthcoming complex, contentious or sensitive issues affecting the Trust.

3.1.9 Supporting the Chair in their tasks of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive members of the Trust Board.

3.1.10 Providing information and advice on succession planning, to the Chair, the Remuneration and Terms of Service Committee, and other members of the Trust Board, particularly in respect of Executive Directors.

3.1.11 Maintaining and strengthening effective working relationships and communications with stakeholders including staff and patients.

3.1.12 Maximising the potential of the Trust's organisation and people by ensuring an appropriate and effective Trust culture, organisation and leadership, supported by effective strategies and systems to manage and develop the Trust's human and physical resources.

3.1.13 Providing leadership and development of the Executive Directors and other Senior Management reporting to him/her and ensuring that the Trust has the capacity, capability and the effective management systems to deliver on the Trust's objectives.

3.1.14 Ensuring that performance reviews are carried out at least once a year for each of the Executive Directors. Providing input to the evaluation process and to the Remuneration Committee as appropriate.

3.1.15 Promoting and conducting the affairs of the Trust with the highest standards of integrity, probity and corporate governance. Promote continuing compliance across the organisation.

3.1.16 Maintaining and enhancing the Trust's reputation and profile with stakeholders and with the community which the Trust serves.

4.0 Shared Responsibilities of the Chair and Chief Executive

4.1 There are a number of areas where the Chair and the Chief Executive carry a joint or shared responsibility, often because there is inter-dependence between the two roles for a responsibility to be fulfilled. These areas of shared responsibility include:

4.1.1 Leading and demonstrating the necessary behaviours that support the values of the Trust.

4.1.2 Ensuring that the Trust Board receive accurate, timely and clear information that is appropriate for their respective duties.

4.1.3 Handling high profile media coverage, particularly where this could be damaging to the reputation of the Trust.

4.1.4 Ensuring that the Trust has in place a clear schedule of matters reserved for the Board and, for the others, ensuring that a Scheme of Delegation is agreed and in place.

4.1.5 Sharing line management of the Trust Secretary, who has a dual reporting line to the Chair and Chief Executive.

Action Requested of the Trust Board

The Trust Board is asked to consider the division of responsibilities between the Chair and Chief Executive and approve them.

STANDING ORDERS

REFERENCES

Only PDFs are attached

6.10 - Standing Orders - May 2023.pdf

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	09.05
Title	Standing Orders				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The report was previously considered at the February 2023 Trust Board				

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

Key Recommendations to be considered:

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders May 2023

1 Purpose of the Report

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

2 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows: This paper summarises all use of the Trust seal since February 2023.

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2023/02	Hull University and Hull Maternity Development Ltd and Apleona LPP Ltd – Deed of variation to the project agreement and the services contract both dated 8 December 2000 relating to the surrender of part of the Hull Women's and Children's Hospital PFI site.	14/04/23	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2023/03	Hull University Teaching Hospitals NHS Trust and Hull Maternity Development Ltd – Deed of surrender of part and deed of variation relating to a Head lease of part of HRI	14/04/23	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2023/04	Hull University Teaching Hospitals NHS Trust and Hull Maternity Development Limited – Deed of surrender of part and deed of variation relating to an under lease of part of HRI	14/04/23	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer

3 Recommendation

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Rebecca Thompson
Head of Corporate Affairs
May 2023

DIGITAL STRATEGY UPDATE

REFERENCES

Only PDFs are attached

- Trust Board Cover Sheet - May 2023.docx
- Digital Update HUTH Board May23 Final.pdf
- Digital Update HUTH Board May23.pptx

Digital Services

Hull University Teaching Hospitals NHS Trust Board Report

May 2023

Shauna McMahon, Group Chief Information Officer

shauna.mcmahon@nhs.net

Contents

Executive Summary

Digital Services provided a detailed presentation on the current status at a joint board meeting in February that focused on the current state of the digital consolidation with Northern Lincolnshire & Goole NHS FT (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH). This document provides a written report on the how HUTH has progressed tracking to the digital strategic framework and objectives for the 22/23 year. The report also provides information on the national level digital programme.

Our Digital Vision:

"To embrace digital technologies so we can provide a workplace that enables our staff to deliver the best possible care for our patients and to improve health outcomes in our community.

The past year can best be described as agile working for digital services at both HUTH and NLaG. The Group CIO was in place with a new senior leadership team in post that is service focused not site focused. With a focus on our people, we continue to work with our employees and stakeholders to consolidate digital services so we can leverage the talent, expertise, and improve resiliency for service delivery.

The establishment of the Integrated Care System has meant that several team members now support the ICS projects which has placed an increase stress on the team. Even with that expanded demand, we implemented the following major four programmes of work this past year:

1, Continued roll out of nerve centre for case notes on wards and for clinical clerks.

2. Upgrades to specific network areas to improve performance.

3. Migrated off the old Radiology IS to the new Soliton platform.

4. Began the implementation of one Patient Administration System for HUTH & NLaG. This project will continue into 23/24 with a completion date of Sept. 2023.
5. Began work with NHSE, ICS to build the case for an Electronic Patient Record. The goal is to have one solution for the four acutes in the ICS, at minimum a single EPR for HUTH and NLaG.
6. Supported the Integrated Clinical Program (ICP) providing access to WebV (NLaG) and Lorenzo (HUTH) so care providers can access patient information at the two Trusts.
7. Scan4Safety continues to be deployed with a focus now on Radio Frequency ID (RFID) to track people and objects.
8. Using Patient Knows Best and Lorenzo we have enabled increased patient access on a digital platform. Many of our patients use mobile phones and sending appointment reminders, letters and correspondence enables improved access and timely responses.

These are just a small example of the digital areas of success this year.

Challenges

We have two major challenges: workforce and funding.

Recruiting skilled team members especially in areas such as coders, business information specialists, system developers and project managers is a challenge across the NHS but more so in rural areas or as you move away from London or larger cities. A contributing factor is our digital maturity is generally below those Trusts south of us. In the south where digital maturity tends to be higher, they have full electronic patient records and can offer remote working and due to proximity to London or a larger city centre and they tend to have higher pay scales. Investing in our digital environment will have a positive impact to some degree, however we do have to balance out the pay inequity for our digital staff. Our staff are not only being sought after by other Trusts, we also compete with the private sector. We have experienced more impact in this area since Covid, as the increase in home working and flexible working exploded during that time.

An ongoing challenge continues to be managing the internal needs of both organisations as they look to support elective recovery and an Urgent and Emergency Care system that is creaking while responding to National and Integrated Care System initiatives.

The **Priorities for 23/24:**

- Complete PAS and Data Warehouse projects
- Complete ICNET Infection Prevention implementation
- Complete PKB pre assessment to all day surgery
- Complete Lab Information LIMS integration to Lorenzo
- Complete NLaG migration to Medicode 360
- Complete HUTH ICS Maternity implementation
- Complete EPR OBC, procurement and FBC
- Complete eObs escalations and task management roll-out
- Complete PKB pre assessment roll-out
- Continue to consolidate the IT Infrastructure

Developing and Supporting our Digital Workforce

Our commitment to developing our most important assets (our staff) continues to be high on the agenda. Our services must be shaped to deliver on the requirements for the organisations we serve, and we must have our staffing resources appropriately skill and trained.

This past year has been one of transition and this will continue into 23/24. The staff are amazing and doing extremely well under significant pressure to deliver on many projects. In addition, our consolidation of service delivery, as

any major change will do, creates some anxiety. We have had facilitated workshops, combining staff from both sites, with an external OD consultancy. We are looking at the responses on the staff survey and making focused efforts to improve and tackle those areas that the staff have noted. With a score of 40.6% in the area of having input in the decisions that affect my work. As part of this change, I committed to the staff that they would help shape the department. I do not expect we will meet everyone's expectations however the senior team is making a very concerted effort to do so. We have had excellent engagement and are now seeing the culture shift as staff seek to work with their counterparts at the other sites. Collectively, staff and management will continue to work to improve those areas that the staff have brought forward in the survey. We do know that we need to modernize job descriptions and ensure there is clarity in the roles. This work is ongoing into fiscal 2023/24.

BCS Memberships

We have enabled two routes for staff to train for both professional certifications and technical qualifications. These offerings will help career development and provide the latest relevant training for individual roles. Since becoming a member of the British Computer Society (BCS) employees can register to complete either a registration for IT Technicians (RITTech), Federation for Informatics Professionals (FEDIP) or Chartered Engineer Registration (CEng). We continue to encourage participation. The BCS has recently awarded NLaG Platinum Partner Status which "demonstrates the highest level of dedication to the mission of delivering talented, ethical and dedicated professionals for the benefit of the industry and society". With the consolidation of Digital Services our aim is for HUTH participation to reach that Platinum status. We continue work on finances so we can have some funds ring fenced to support digital development of our employees as this is a major factor that impacts retention. Also, we must continue to develop our employees, so they are able to work effectively in a changing digital landscape.

Financing Innovation and Transformation

The finance allocation as presented at a recent Board meeting has not kept pace with the demands and expectations. The four-year average digital spend at HUTH was 2.11% of outturn where recent audit reports conducted by the National Audit Office suggest 5% should be the average in the public sector. Many businesses today are reaching the 8-10% range as digital is the backbone of the business. Modernizing digital services in a way that will connect HUTH and NLaG requires funding and the current capital allocations that have occurred in the past will not support the pace required to meet the needs of our end users. It is anticipated that previous levels of NHS funding will decrease and this will create a tension given the current financial position in our ICS and Trust. It means we must sweat every digital asset we can and use systems to their full capability. Focusing on the biggest benefit areas for limited funds should also be our approach.
These challenges can be overcome with a more planned approach to digital deployments. This would include doing less and focusing on those projects with strong benefits and delivering them on a faster time scale, while deferring others.

The five-year projected capital plan for HUTH is £36.782 Million (avg. 7.3 M/yr). this is about 1.0% of the current out turn of £726 M annually and the full plan of £36M just hits the 5% mark, keeping us in an expected range for a modern organization. Investing in a modern, digital hospital should improve recruitment and retention as well and overtime we would expect to see reduction in agency costs. A planned and robust investment in digital if the cultural and business transformation is done well with clear operational targets, should deliver improved efficiencies, safer care, improved data quality, with the ability to be in a position to be more agile with decision making.

Data Security and Protection Toolkit (Cyber Security)

The Data Security and Protection Toolkit return demonstrates the increasing focus on cyber security by design, and the need for more engagement with staff to understand their training needs and support mandatory training completion.

The improvement plan current state was submitted to NHS Digital (Now NHS England) in February 2023. NHS England are reviewing submitted plans and planning to contact any organisations where they believe further support is needed. The Trust to date has not received any contact from NHSE, so our assumption is that NHSE are satisfied with the trust's progress. The improvement plan was reviewed by the Information Governance Committee prior to the February submission.

The 2022/23 DSPT focus is currently on the 13 Assertions at both organisations which Internal Audit are reviewing as part of the annual audit. These 13 assertions are the same assertions which were reviewed as part of 21/22 audit. (NHS England decide which assertions are reviewed). These are reported to Audit Committee.

Next Milestones:

- 04/05/2023 – Initial submission due to the auditor for review
- 12/05/2023 – Draft Report from auditor expected
- Deadline for final submission to be agreed and then final report findings to follow.

One of the current concerns is around training and this has been decreased in our compliance ratings month on month despite the weekly sessions that IG have been conducting for all staff online as well as the invite to attend any

team meetings to capture learning for the whole team at once. This is an area where operational managers need to directly manage and ensure staff have completed mandatory training. It is expected that on submission for 2022/23 the trust will have a rating of *'Approaching Standards'.*

Going forward, Digital Services is continuing to deliver the necessary technical and process driven improvements to meet the requirements of Cyber Essentials Plus & ultimately ISO27001 accreditation. In our recent audit the priority item noted was improving the cyber incident response plan and our procurement practices for digital in the Trust. The former we are working on as part of our service consolidation and the later we are working with procurement to bring in a specialist contractor for a period to focus on contracts and procurement best practice.

Cyber security and DS&P is an ongoing and iterative process. As Hackers become more sophisticated the need to be ever vigilant will continue. Our Trust is in a good place with a planned approach for continuous improvement.

Digital & Infrastructure Services

We continue to build on our digital foundations with a better understanding of our infrastructure and where to target and share investment based on our recent review. As part of the digital aspirant funding, we engaged an external IT specialist consultancy company to undertake a review of NLaG and HUTH IT infrastructure to assist us with future planning. The findings were shared in a joint board presentation and in summary our focus is on continuing to deploy modern devices and hardware for staff. We are actively improving our network connectivity, expanding Office365 to support collaboration and productivity as well as implementing a new IT service management system as a single service across both Trusts that will streamline our ability to support services more efficiently.

The Clinical Coding and Information Governance service areas are now fully aligned under one management structure. The Managers continue to support the team and are now working on levelling up to deliver a more standardized service across both Trusts. This has required filling of vacancies in IG and updating some roles and job bands in coding. This supports the work on process alignment. These changes are starting to deliver results with the SHMI now in a downward trend since November sitting at 1.08 moving toward the target of 1.0. We expect as the trend to continue.

Progress on HUTH 22/23 Strategic Priorities Against the Strategic Framework

22/23 Year 1 Complete rollout of ePMA, eObservations and electronic nurse assessments

eObs and Nursing assessments completed as below:

- E-obs to all adult wards, ED, paediatrics
- Critical Care Digital Nursing Record
- Blood Observation Module
- Nursing Digital Record including assessment and Care Plans
- Frailty , Alcohol and Smoking assessment and referral
- Weight, Height and Fluid Balance Recording
- ED Digital Nursing Record
- Digital Kitchen White Board
- Digital Safety Huddle
- Digital Sepsis Dashboard
- Digital Sepsis Screening Tool

ePMA completed including:

- All inpatients adult wards
- Theatres & Recovery
- Critical Care Areas
- Digital Fall Back and Downtime box for each ward and Departments in place

Inpatient Roll out of Advanced bed Management complete including:

- LIVE ADT Dashboard
- Floor Plan
- Drag and Drop Discharge

- NCTR Data collection
- NCTR Live reporting
- Discharge Live BI
- Escalation Live BI
- Covid, Flu, & VRE live BI Dashboards
- Digital Discharge to assess for social care and community Partners
- Successful pilot of digital medical clerking roll-out under way

My Assurance developments completed including

- Digital audit solution for 25 + audits
- Digital Matron assurance Handbook
- BI Dashboard e-obs, assessments
- BI Dashboard for WHO compliance audits
- Bi Dashboard for Infection Control Compliance
-

In addition:

- A New Radiology Management System (Soliton) implementation was completed
- ORMIS Theatre Management AWS cloud migration completed
- Migration of BI service onto new resilient infrastructure
- The purchase of the ICNET (Infection Prevention System) complete. This will enable the IPC team to identify and track the management of patients with infectious diseases.
- Pilot of Alertive Clinical Communications software underway in the Queens Centre. Radiotherapy, nursing and pharmacy staff now using it, medical staff to follow. Being used as a messaging tool – improved communication, positive feedback so far.
- ICS Maternity implementation underway
- EPR Procurement to Pre-market engagement completed

22/23 Year 1 Objective - Support the transition of services as part of HASR Phase 1: Interim Clinical Plan to enable shared service models across the Humber region

- Lorenzo WebV click through integration complete
- Streamlined access process in place for Lorenzo & Web V
- Cross site BI access in place
- ICP BI Dashboards developed
- Joint coding team in place across HUTH and NLaG
- HUTH Medicode Upgrade to Medicode 360 complete
- PKB registrations increased to 145K and 50K letters being sent digitally per quarter, pilot of Digital Patient pre-assessment questionnaires completed. Roll-out underway to all day surgery specialties in line with the new Day Surgery Centre opening in June 23

- Support for Goole Surgical Hub to produce single PTL and a streamlined pre-assessment pathway
- Provision of specific dashboards to support transfer of NLaG Oncology patients to HUTH as part of ICP Programme

22/23 Year 1 Objective - Shared PAS with NLAG; Shared Data Warehouse and analytics team; Shared LIMS and Pathology service; Integration with regional shared care record to support patient pathways

- Ongoing support and joint working between HUTH and NLaG on PAS and data warehouse implementation
- Shared HUTH / York LIMs service in place.
- Ongoing support on integration as part of the new LIMs system implementation
- YAS integration with Lorenzo via YHCR completed, YAS pre arrivals and patient records available within Lorenzo
- GP Connect integration with Lorenzo completed providing GP record access within Lorenzo, including transfer of medications, allergies and alerts into the acute record
- Provision of ADT integration with via YHCR with CHCP completed to support discharge and timely primary care intervention.

22/23 Year 1 Objective - Meet DSPT standards and work towards Cyber Essentials plus compliance; Complete a baseline assessment of What Good Looks Like (WGLL) and continue improvement work against HIMSS digital maturity framework

- National DMA (WGLL) survey completed
- Above projects implemented in response to HIMMS digital maturity framework improvement plan. Trusts are asked to reach HIMSS level 5 by 2024/25 or demonstrate a clear plan with a target delivery.

Priorities for 23/24

- Complete PAS and DWH projects
- Complete ICNET Infection Prevention implementation
- Complete PKB pre assessment to all day surgery
- Complete LIMS integration to Lorenzo
- Complete NLaG migration to Medicode 360
- Complete HUTH ICS Maternity implementation
- Complete EPR OBC, procurement and FBC
- Complete eObs escalations and task management roll-out
- Complete PKB pre assessment roll-out
- Continue to consolidate the IT Infrastructure

Clinical Leadership Team Update

Dr Alastair Pickering, Chief Medical Information Officer & Steve Jessop, Chief Nurse Information Officer

The mainstay of work for the last few months has been alignment of digital projects between NLAG and HUTH, planning priority areas for delivery into the end of the financial year and ensuring we (our senior digital team) are embedded at ICS level. This is demonstrated with both the Group CIO and CMIO being members of the ICS Digital Executive and Strategy Boards and supporting the ICS wide acute collaborative. In addition, the clinical team is very active with the current EPR tender work and working with our ICS colleagues and clinicians at both Trusts to ensure our motto of *making life easy* for our clinicians is met and that we deliver the best digital enabling tools we can with a focus on future needs.

A key priority has been on the Interim Clinical Plan Specialties to ensure we support the single service models being developed, and this closely links with the ongoing project work to deliver a single Patient Administration System across the two organisations. This work has delivered systems access across staff groups in each organisation as well as the in context click through links to the relevant areas of the patient's records.

We continue to roll forwards our paperless approach – reducing unnecessary printing and generating regular reports on high print use areas, expanding our digital clinical notes and outpatient pilots, as well as pre-assessment forms. The new maternity and eye referral systems that have been procured regionally will also enhance clinical teams working but will need their expert input through delivery to ensure they work as expected.

As we bring on more complex digital solutions the need for enhanced communications for clinical staff specifically focusing on what it means for services and individuals. The service consolidation with NLaG resulted in us having three senior clinical leaders – Alastair Pickering, Steve Jessop and Martin Sykes. They will require other digital champions to support the major programme of work – new EPR and Enterprise Content Management System (eliminate paper). As part of this expansion, we have procured the services of an external company with expertise in Human Centred Design for digital solutions. They will work closely with our frontline clinical areas to ensure that we procure solutions that are more aligned to user needs. This will also support staff in understanding their own digital literacy and building their confidence with digital systems that can directly benefit them and the patients they care for.

Regional Digital Developments

Building on the previous work done by NHS Transformation, the Secretary of State for Health and Care released the latest plan for Digital health and social care at the end of June 2022. This focused on patients and the expansion of digital systems and services, while also supporting the recommendations in the Goldacre Report “Data Saves Lives”.

While each system (ICS) is developing its costed plan for digital and data investment – these will be integrated into the wider operational planning process with extension to multi-year planning from the end of this year. The aim is to embed digital and data planning not only into multi-year operational planning, but to then extend this, in the form of digital maturity assessments, into regulatory body assessments e.g., CQC.

Digital Maturity at both Trust and ICS level are already a focus for delivery by the end of 2023. A financial support plan was released defining where national and regional funding efforts will be targeted.

National funds will focus on:

- NHS App development as the single point of digital contact for patients

- A national Federated Data platform
    - Including Trusted Research Environments
- National Cyber Security support
- Cloud based services

Regional and local investment will be distributed to support:

- EPR convergence (in support of better digital processes and maturity)
- Implementation of the chosen data platform
- Patient engagement portals – linked to the NHS App
- Tech enabled remote monitoring (linked to virtual wards)
- Cyber security and connectivity
- Shared Care Records

With the tech elements of wider funding that has already been distributed being:

- Diagnostics programme
- Targeted Investment Funding
- Virtual Wards
- Primary and Social Care support

A Federated Data Platform (FDP) will be an ecosystem of connected platforms, placed in and ultimately determined by individual NHS organisations and will provide decision makers with access to real time information to make informed, effective decisions to transform how we plan, manage, and sustain services. The WGLL framework for Digital Maturity has 7 success measures that we will be assessed against:

- Well led
- Ensure smart foundations
- Safe practice
- Support people
- Empower citizens
- Improve care
- Healthy populations

One of the tools being launched in 2023 was an assessment framework which is used to measure our level of digital maturity (Digital Maturity Assessment – DMA). The aim is to help identify gaps and prioritise areas for local improvement. Assessments will be repeatable so organizations can track progress year-on-year. Frontline support in terms of funding and expertise will also be available. In addition, we have a regional maternity system recently procured so all women can access their maternity notes and information through smart phone or other device by 2023/24. The system will provide information in digital format to those that are supporting mums-to-be. We will remove paper processes for this population. HUTH and NLaG both have helped to shape the ICS digital and data strategy, establish governance and working on “levelling up” plans for the region.

HUTH has worked with our ICS colleagues to create our ICS funding priorities. As an ICS our digital strategy is based on the principle that we will adopt open standards and an open platform for our digital environment so data and information is within our control, and we can manage how we share our data. We are continuing to work with our ICS colleagues to “level up” across our region and make the most of the funding opportunities with the target to have a new EPR procured by end of fiscal 23/24.

Other areas where our work aligns directly with national strategy is our systems integration with the regional shared care record and close working relationship with the regional cybersecurity lead. As the ICS continues to mature, digital funding will be allocated through the partnership and place-based systems and collaboratives. It is essential that we maintain our presence at ICS Digital Transformation Senior Leadership Team and strategic level to ensure we continue to align in our priorities and secure suitable financial support for local delivery. The need for local investment to support some projects will continue, but most of the transformation work will become funded through national and regional programmes and our role is to ensure

that not only our digital services, but also our staff are in the best position to use this when available to deliver the expected transformation.

Conclusion

This update was written to provide assurance that the digital teams are working on the strategic framework that was agreed. There has been significant positive improvements and achievements delivering what would be described in the digital world as major programmes of work.

Areas of Focus next 6 Months:

- Continue to focus on our staff and working together through our transition to a single service
- Completion of the single PAS implementation
- Focus on the tender for a single EPR and EDMS
- Continue to reduce barriers to joined up working -focus on network integration
- Streamline governance processes for Digital Services with a single Group Digital Strategy Board and Digital Solutions Delivery Group
- Enable RPA across two priority processes to deliver measurable benefits
- Develop a single digital strategy for the Trusts
- Support operations to lead on business transformation to ensure the best possible benefits are being realized from digital and technology solutions.
- Establish a more consistent funding level to deliver on the EPR programme as well as the other transformational solutions prioritized.

The current period continues a trend of significant demand for digital enablement across the wider organisation. New and exciting technologies are being offered for use in care delivery which is creating exceptional demand for

Digital in our front-line teams. Using robust governance processes, the Digital teams assess where digital initiatives fit within the wider strategy and priorities of the organisation. Our programme must remain ambitious but realistic to the challenges around capacity and funding, hence why prioritisation is key.
Our efforts remain focused on how to reduce the gaps in digital and make life easier for our end users and patients to work within the system. To achieve this, we will continue to balance the challenges around maintaining and improving existing IT Infrastructure and systems, while ensuring we capture opportunities to digitally innovate within the Trust and with our key partners.

Digital Highlights

PAS Replacement Project

The consolidation to one PAS system (NLaG & HUTH) with Lorenzo is progressing forward. The work will streamline the patient administration processes, allowing far more effective coordination of care that support collaborative clinical models.

Teams from across both NLaG and HUTH have come together and focused on a go-live of the new system. We had hoped to go live in May however due to volume of records transferring over we have had to move the date to Sept. 2023. The dependencies on PAS for a wide range of other processes need to be carefully mapped out to ensure that unplanned consequences from such a major system change are minimised and that risks are managed appropriately.

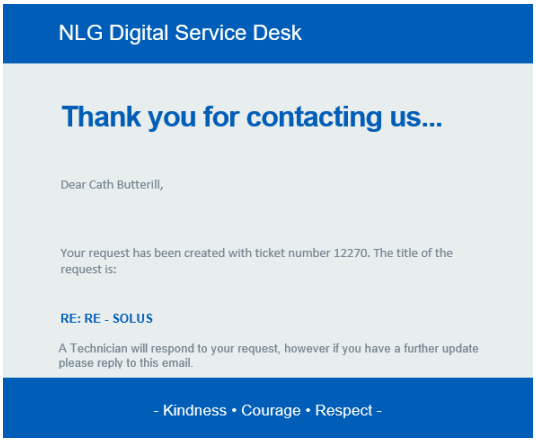
Robotic Process Automation (RPA)

The RPA project aims to eliminate a large proportion of repetitive data entry in the Trust by using 'bots' to support staff and free their time for more productive tasks. The project has 4 identified process between NLaG and HUTH that will be the focus of delivery in 2022/23.

The Trusts are being onboarded into the NHSE RPA UIPath Infrastructure and finishing local set up. We are focused on Electronic Referrals (Advice & Guidance) and referrals into Lorenzo at HUTH.

IT Service Management System (ITSM) – Service Desk Plus

This solution initiates a major transformation across digital and infrastructure services. We have deployed and tested the coare modules of the ITSM system & Service Desk Plus at NLaG and are bringing HUTH and NLaG together to level up on the one platform. This system now allows users to directly log a problem or service request with Digital Services by e-mail, but you can still use the telephone if you wish. Coming soon you will be able to use the self-service web portal to also access our services, this will help direct you to the correct team in Digital Services and even get direct online help and assistance. We will be onboarding all Digital Services sections onto this new platform over the coming months so there will be a single point of contact to gain access to all of our services. This single service desk for both Trusts enables improved root cause analysis and the opportunity to leverage quality improvements and we will be able to pull out Key Performance Indicators for our services.



Additional References

A plan for Digital Health and Social Care
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Data Saves Lives: reshaping health and social care with data
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https://www.nhsx.nhs.uk/digitise-connect-transform/who-pays-for-what/

REFERENCES

Only PDFs are attached

7.2 - RDI Trust Annual Report 2022-23.pdf

Agenda Item		Meeting	Trust Board	Meeting Date	09.05.23
Title	Research Development and Innovation Annual Report				
Lead Director	Thozhukat Sathyapalan, Director of RDI				
Author	James Illingworth, RDI Manager				
Report previously considered by (date)	The report has been considered at the Quality Committee in April 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 to be considered:

The Trust Board is asked to receive the RDI Annual Report and decide if any further assurance or information is required.

RDI progress is regularly monitored at the Quality Committee.

Research Development and Innovation

The ambitious HUTH R&I Strategy seeks the creation of a well-led 'research active and aware' workforce enabling high quality care for every patient through research opportunities. To achieve this, it is fundamental that there are mechanisms to increase our capacity and capability for research in order to recruit and retain remarkable staff and high-quality researchers and develop the research potential further in all professional groups, service users and carers.

The number of patients receiving NHS services provided or sub-contracted by Hull University Teaching Hospitals NHS Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee or Health Research Authority was **7,771**.

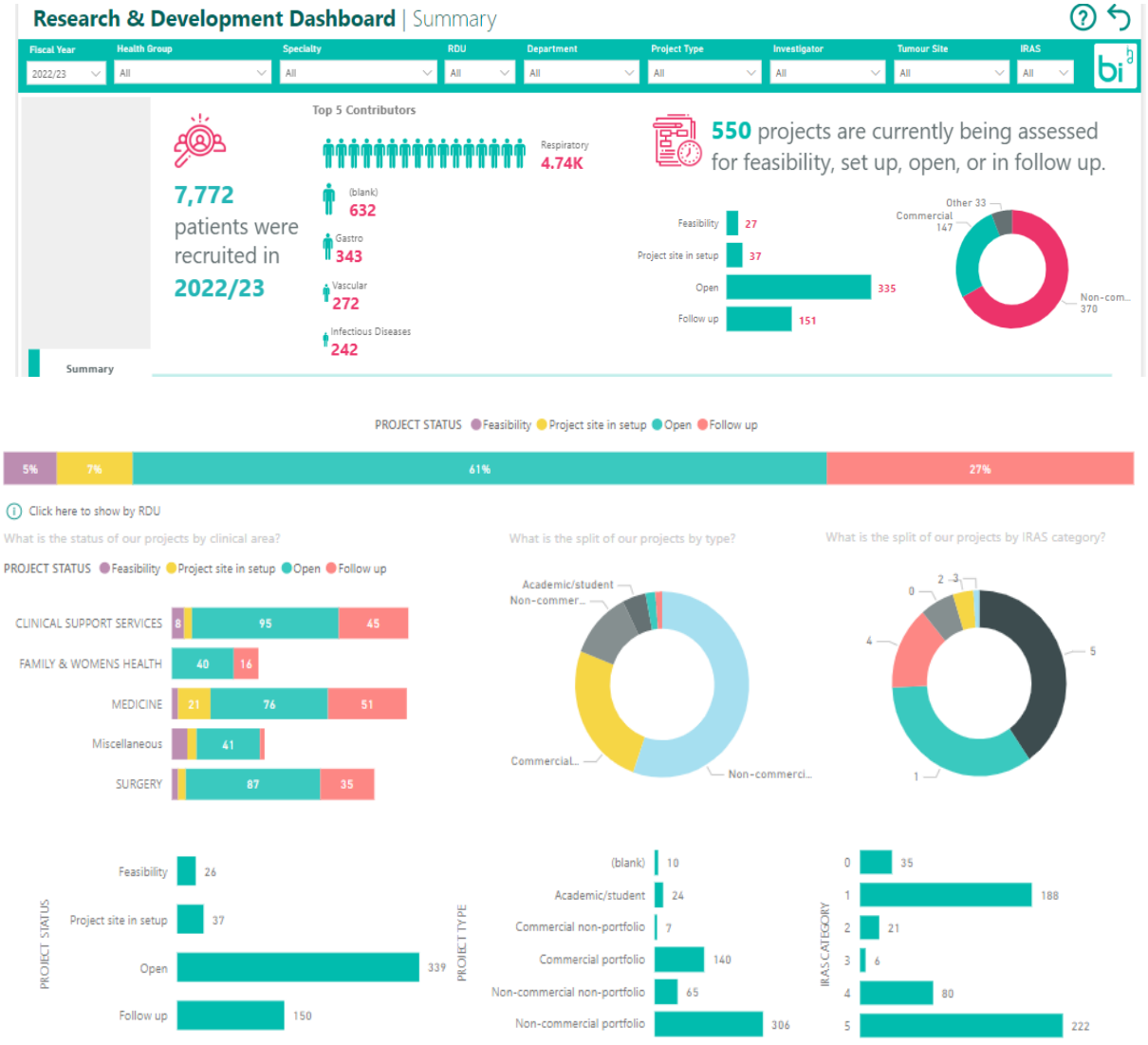
Clinical Research Network – National Institute for Health Research portfolio:

There were **7,260** participants recruited onto **165** National Institute Health Research (NIHR) portfolio adopted studies. Specifically, we would like to highlight the following:

- Participant recruitment for 2022-23 is **68%** above the target set by our clinical research network (Yorkshire and Humber) representing notable value for money and impact on the local community.
- Our overall portfolio recruitment for 2022-23 ranked the Trust third in Yorkshire and Humber behind only Leeds and Bradford in terms of Teaching Hospital performance.
- The Trusts commercial activity is also ranked third highest in the network with 40 studies, showing a commitment to delivering the CRN 'Managed Recovery' for the Life Sciences Industry post-pandemic.
- Respiratory Diseases was the top recruiting specialty in the Trust's portfolio with the 'Hull Lung Health' and a broad range of interventional drug studies.
- The Trust continues to deliver a broad research portfolio with **165** active and open portfolio studies – again, ranked third highest in the network.
- Notable activity areas to highlight include; Gastroenterology and Haematology (*ranked 2nd across Yorkshire and Humber*), Diabetes, Renal, Paediatrics and Hepatology (*ranked 3rd across Yorkshire and Humber*), Cancer, Trauma and Emergencies (*ranked 4th across Yorkshire and Humber*).

We feel sure that the ongoing delivery of our Research and Innovation Strategy (and continued pursuit of this throughout the pandemic) has contributed to this notably strong performance in 2022-23. In particular, we are also aware of the significance of the step-wise increase in Trust-led research undertaken nationally, which is providing the catalyst for the Trust's planned expansion of research capability and capacity. This commitment to research and innovation is underlined by our Trust Strategy with 'Ground breaking research' one of the four cornerstones setting the agenda for our annual objectives and every support is given to our operational teams to ensure that they are delivered. Each cornerstone is part of a wider story about what we stand for and what that will mean in years to come for our Trust, the people we care for and the whole community.

R&D Summary Dashboard 2022-23



Celebrating Research Success in 2022-23

- **Renal Research leads national trial:** The STOP ACEi Trial led by Professor Sunil Bhandari, is a long awaited landmark RCT trial funded by the NIHR and sponsored by Hull University Teaching Hospitals NHS Trust that completed in 2022-23. It was performed in 37 UK hospitals and has shown that in advanced and progressive chronic kidney disease that stopping Ace inhibitors or angiotensin receptor blockers does not lead to any benefit in kidney function, such as delaying the need for dialysis or transplantation, and could deprive patients of the cardiovascular benefits of these drugs.
- **Success for HUTH's Academic Vascular Research Unit:** Our Vascular Research unit, led by Prof Ian Chetter, had tremendous success at the Vascular Societies' Annual Scientific Meeting, (Brighton 23rd – 25th November 2022) showcasing some of their fantastic work. Amongst several successes- Ross Lathan won the VERN

Dragons' Den Prize 2022 and was awarded £3000 towards his project on: Prevention of Surgical Site Infection: an international pan specialty survey of practice.

- **Paediatric Research Team successful recruitment to vaccine study:** The team were extremely proud to be running the Trust's first paediatric commercially funded RSV vaccine trial in 2022-23 and exceeded target recruitment. RSV (Respiratory Syncytial Virus) is one of the leading causes of hospitalisation in all infants worldwide. It affects 90% of children before the age of two. This study evaluated the effectiveness of nirsevimab, a monoclonal antibody vaccination. RSV often causes only mild illnesses, like a cold. Yet, for some babies, it can lead to more severe lung problems such as bronchiolitis and pneumonia. The team surpassed the recruitment target of 50, and managed to enrol 59 infants to the trial. They finished the year 3rd in the recruitment tables for the region, against some of the large children's hospitals. ensuring opportunities for children to benefit from research is maximised. The future aim is to provide every child/baby the opportunity to participate in clinical research and by doing so contribute to improving the diagnosis, treatment and outcomes for themselves and others.
- **Participant in Research Experience Survey:** Every year, the NIHR Clinical Research Network asks thousands of research participants to share their experiences of taking part in research. The Participant in Research Experience Survey (PRES), aims to put participant experience at the heart of research delivery. Responses from our research participants demonstrate improvements year on year, and this year's responses to date are no exception. 98% of our HUTH research participants feel that they are fully prepared for their research experience by HUTH research staff and feel valued when taking part in HUTH research.100% of our HUTH research participants feel they are always treated with courtesy and respect by HUTH research staff and 96% of our HUTH research participants would take part in further research trials.

Progress on key strategic priorities in 2022-23

- **Significantly increasing Trust-led research undertaken nationally:** As our research activity and workforce capacity incrementally expand, our success in securing externally funded grant income from the NIHR continues. We can now boast to lead multi-centre national research in the areas of Vascular Surgery, Gastroenterology (IBD and Hepatology), Renal, Orthopaedics, Respiratory, Infection and Haematology and Cardiothoracic Surgery and Rehabilitation.

- **Establishing research programmes with the potential to positively impact our key performance and quality indicators**: HUTH is currently supporting the set-up of the 'Born and Bred in' (BABi) study which originates from the work of Bradford Teaching Hospitals Trust. The BABi study is a data linkage birth cohort study supporting the review of to the health and wellbeing of families across our region. This study offers fantastic potential to; assess the determinants of childhood and adult disease, assess the impact of migration, explore the influences of pregnancy and childbirth on subsequent health and generate further research work that has the potential to improve health for some of the most disadvantaged within our society. External support funding has been secured for this initial work and discussions are

ongoing with maternity services and external partners (UoH and Hull City Council) about how we can maximise the benefits of this cohort work.

- **Exploiting our research potential:** A concerted effort by our local partners (Hull York Medical School and University of Hull) to bring together all key stakeholders to embed a pipeline of PET-CT research is gathering momentum with one study with an international commercial company in the final stages of setup.

- **Increasing research capacity in our workforce** – The Trust continued to work towards securing additional research capability and capacity. Areas supported by additional funding in 2022-23 include; Surgery, Imaging, Pathology, Pharmacy Paediatrics and Reproductive Health.

- **Research Workforce Strategy** – in 2022-23, 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 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 was launched in November and a number of participant engagement videos are available on our website: Research, Development and Innovation – Hull University Teaching Hospitals NHS Trust and Research Stories – Hull University Teaching Hospitals NHS Trust. An annual 'Research Celebration Event' has been established providing a platform to showcase the fantastic research undertaken across the Trust, the University of Hull and Hull York Medical School.

- **Exploiting our innovation potential**: As part of joint University of Hull (UoH) and Trust initiative, Aarthi Rajendran, commenced in post as 'Health Innovation Manager' in April 2022. Aarthi is crucial in identifying our collective innovation assets as well as pulling together the prioritisation of innovation projects that would harness the academic and clinical synergies of our partnerships. Projects and themes emerging over the last year include; 3D anatomical printing, virtual wards, rehabilitation, use of AI in clinical radiology and simulation training and mobile healthcare technology solutions.

- **Proactive Partnerships: Northern Lincolnshire and Goole (NLaG)** – in parallel to the provision of plans to ensure HUTH and NLAG clinical pathways and synergies are realised, the RDI Teams at both organisations have commenced informal dialogue about how we might pool resources, expand research programmes across both sites (increasing inclusion opportunities for patients in research) and streamline governance pathways. This work will also be critical to our respective and joint influence within the research and innovation strategies of the emerging Humber and North Yorkshire ICS.

- **University of Hull/Hull York Medical School** – The Trust continues to support the UoH/HYMS implementation of the 'Clinical Sciences Centre' that aims to provide a platform within the HYMS faculty of Health Sciences for the HUTH clinical researchers and healthcare professionals and the opportunities to work with scientists and healthcare researchers of the University of Hull from a range of disciplines to address some of the major challenges in clinical medicine. Within this infrastructure, a forum for peer-to peer discussions across clinical and academic researchers has been established to further nurture cross and inter institutional collaboration, explore all potential opportunities, develop co-ordinated strategic business cases for further resource-manpower investment, discuss and agree on strategic approaches on the clinical research priorities of the partner institutions, as well as reflecting on, and promoting, our collective outputs and achievements.

- **Patient Finder (IQVIA)** – working with IT colleagues and the commercial company IQVIA, the RDI Office have been working on a 'Patient Finder' initiative to explore the use of their research services and trial matching solutions to optimise research as a treatment option for many more patients in our Trust. As well as saving valuable hours of pre-screening that is currently done manually, this will allow us to ensure everyone eligible for certain studies have the opportunity to consider participation.

- **Donate For Research Initiative (DRI)** – The RDI Office continues to work with the DRI to support the use of otherwise surplus tissue and bio-samples to researchers globally in the academic or commercial sector. It is hoped this will be a vehicle to increase the understanding of research in frontline clinical staff as well as communicating how patients can support research as part of their routine clinical pathways. To date, two projects (ENT, Haematology) have been facilitated with several more across interested specialties planned in 2023-24.

- **BAME and Research Ready Communities initiatives** – work led by Jenny Ubi is looking at how best we can provide opportunities to engage BAME and socially deprived communities in research participation. Working alongside the NIHR Ethnic Minority Research Inclusion (EMRI) colleagues, Jenny continues to make a real impact in this area and is working closely with the commercial research companies to ensure BAME representation is increased.

QUALITY REPORT

REFERENCES

Only PDFs are attached

8.1 - Quality Report - Quality Committee April 2023.pdf

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	May 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 Head of Patient Experience and Engagement, Head of Continuous Quality Improvement				
Report previously considered by (date)	This report has previously been considered at the Quality Committee April 2023.				

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:

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

The Report is also considered at the Quality Committee with supporting in-depth papers.

The Trust board is recommended to delegate authority to the Quality Committee to sign off the final Quality Account in June to meet the legal requirement to publish by the 30th June 2023.

Quality Report

March 2023 Performance Data

Produced for the April 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 March 2023.

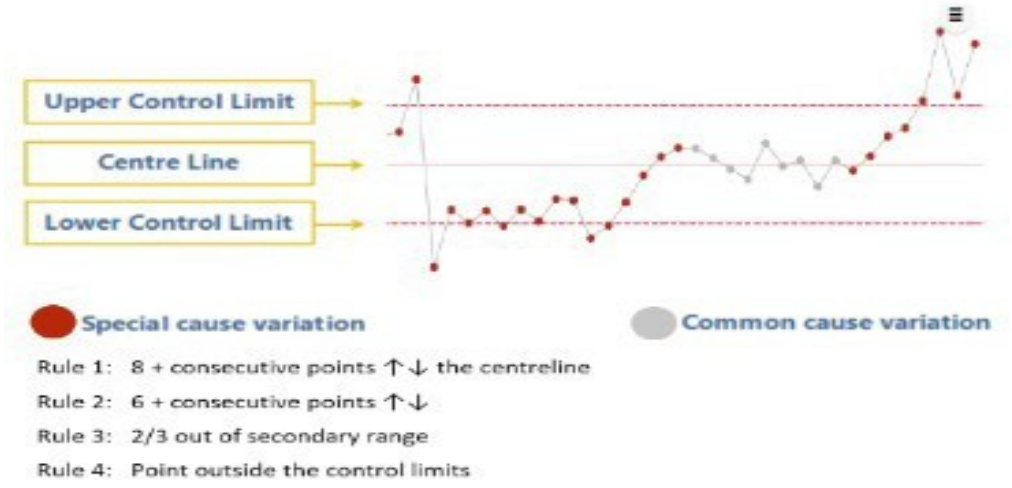
	Indicator	Successes	Risks / Challenges	Actions / Future Plans
Safe Domain	Patient Safety Incident Reporting	The Trust has a positive patient safety reporting culture (high volume, low harm)	There has been a slight decrease in the incidents that are being reported. Incidents causing moderate harm or above have increased but remain within control limits	The learning from incidents is shared through various avenues in the Trust to communicate key information and key learning and to share and celebrate success. Key quality improvement programmes linked to the Quality Strategy are informed by incident data.
	Serious Incidents	The trajectory to be in a sustainable position of ~35 SI open at any time has been met. Transition to PSIRP took place as planned on the 1st April 2023.	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 an overall downward trend of SI's open over 100 days, although this has slightly increase during the month due to additional pressures on the service. All incidents are discussed at the Weekly Patient Safety Summit (WPSS). From 1st April the format has changed in line with as PSIIs with PSIRP and the different investigation and learning responses. Approaches used are AAR, Safety Huddles, and Thematic Reviews to identify if there are other improvement opportunities. SI's are only declared if this meets the PSRIF criteria.

				Ongoing PSIRF training is taking place. Pattie pages have been updated. Additional support is being provided from the wider governance team to support during a period of staff absence and recruitment to 2 roles.
	Indicator	**Successes**	**Risks / Challenges**	**Actions / Future Plans**
Effectiveness Domain	HSMR	The latest HSMR figure available is 108.56 (January 23) Showing a positive decrease since the previous month of December 2022.	The Trust continues to demonstrate “higher than expected deaths” in relation to HSMR.	The Trust continues to monitor HSMR data via regular reporting and committee meetings, whilst streaming into bespoke and overarching quality improvement work plans.
	SHMI	The Trust SHMI continues to remain within the “as expected” levels of death, with the latest SHMI figure (November 2022) of 1.08. Pneumonia SHMI remains within the “expected” range, at 1.03, the lowest it has been post-pandemic, and appears to have levelled out. Sepsis SHMI is currently 1.25, showing a marginal reduction again over the previous month.	Sepsis, stroke and pneumonia are the Trusts 3 most prevalent clinical condition diagnoses at the time of patient death.	The Trust continues to monitor HSMR data via regular reporting and committee meetings, whilst streaming into bespoke and overarching quality improvement work plans.
	Stroke	Stroke SHMI remains at 1.07.The Stroke service continue to undertake SJR’s on all Stroke related deaths.	HUTH is one of the middle performing Trusts when compared to its peers against stroke.	Continual delivery of the Stroke improvement plan, improving service and outcomes for stroke patients. Continual review of stroke deaths, including discussions at Stroke M&M meetings. Regular updates in relation to Stroke mortality given to the Trust Mortality and Morbidity Committee.

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
Responsive Domain	PALS and Complaints	Although the target of 80% has not yet been achieved 49% of complaints were closed within 40 days in March 2023, this is the highest that has been achieved since October 2021, which was 57%. Introduction of a 'table top' approach to complex complaints, bringing the relevant specialties together with support from the Patient Experience Team to be able to co-ordinate review of the questions, patient's notes and drafting a joined up response.	The target of 80% of complaints closed within 40 days has not been achieved since July 2020. Recent improvements have been noted and it is clear from the backlog meetings that the services are working hard to address complaints within the targets. Further improvements are required; however, some complaints received are becoming very complex, involving a number of specialties. There is a backlog of logging complaints with the latest delay been 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. Increased awareness of the requirement for rapid turnaround and early resolution Consider the Patient Experience Team to co-ordinate cross-Health Group complaints to ensure a joined up approach is undertaken and all questions are answered in a timely manner Improved processes for the closing of complaints. Moving towards using the electronic signatures from then Nurse Directors following quality checking of the response within the Patient Experience Team. This will improve the timeliness of closing down and sending the final response to the complaint but will only take place on those complaints that require no changes. If the complaint response requires changes this will be sent back to the Nurse Director for action
Well-led Domain	Continuous Quality Improvement	Cohort 4 QSIR Practitioner is our first QSIR Practitioner cohort being solely delivered by the Trust and is been supported by associates from a range of areas including Medical QI Leads, Operational Improvement Team, Pharmacy and Quality Governance	Due to Easter and the Junior Doctors strike has resulted in some QSIR training being cancelled.	The Quality Improvement Team are working with the Nurse Directors to improve the patient experience based on three key themes taken from concerns and complaints. These are around communication, visiting times and nutrition. Continued development of the CQI website.

1.2 EXECUTIVE SUMMARY SCORECARD

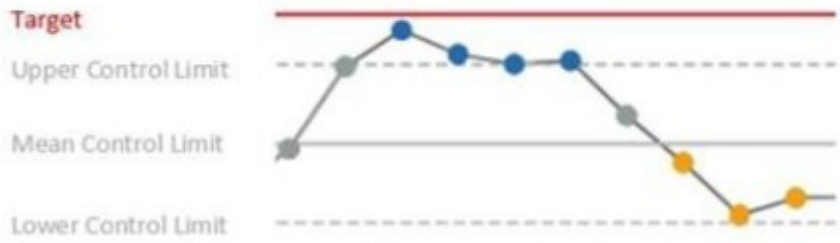
The following provides a high level executive summary of the number of Quality Indicators which are achieving, those which are displaying variance between achieving and failing and those that are consistently failing as detailed on the Integrated Performance Report March 2023.



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 34 patient safety incidents per 1000 bed days recorded in March 2023 (n=1619); 2.47 (per 1000 bed days) incidents resulted in moderate, severe or catastrophic harm to the patient.
- The number of incidents being reported against all severities per 1000 bed days has seen a reduction over the last 5 months however the variance remains low
- 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 9 months; with the March data point being outside the upper control limit.

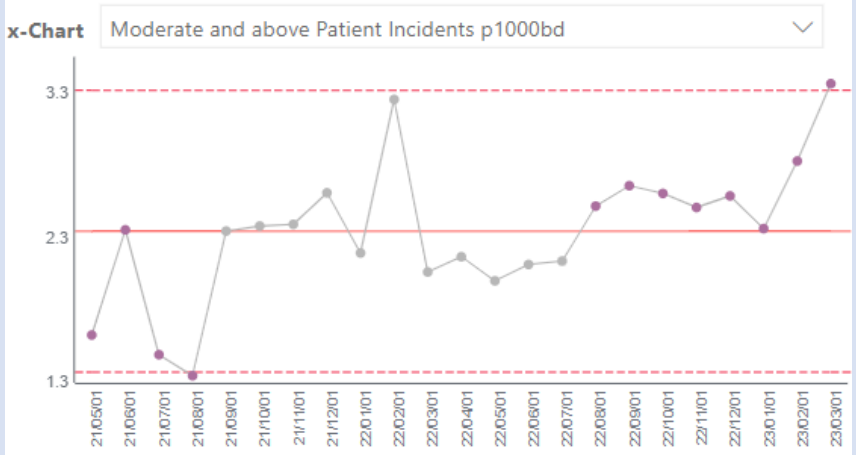
Successes:

- 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 with 50 per 1000 bed days.
- The WPSS continues to meet to discuss patient safety incidents for learning; the format has changed slightly from the 1st April 2023 in line with PSIRP and the different investigation and learning responses.

Key Risks and Challenges:

- The highest reported harms to patients were hospital acquired pressure ulcers including device related harms followed by slips, trips and falls.
- There number of hospital acquired pressure ulcers reported rose again in March 2023.
- March saw 15 treatment and care incidents causing harm with 5 incidents reported in EMHG, 4 in F&WHG and 4 in MHG; this was double the number reported in February.
- There were 7 incidents causing harm reported for access, admission, transfer and discharge incidents (none in February).
- MHG had the highest number of incidents overall, with SHG having the most that had caused 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

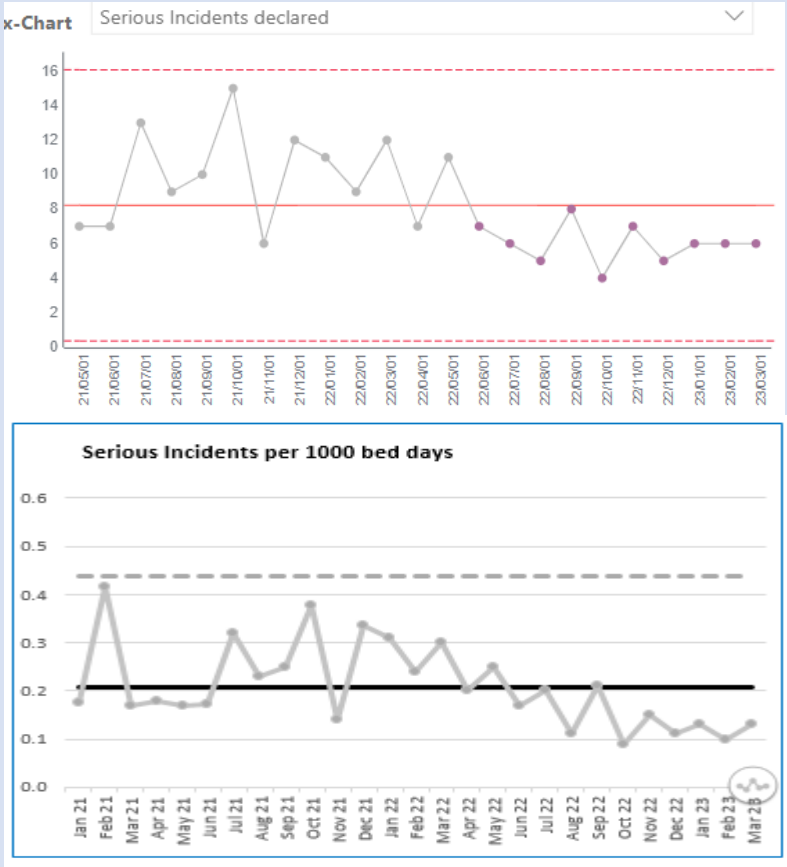
- There were 10 patient deaths reported in March, 5 in EMHG, 4 in MHG and 1 in SHG. 6 of the 10 deaths met the criteria for SI declaration.

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 where care is identified as a contribution will be discussed at Weekly Patient Safety Summit (WPSS) for investigating as PSIIs from April 2023.

2.2 SERIOUS INCIDENTS

Number of Serious Incidents reported Serious Incidents per 1000 bed days



Aim: To reduce the number of serious incidents being declared

Target: Zero serious incidents in the month

What is the chart telling us:

- The Trust declared 6 serious incidents in March 2023 equating to 0.13 serious incidents per 1000 bed days.
- The graphs show a downward trend in the number of Sis declared since March 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.
- The WPSS has been used as a forum to discuss and escalate externally reported incidents through multidisciplinary discussion.
- The Trust is transitioning from the SI Framework (2015) to PSIRF from 1st April 2023.
- PSIRF information added onto Pattie.

Key Risks and Challenges:

- 5 serious incidents resulted in the death of the patient
- 3 of the deaths were in MHG with 2 in Cardiology; one patient died whilst on the TAVI waiting list
- 2 SIs occurred in SHG; both in Critical Care but across sites both HRI and CHH. One resulted in the death of the patient and was escalated from NLAG, the investigation jointly undertaken with NLAG
- One patient died in the ED; the patient had re-attended the ED 4 hours after leaving a previous attendance.

Actions / Future Plans for Improvement:

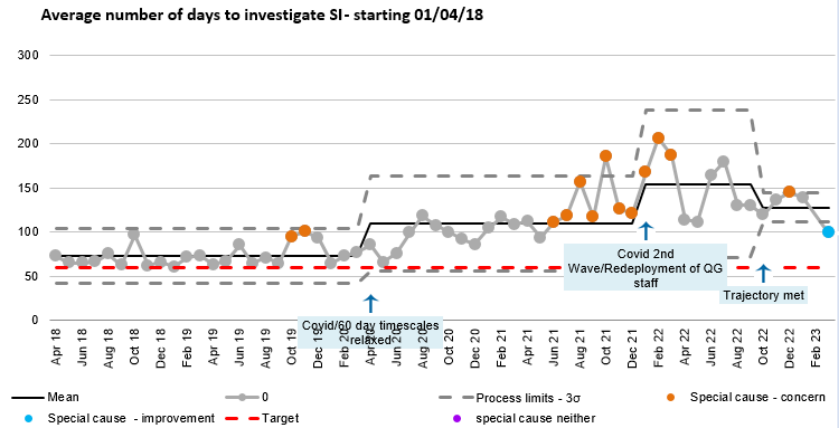
- Transition to PSIRF from 1st April 2023 will transform the approach to patient safety incident investigations (PSII) with a move away from the traditional root cause analysis training that most are familiar with to a proportionate systems based approach. This is grounded in human factors, engaging families and

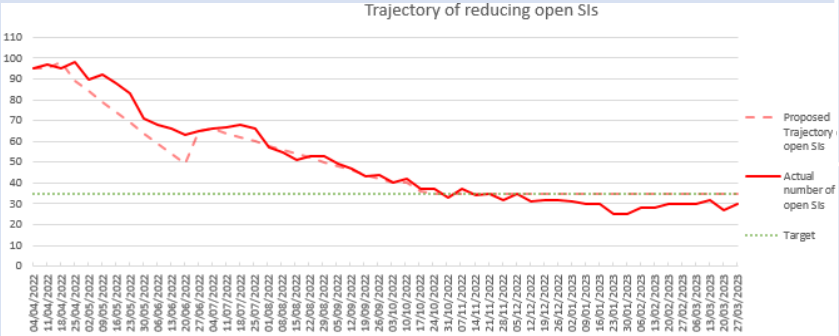
Number of Serious Incidents reported Serious Incidents per 1000 bed days	**Aim:** To reduce the number of serious incidents being declared **Target:** Zero serious incidents in the month
	staff affected by the incident and a focus on continuous improvement. • The PSIRF transition proposal was reviewed at Patient Safety and Clinical Effectiveness Committee in February 2023 and has been endorsed, this included the Patient Safety Incident Response Plan. The transition proposal was accepted at the ICB Quality committee in February 2023 and is scheduled for review at the next Trust board for approval. • To develop a system approach to harm free care across our organisation. • To work with partner organisations such as the ICB to develop a coordinated system approach to PSIRF.

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 open investigations during March remains static and within the agreed tolerance levels with 26 open.
- The number of Serious Incidents that have been open over 100 days has reduced to 8.
- The average number of days taken to investigate SIs has reduced. Both longest open and newest declared are investigated simultaneously.

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 March 2023.

Key Risks and Challenges:

- Due to absences and vacancies within the patient safety team the number of SIs being closed has slowed.
- Support has been sought from the wider governance team to ensure delivery of the team's closure trajectory.
- The number of SIs that remain open means that it will be a number of months before the Trust can fully transition to the new way of investigating PSIIs.

Actions / Future Plans for Improvement:

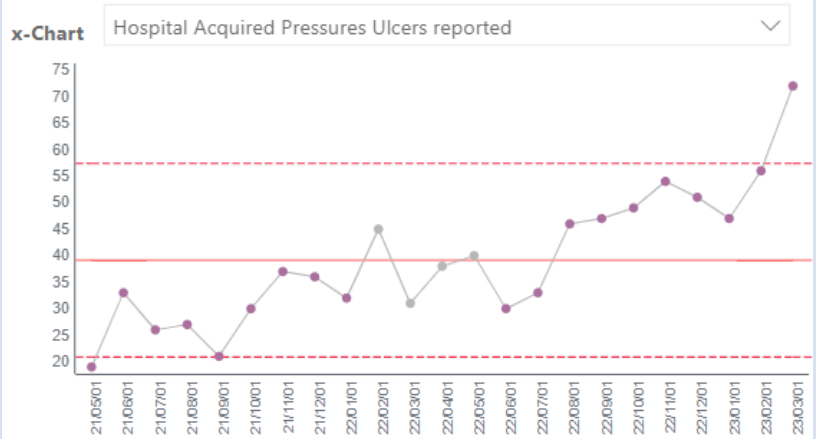
- Work continues to close SIs over 100 days and to ensure families are kept updated.
- The reduction in the number of serious incident investigations being open has resulted in a smaller more manageable caseload that will allow for timelier completion of investigations.
- Responding to patient safety events that require PSIIs will ensure learning is driven from a systems and human factors approach and that learning is communicated to all areas within the Trust and improvement is identified are embedded.
- An additional Patient Safety Lead has been recruited and will drive forward improvements in line with PSIRF.

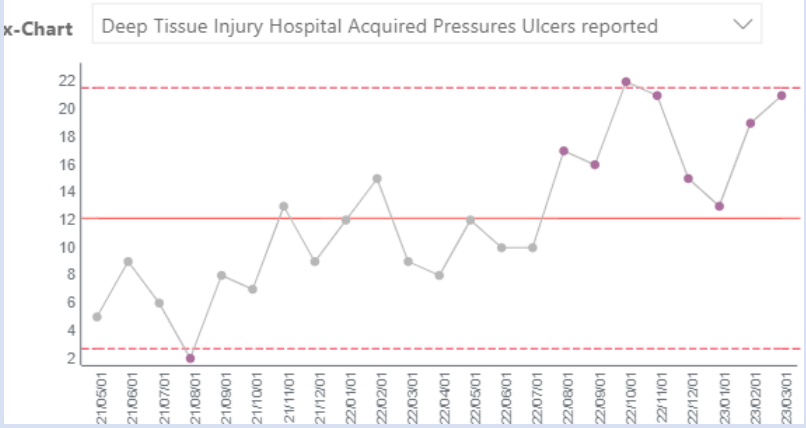
2.4 HOSPITAL ACQUIRED PRESSURE ULCERS CAUSING HARM

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 1.42 pressure ulcers per 1,000 bed days resulting in moderate and above harm in March (n=67).
- The number of pressure ulcers reported has increased and is above the increased upper control limit.
- Category 2 pressure ulcers have increased to 39 and are above the upper control limit in March.
- DTIs have increased in March to 20; however, these remain within the control limits.
- Unstageable pressure ulcers have increased to 5 incidents, this is within control limits.
- There has been an increase in overall pressure ulcer incidents across the organisation.

NB the SPC charts do not include device related pressure damage

Successes:

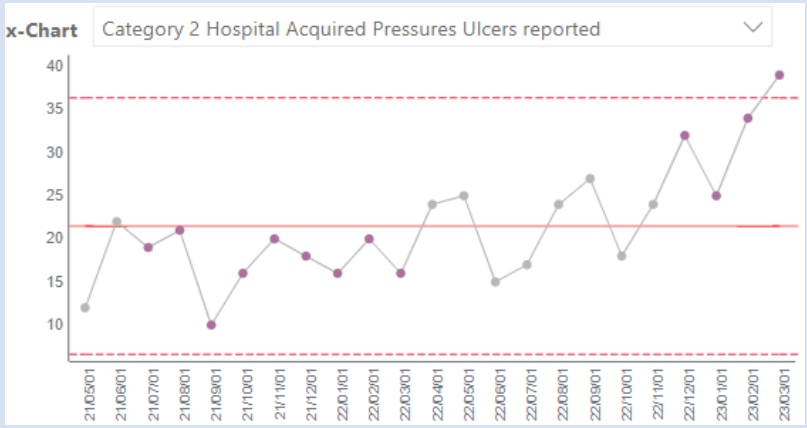
- Fundamental standards reviews for tissue viability are now fully up to date.
- HDigital updating the photography profile on Nerve Centre.
- Safety cross for tissue viability is being relaunched with falls on 1st March 2023 – starting to be implemented in more areas.
- HEY 24/7 training updated and scenarios being employed.

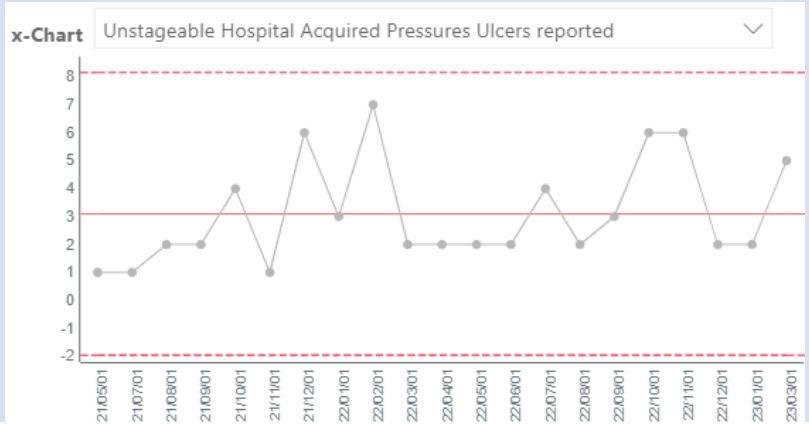
Key Risks and Challenges:

- There were 39 Category 2 pressure ulcers reported (plus 12 device related); 0 Category 3 pressure ulcers, 20 Deep Tissue Injuries (DTI) (plus 5 device related) and 5 unstageable pressure injuries (plus 1 device related).

Actions / Future Plans for Improvement:

- Safety Week 3rd April – QR codes for bed profiling to be applied and demonstrated to staff.
- Starting non-register link nurse network – in the process of being arranged; 4 dates





over the next year.

- Pattie pages being updated currently to support staff with information.
- Training date for housekeepers alongside the falls team – June 2nd is first date.

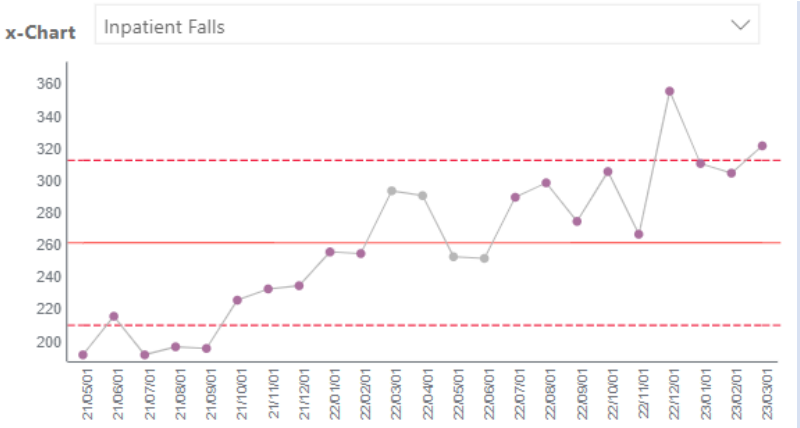
2.5 INPATIENT FALLS CAUSING HARM

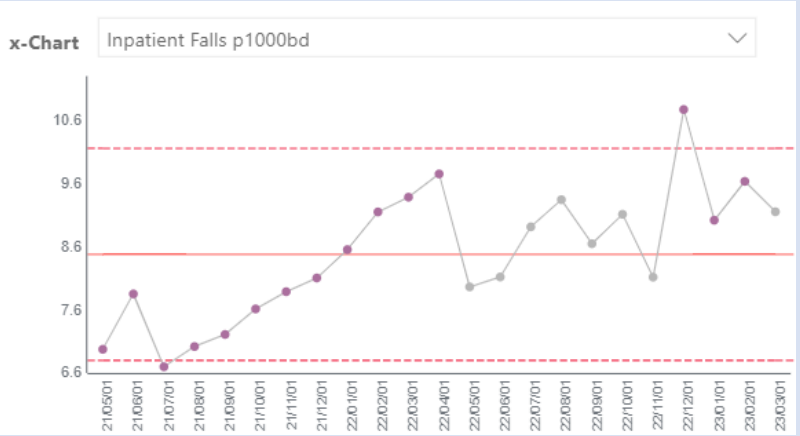
Inpatient falls per 1000 bed days

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 7.0 inpatient falls per 1000 bed days in March 2023 (n= 330)
- 0.19 (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, is still above the upper control limit.
- The number of inpatient falls per 1000 bed days has decreased during March 2023.

Successes:

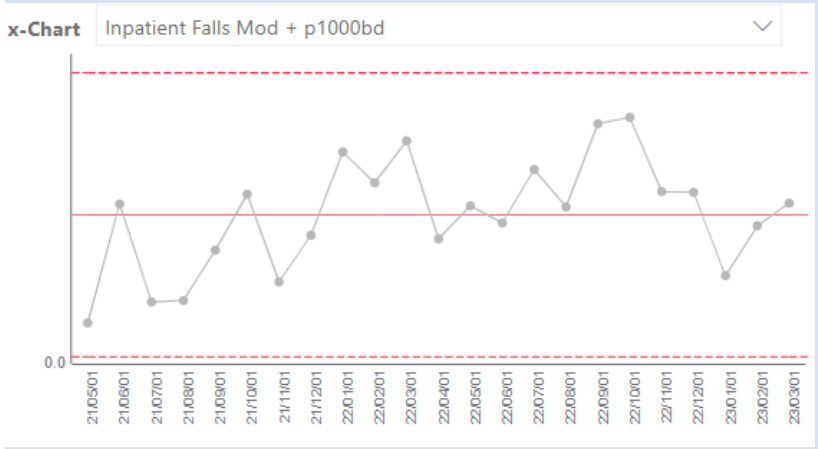
- 86 staff received face to face training in March
- Falls training overall has increased from 51.8% to 56.1%
- Staff training continues across the Trust, both online and face to face, Trust target is 85% of staff having completed training in line with their role. This includes staff from Radiology and Ophthalmology.

Topic	Certified	Not certified	Grand Total	%
Falls Prevention	388	905	1293	30.0%
Preventing Falls in Hospital: Carefall	43	26	69	62.3%
Preventing Falls in Hospital: Fallsafe	1966	945	2911	67.5%
Grand Total	**2397**	**1876**	**4273**	**56.1%**

The first Falls Champion training session was held on the 5th April for the champions in Oncology. It was a successful day and incorporated a full package of training support and general falls prevention information using the Padlet platform. GBUK came and facilitated a train the trainer session for Flojac flat lifting equipment.

Key Risks and Challenges:

In March there were 8 inpatients who sustained a fractured NOF's in our care, this is the highest number reported in a month since recording started. This totals 14 cases this year this



concern, has been escalated to the Chief Nurse and Deputy Chief Nurse.

- These cases all are from different clinical areas, 50% of patients had been admitted with a fall.
- 75% had cognitive impairment, of the 8 [patients only 1 had fallen in hospital previously to the # occurring

We still have no training rooms identified at HRI

Actions / Future Plans for Improvement:

- A business case for flat lifting equipment has been sent to the Chief Nurse and the Deputy Chief Nurse
- Ongoing search for a suitable training room

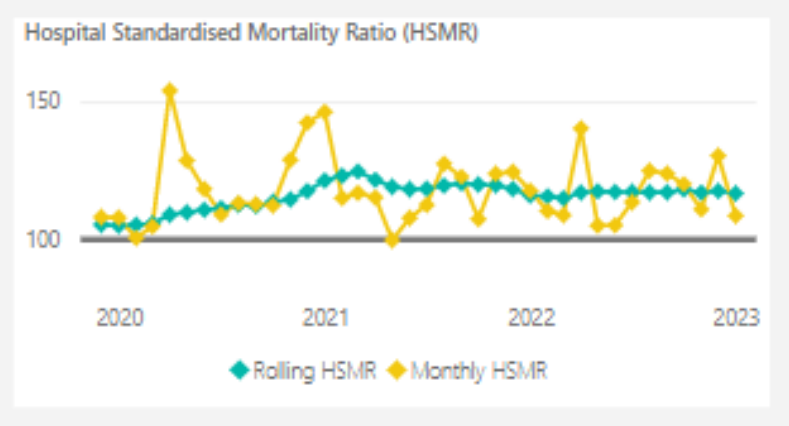
3. EFFECTIVENESS DOMAIN

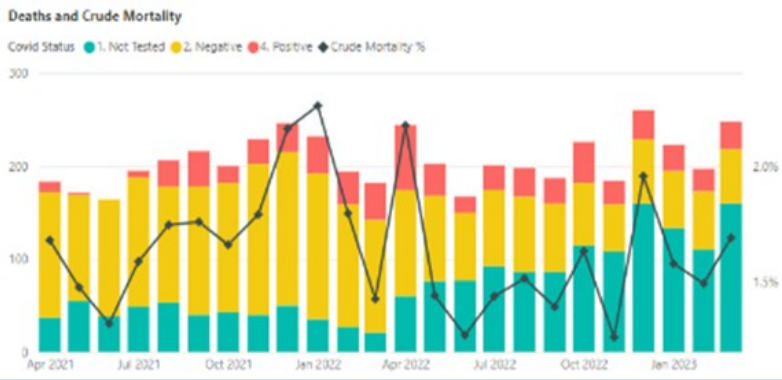
3.1 MORTALITY

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 January 2023.
- HSMR continues to demonstrate 'higher than expected deaths' and is above the national average and target of 100.
- The rolling HSMR is 116.07 and the monthly (January 2023) HSMR is 108.56 which has decreased compared to the previous month.

Successes:

- The rolling HSMR is showing a steady rate and displays no sudden elevations.

Key Risks and Challenges:

- The Trust continues to demonstrate a HSMR with "higher than expected" deaths and is therefore an outlier in HSMR.

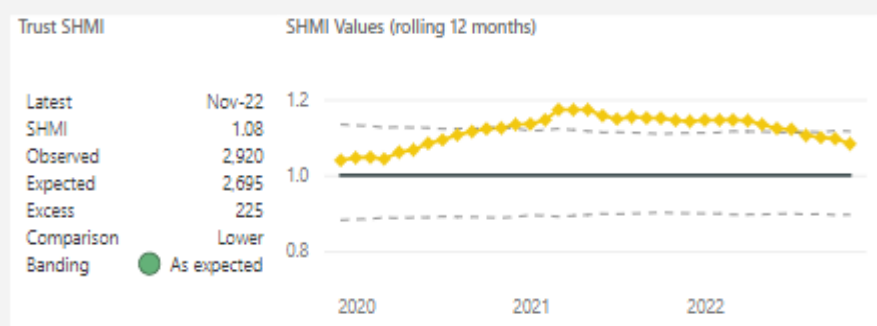
Actions / Future Plans for Improvement:

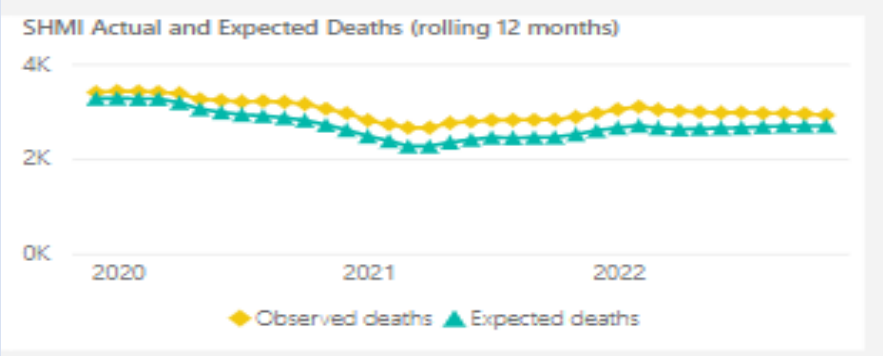
- Continual improvement work streams are formed and monitored via the Trust Mortality and Morbidity Committee, with careful and continuous monitoring taking place on a regular basis.
- The Sepsis and Pneumonia steering groups continue to provide better insight data, along with detailed action plans being delivered in order to further improve outcomes for these patient cohorts.

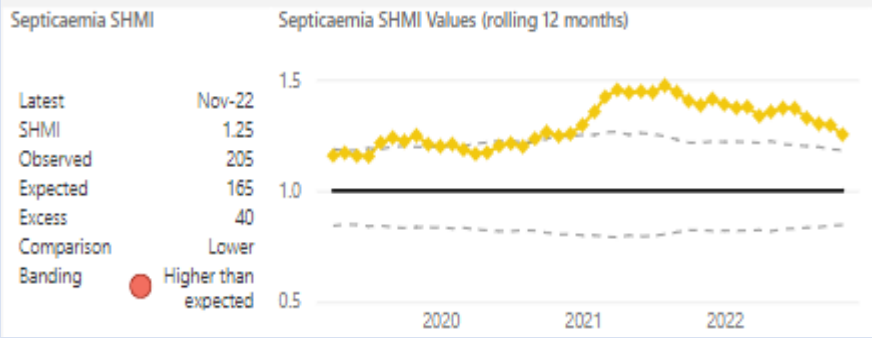
Summary Hospital-level Mortality Indicator (SHMI)

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 November 2022
- Trust SHMI has continued on a downwards trend since the end of 2021 and in November 2022 has dropped further to 1.08.
- The out of hospital deaths remain consistent against the SHMI.
- Pneumonia SHMI continues to remain “as expected” and has remained at 1.03 since August 2022.
- Sepsis SHMI continues to demonstrate ‘higher than expected deaths’ with an excess of 40 deaths in November 2022. Although it remains ‘higher than expected’ performance is demonstrating an improving journey from its highest point of 1.47 in August 2021 to 1.25 in November 2022.
- Stroke SHMI has remained at 1.07 in November 2022.

Successes:

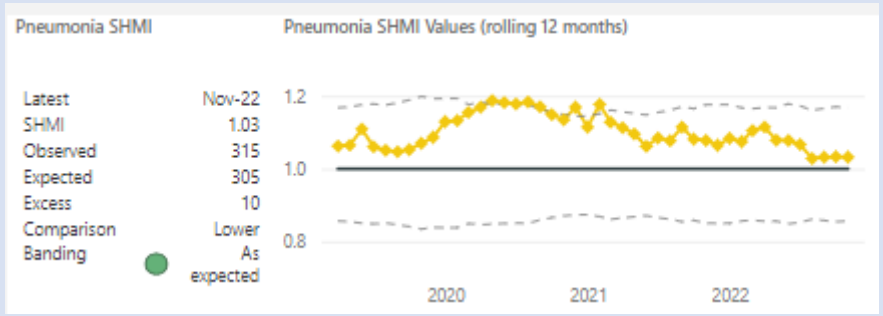
- The overall Trust SHMI has decreased slightly compared to the previous month and is now 1.08 above the national average of 1.0 and the reduction of excess death from 260 to 225.
- Although the pneumonia SHMI remains above the national average of 1.0 it remains only slightly elevated at 1.03 with the excess deaths at 10.
- Sepsis SHMI has reduced again to 1.25.

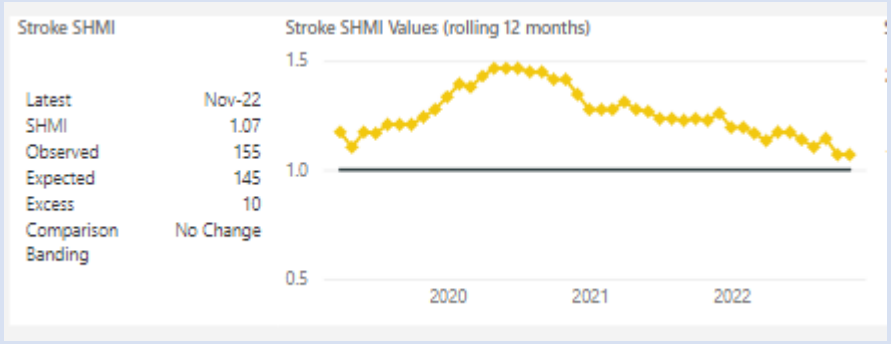
Key Risks and Challenges:

- The top 3 common clinical conditions remain Sepsis, Pneumonia and Stroke

Actions / Future Plans for Improvement:

- The Trust continues to monitor HSMR data via regular reporting and committee meetings, whilst streaming into bespoke and overarching quality improvement work plans.



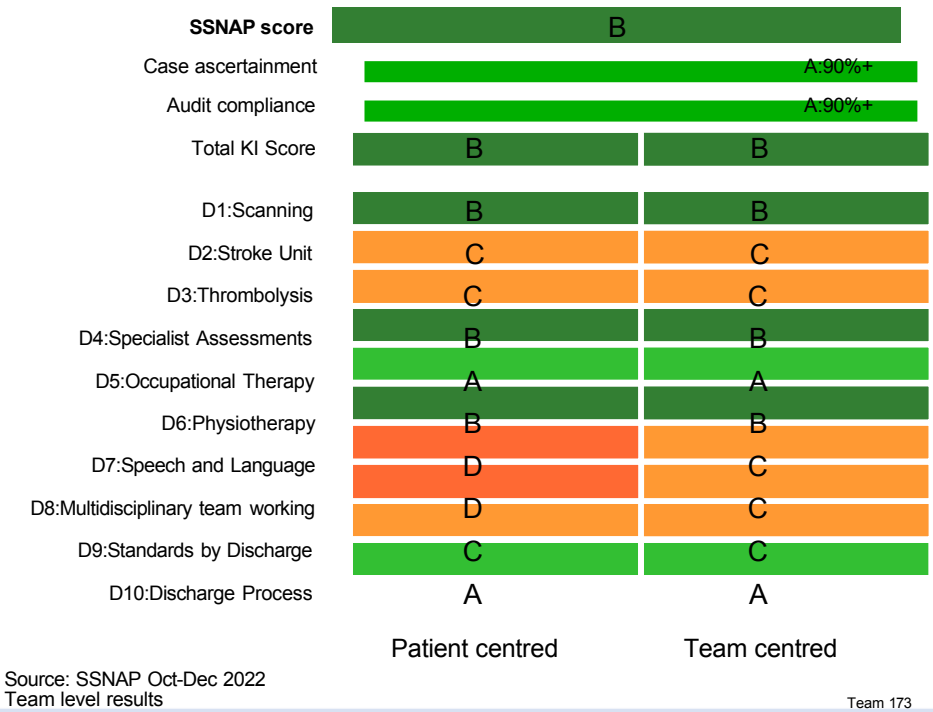


- Continual delivery of the Stroke improvement plan, improving service and outcomes for stroke patients.
- Continual review of stroke deaths, including discussions at Stroke M&M meetings.
- Regular updates in relation to Stroke mortality given to the Trust Mortality and Morbidity Committee.

3.2 SSNAP Please note this is the same as the previous report, awaiting new information

October to December 2022

The below chart represents HUTH's SSNAP score between October to December 2022, so provides a more current picture.



A- Indicates highest score to E- lowest

2021-2022

The figures below are focused on patients who had a stroke between 1st April 2021 - 1st March 2022. NB: This data was released in November 2022, further updates are expected towards the latter part of 2023.

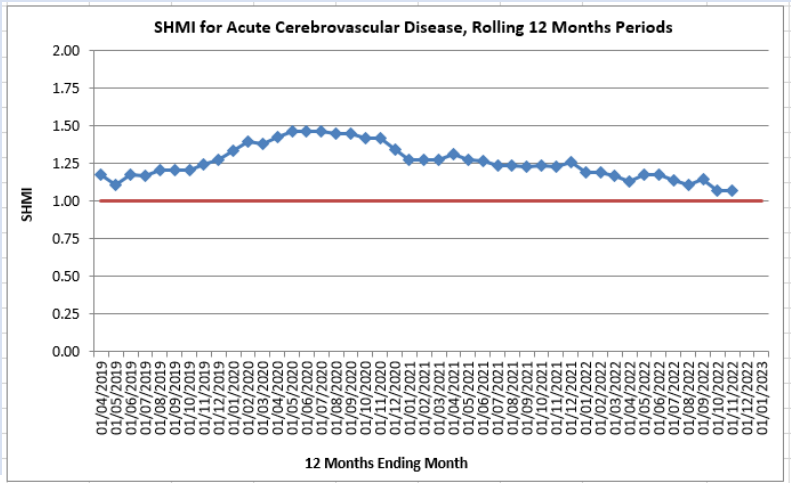
Key Successes:

- The proportion of all stroke patients given thrombolysis was 15.1%. This is higher than the 2021/22 result of 11.9%. It is also higher than the national average of 10.4%.
- The proportion of patients assessed by a stroke specialist consultant physician within 24h of clock start has remained consistent at 93.3%. It is also higher than the national average of 83.6%.
- The proportion of applicable patients who were given a formal swallow assessment within 72h of clock start was 94.6%. This is higher than both the 2020/21 result of 83.1% and also the national average of 87.6%.
- 84.7% of patients were compliant against the therapy target. This is higher than the 2020/21 result of 80.9% and is similar to the national average of 85.8%.
- The proportion of applicable patients who were assessed by a speech and language therapist within 72h of clock start was 89.1% in 2021/22. This is higher than both the 2020/21 result of 77.6% and also the national average of 88.1%.
- 95.8% of applicable patients were screened for nutrition and seen by a dietitian by discharge. This is considerably higher than the 2020/21 result of 27.3%. It is also higher than the national average of 79.5%.
- 89.9% of patients had a continence plan drawn up within 3 weeks of clock start. This is better than the 2020/12 result of 74.8%. However, it is slightly lower than the national average of 94.7%.
- 40.3% of patients were treated by a stroke skilled Early Supported Discharge team. This is better than the 2020/21 result of 24.2%. However, it is slightly lower than the national average of 47.1%.

	2021-2022 The figures below are focused on patients who had a stroke between 1st April 2021 - 1st March 2022. NB: This data was released in November 2022, further updates are expected towards the latter part of 2023.
	Key Concerns: • The proportion of patients scanned within 12 hours of clock start has decreased to 49.5%. This was previously 51.6% in 2020/21. This is also lower than the national average of 54.7%. • The proportion of patients directly admitted to a stroke unit within 4 hours of clock start has decreased to 57.2%. This was 66.1% in 2020/21. However, this is higher than the national average of 44.5%. • The proportion of patients who spent at least 90% of their stay on the stroke unit was 86.9% in 2021/22. This lower than the 2021/22 result of 91.2%. It is however, higher than the national average of 76.6%. • Proportion of patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ('no but') for why it could not be given has decreased from 66.1% in 2020/21 to 57.2% in 2021/22. However, this is higher than the national average of 44.4%. • Median % of days as an inpatient on which physiotherapy is received was 73.2% in 2021/22. This is lower than the 2020/21 result of 82%. It is slightly higher than the national average of 72.6%. • Median % of days as an inpatient on which speech and language therapy is received has decreased from 56.3% in 2020/21 to 43.5% in 2021/22. It is also lower than the national average of 51.9%.

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 marginally higher than the National Level of 1.0 at 1.07; however as both charts demonstrate, the Stroke SHMI is continually reducing and is very close to the “as expected” range.

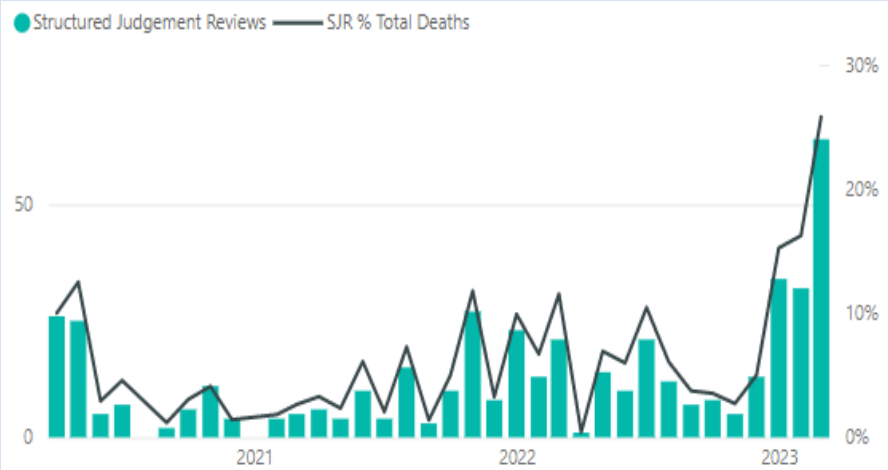
Successes:

- Stroke SHMI is the lowest it has been in 4 years.
- The Stroke service continues to deliver structured judgement reviews on all of its deceased patients.

Key Risks and Challenges:

- The SHMI for Stroke continues to be higher than the average national figure, it is reducing overall.

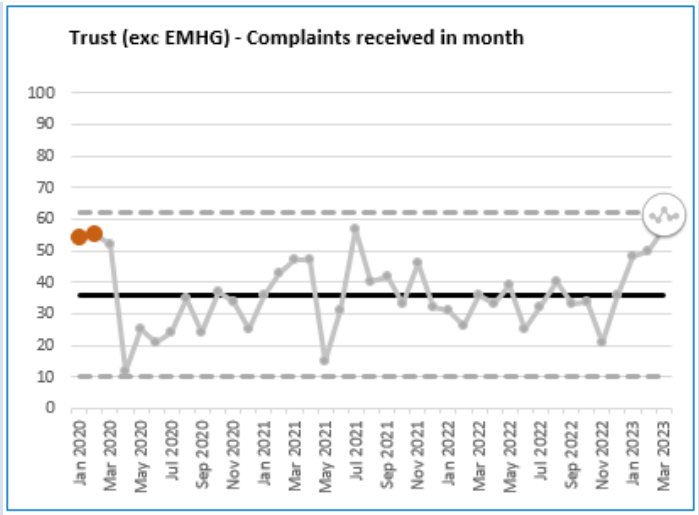
3.4 STRUCTURED JUDGEMENT REVIEWS (SJR)

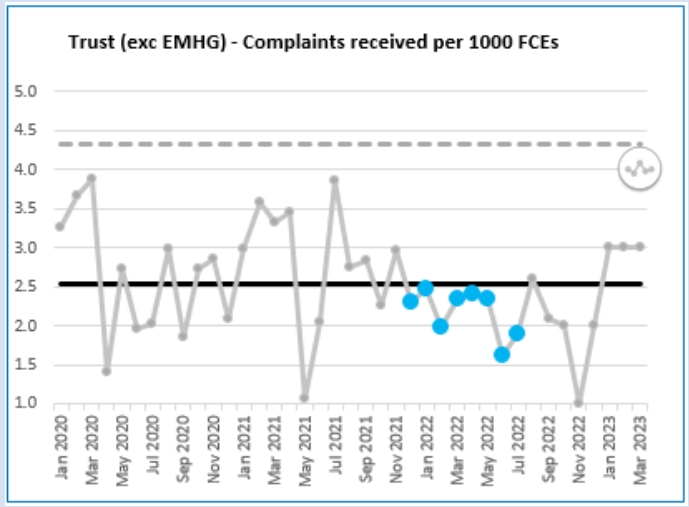
Structured Judgement Reviews Completed and Staff Trained	Aim: To increase the number of SJR completed to inform learning from deaths Target: 10%
	**What is the chart telling us:** • The chart shows a positive uptake in the number of Structured Judgement Reviews being completed, as an overall monthly percent against the total number of in-hospital deaths. The Trust aims to review at least 10% of deaths per month, via the SJR methodology, in addition to the M&M approach led by each Specialty. •
	Successes: • 25% of deaths have had a Structure Judgement Review, which has continued to improve following increased engagement from clinicians since late 2022 • 434 members of staff have undertook the online (HEY247) SJR training module since January 2022. The training is directed at ST5 and above grade clinicians, in addition to Specialist nurses and Matrons. This has, in turn, had a positive impact on the number of SJR's being completed to a high level of quality.
	Key Risks and Challenges: • Development of feedback mechanisms, also identified by RSM Auditors as a minor action for improvement following the Mortality and Learning from Death internal audit
	Actions / Future Plans for Improvement: • As a result of an action identified by a recent audit of the Learning from Deaths framework, undertaken by RMS, a quality control process is required to check the quality of the SJR against the expectations set out by Trust policy, as well as the National Quality Board. A regular quarterly audit will now be undertook on a sample of completed SJR's to check that they contain the expected quality of content, as well as ensuring any pertinent actions flagged from review were in fact carried out. This audit will also present opportunity to give constructive guidance to any staff who need assistance. This audit will commence from April 2023.

4. RESPONSIVE DOMAIN

4.1 COMPLAINTS RECEIVED

Trust (excluding 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 57 complaints (excluding EMHG) received in March 2023 – rate of 3.0 against the target of 2.5

Successes:

- Early Resolution (responding within 10 working days) successfully reducing complaints that move to the full formal process)
-

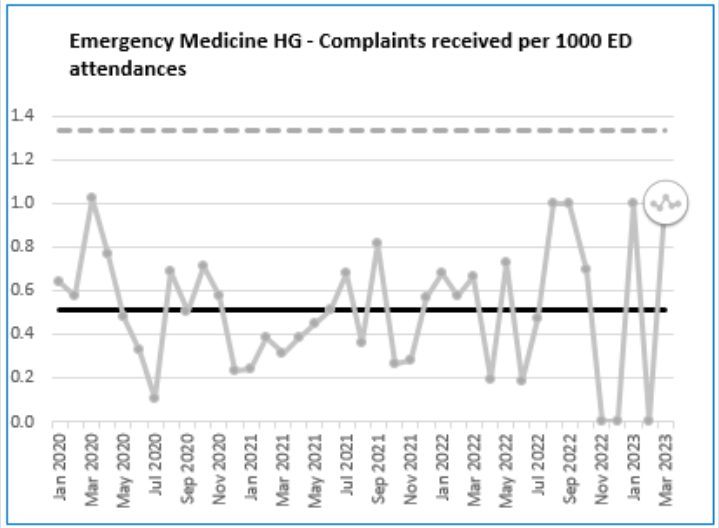
Key Risks and Challenges:

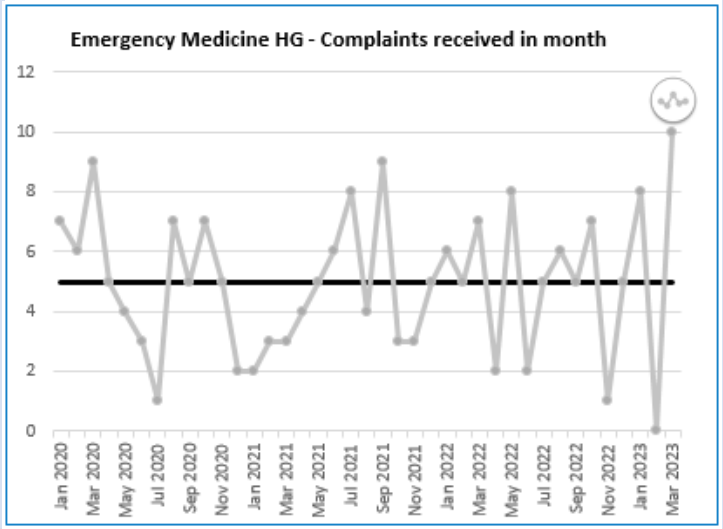
- There is a backlog of logging complaints (26 at the time of writing this report) with the latest delay being 3 weeks, reducing from 4 weeks in the previous report

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.
- KPIs to be closely monitored within the Patient Experience Team
- Established the New NHS Complaints Standard Steering Group chaired by the Director of Quality Governance to address how the Trust will implement the new standards improving how we respond to complaints

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; although there has been a slight increase in January and March 2023

Successes:

- The Emergency Medicine Health Group do not have any complaints open over the 40 day target

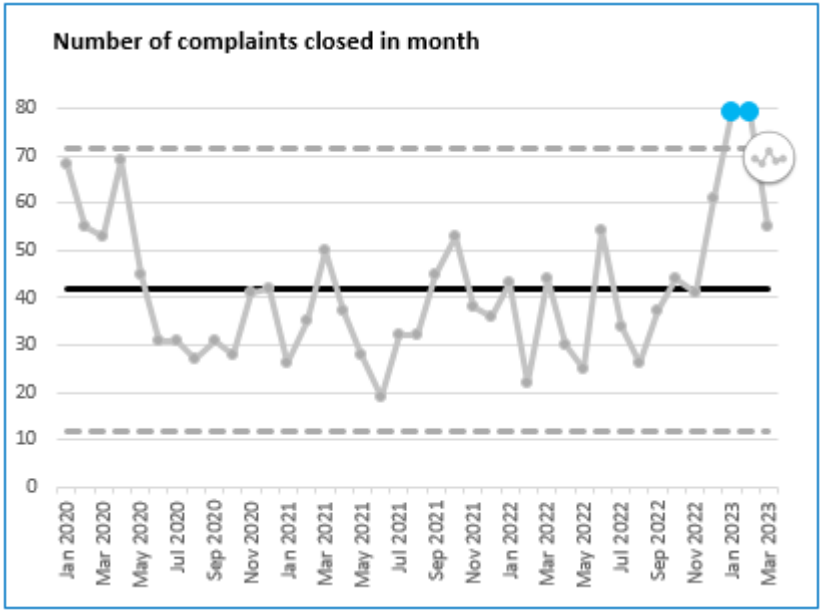
Key Risks and Challenges:

- None

Actions / Future Plans for Improvement:

- To engage with the new NHS Complaints Standard Steering Group chaired by the Director of Quality Governance to address how the Trust will implement the new standards improving how we respond to complaints

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 continued improving position against closing complaints since November 2022. Achieving this target to close 40 complaints per month; 55 were closed in March 2023.

Successes:

- A continued improving position against closing complaints since November 2022; when the backlog recovery plan was instigated.
- Continue weekly challenge meetings with Medicine, Surgery and Family and Women's with improved engagement
- Achievement of this target

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

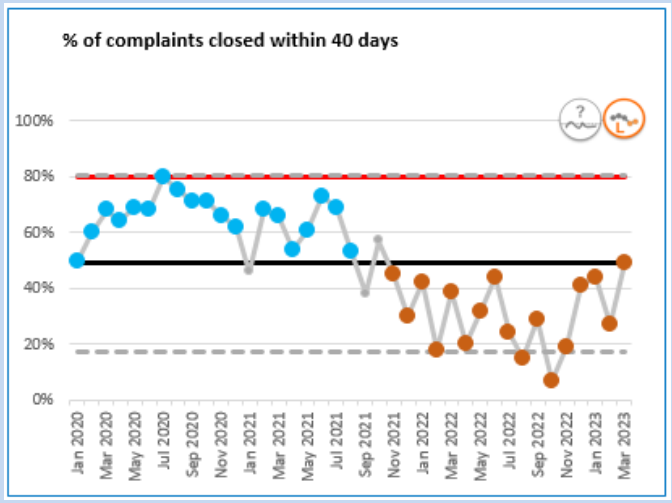
Actions / Future Plans for Improvement:

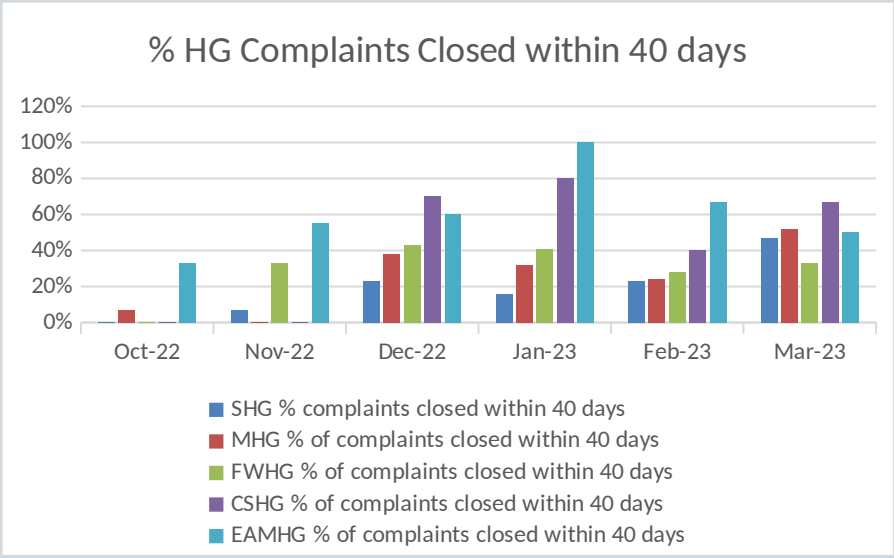
- Patient Experience working with colleagues to provide additional support to reduce the backlog
- Continue weekly challenge meetings with Medicine, Surgery and Family and Women's
- Improved processes for the closing of complaints. Moving towards using the electronic signatures from then Nurse Directors following quality checking of the response within the Patient Experience Team. This will improve the timeliness of closing down and sending the final response to the complaint but will only take place on those complaints that require no changes. If the complaint response requires changes this will be sent back to the Nurse Director for action

% of complaints closed within 40 days

Aim: Increase % of complaints closed within 40 day target

Target: 80%





What is the chart telling us:

- The chart demonstrates continued improvements against the closing of complaints within 40 days. Although the target of 80% has not yet been achieved 49% of complaints were closed within 40 days in March 2023.

Successes:

- Although the target of 80% has not yet been achieved 49% of complaints were closed within 40 days in March 2023, this is the highest that has been achieved since October 2021, which was 57%.

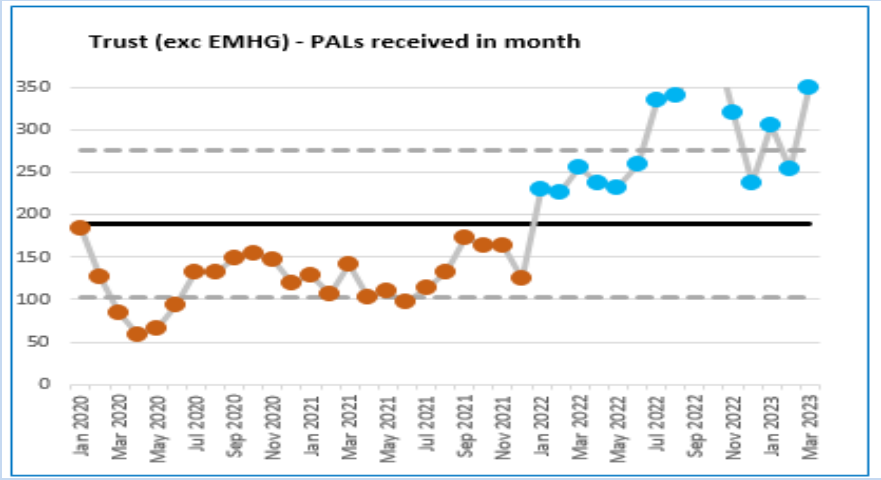
Key Risks and Challenges:

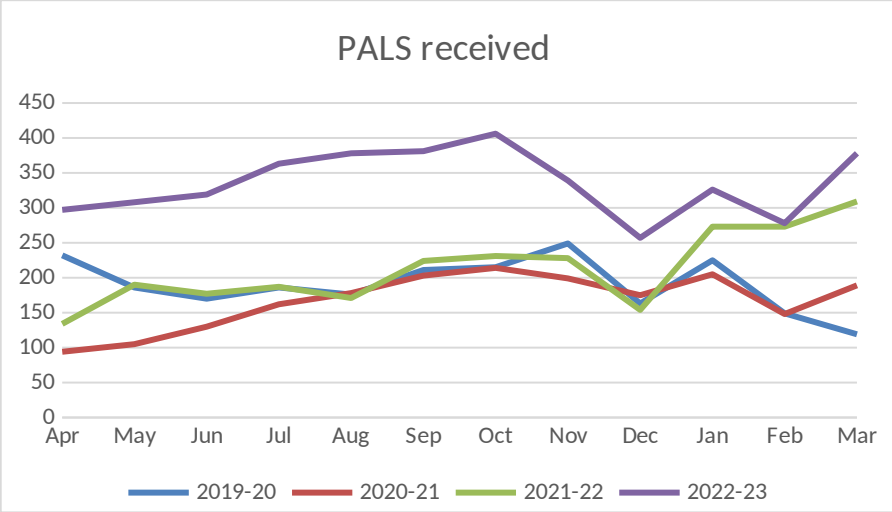
- The target of 80% of complaints closed within 40 days has not been achieved since July 2020. Recent improvements have been noted and it is clear from the backlog meetings that the services are working hard to address complaints within the targets. Further improvements are required; however, some complaints received are becoming very complex, involving a number of specialties.

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
- Improved processes for the closing of complaints. Moving towards using the electronic signatures from then Nurse Directors following quality checking of the response within the Patient Experience Team. This will improve the timeliness of closing down and sending the final response to the complaint but will only take place on those complaints that require no changes. If the complaint response requires changes this will be sent back to the Nurse Director for action
- Introduction of a 'table top' approach to complex complaints, bringing the relevant specialties together with support from the Patient Experience Team to be able to co-ordinate review of the questions, patient's notes and drafting a joined up response.
- Consider the Patient Experience Team to co-ordinate cross-Health Group complaints to ensure a joined up approach is undertaken and all questions are answered in a timely manner

PALS Received





Aim: To reduce the number of PALS escalating to a complaint

Target: To monitor

What is the chart telling us:

- Received 350 PALS Trust-wide and 28 for Emergency Medicine Health Group. Therefore, a total of 378 PALS received in March 2023
- Sustained increase in PALS activity during 2022-23

Successes:

- Early resolutions introduced

Key Risks and Challenges:

- PALS team capacity to turnaround cases within 5 days
- Main theme continues to be cancellations, delays and waiting times

Actions / Future Plans for Improvement:

- Increased awareness of the requirement for rapid turnaround and early resolution

5. WELL-LED DOMAIN

5.1 CONTINUOUS QUALITY IMPROVEMENT

Training

Delivery of 2023/24 Quality, Service Improvement and Redesign programmes is progressing well with delegates expressing interest in both our QSIR Fundamentals & QSIR Practitioner programmes. Since the last report to Quality Committee in March, there have been no sessions of QSIR Fundamentals due to planned industrial action and the Easter break.

Cohort 4 of our QSIR Practitioner programme underwent Day 3 of the course which covered Sustainability and Engagement for Improvement. Our QSIR Practitioner programme is also attended by members of the ICB and NHS England & Improvement as a recognised and regarded QSIR Faculty.

HUTH's QSIR Faculty is collaborating with the North West and North East System Improvement Team and other QSIR Faculties across the region to co-design and co-facilitate a regional QSIR Virtual offer. The QSIR Virtual programme offers delegates four bite-sized improvement workshops surrounding key tools and techniques to aid improvement. The collaborative regional programme gives QSIR Faculties, including HUTH, the ability to deliver more bite-sized improvement training with the support and partnership of other NHS QSIR Faculties

Quality Improvement Projects

The repository now includes 57 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, 169 Think Tank ideas have been submitted via the Think Tank platform. There has been a focus on ensuring the ThinkTank forum is updated regularly, which have resulted in the following:

- 60 ideas are classed as 'in progress'
- 71 ideas are classed as 'to be started'
- 36 ideas are classed as 'completed'

The Think Tank Group did not meet in March due to planned industrial action. The focus of April's meeting will be the progress of a number of outstanding submissions and

review of the Improvement Month Evaluation report. This will be later be shared with Quality Committee.

5.3 CELEBRATION AND LEARNING

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. The CQI website is under development and the communications team will advise on the Go Live date.

5.4 QUALITY ACCOUNTS

The 2022/23 Quality Accounts have been developed in line with Department of Health guidance with involvement from all relevant project and statement leads. The quality and safety priorities detailed in the accounts were agreed following consultation with key stakeholders including Staff, ICB, Health watch and Trust Members. The priorities for 2023/34 were agreed following consultation with key stakeholders and have been agreed as;

- Mortality & Morbidity - EFFECTIVE AND LEARNING
- Mental Health Triage in the Emergency Department – FOCUSED
- Learning from Incidents – PATIENT SAFETY
- Medication Errors – SAFE CARE
- Sepsis – SAFE CARE

The Trust board is recommended to delegate authority to the Quality Committee to sign off the final version in June to meet the legal requirement to publish by the 30th June 2023.

MATERNITY UPDATE

REFERENCES

Only PDFs are attached

- 8.2 - Trust Board and Quality April 2023.pptx
- 8.2.1 - ATAIN Quarter 4 (1)Final 2022.pdf
- 8.2.2 - GAP Q4 2022.pdf
- 8.2.3 - PMRT Q4 2022 Final.pdf
- 8.2.4 - PQSAG Q4 2022Final.pdf

Agenda Item		Meeting	Quality Committee and Trust Board	Meeting Date	Q4 2022
Title	**Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme**				
Lead Director	Interim Chief Nurse				
Author	Clinical Governance Midwife Neonatal Consultant (ATAIN program lead)				
Report previously considered by (date)	Quality Committee and 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	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.

FAMILY AND WOMENS HEALTH GROUP

Avoiding Term Admissions into Neonatal Units (ATAIN):
Learning from Term Admissions Quarter 4 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

Current position

As demonstrated by table 1 they has been a decrease in the number of Term Admissions to NNU since 2016.

Table 1 highlights the number of 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) **Quarter 4** (01/01/2023-31/03/2023)

Table 1

Year	Total Term Admissions to NNU	% 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%
2022	**186**	**41%**	**2.3%**

Table 2

Duration	Total Babies Born	% of total NNU admissions	% of term admissions to NNU
Quarter 1 2022	1250	33.4%	3.1%
Quarter 2 2022	1450	35.6%	3.0%
Quarter 3 2022	1210	39.3%	2.3%
Quarter 4 2022	**1198**	**43.0%**	**2.5%**

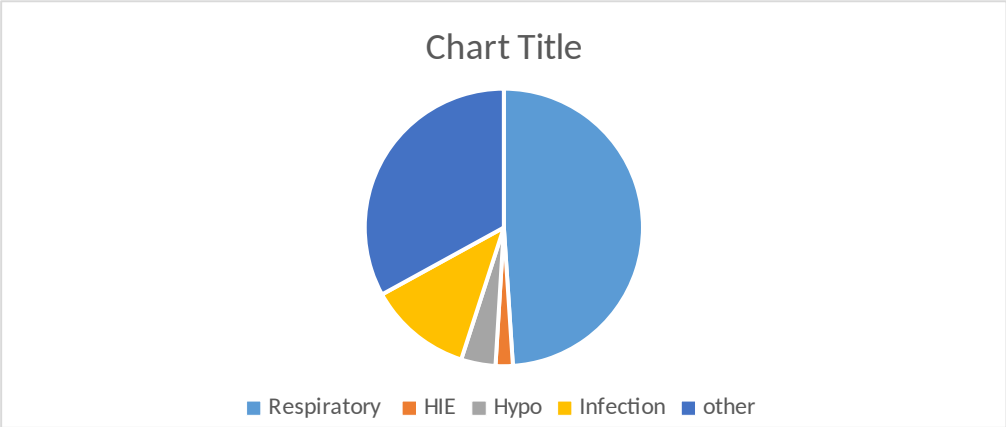
All unexpected term admissions to NNU are reported through the DATIX system and investigated through the weekly Maternity Case Review multi-disciplinary meeting. The CNST approved template ATAIN proforma is completed for data collection purposes. The themes, trends and learning points are shared amongst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

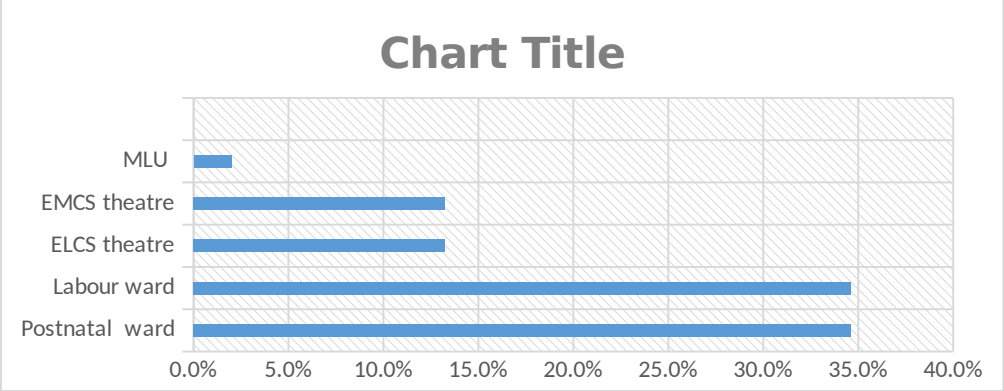
Unexpected Term Admissions to NICU cases, reviewed through Maternity case review equated to 53 cases in quarter 4. Themes identified are presented below. The average gestation at admission to NICU was 39+0 -39+6 weeks.

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 & delivery Suite and The Postnatal 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 – 4.0kg.

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 2.

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 7 compared to 8 in quarter 3 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

Clinical Governance Midwife
Neonatal Consultant (ATAIN program lead)
April 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

Agenda Item		Meeting	Quality Committee and Trust Board Meeting	Meeting Date	Q4 2022
Title	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4** **Safety Action 6 – Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?** **Element 2 – Process Indicators 4 and 7**				
Lead Director	Interim Chief Nurse				
Author	Midwifery Sister – GAP Lead 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 Trust Board is requested to: • Receive the report and decide if any further information and/or assurance are required.

MATERNITY SERVICES
FAMILY AND WOMEN'S HEALTH GROUP

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

1. Purpose of the Report

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

2. Introduction

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

- publication of small for gestational age/fetal growth restriction detection rates and percentage of babies born <3rd centile and >37+6 weeks gestation
- an ongoing case-note audit of <3rd centile babies not detected 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

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

January, February, March 2023 (Quarter 4) –

Number of babies born at HUTH = **1183**

Number of babies born at HUTH < 3rd centile & >37+6 = **25**

Percentage = 2.11%

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 25 cases 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 4 (January, February, March 2023), there were 5 missed cases and of these, it was highlighted that (some cases involved more than 1 of these issues):

- 1 case had incorrect demographics on the growth chart and a missed opportunity for a ultrasound of fetal growth
- 2 cases fell within the 30% variance allowed by the ultrasound parameters
- 1 case involved discrepancies over recording of a multiple pregnancy scans
- 1 case had normal scan results and a birth centile of 1.1

An email was sent to the relevant practitioner to inform them that they had missed an opportunity for a growth scan and incorrect geographical details on the growth chart. Details of the case with the birth centile of 1.1 was sent to the obstetric sonographers for discussion at their multi-disciplinary meeting(s). It was very encouraging that there were no incorrect fundal height measurements apparent 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 contacts with pregnant people. The next GAP newsletter should be due to be produced in late April 2023. Later in 2023, the introduction of the BadgerNet IT maternity system and its links with the Perinatal Institute GAP software for inputting scans and fundal height measurements should further improve data collection and care.

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

Agenda Item		Meeting	Quality Committee and Trust Board	Meeting Date	Q4 2022
Title	**Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool**				
Lead Director	Interim Chief Nurse				
Author	Director of Midwifery Bereavement Midwives				
Report previously considered by (date)	Quality Committee				

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

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

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY SERVICES
FAMILY AND WOMEN'S HEALTH GROUP

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

1. Purpose of the Report

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

2. Introduction

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

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

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

A)

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

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6th May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust

B) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6th May will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

C) For at least 95% of all deaths of babies who died in your Trust from 6th May 2022, the parents will have been told that a review of their baby's death will take place, and that the

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

D) Quarterly reports will have been submitted to the Trust Board from 6th May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

4. Perinatal Mortality Review Tool (PMRT)

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

The PMRT has been designed with the following principles:

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

5. Summary

The below summaries Q4 January to March 2023 which is within the reporting period of the CNST year 4 incentive scheme.

A)

i. In Q4 the Trust was fully compliant with the standard. **100%** of cases were notified to MBRRACE-UK within seven working days and the surveillance information where required was completed within one month.

ii. In Q4 there have been 8 new cases suitable for a PMRT review in the Trust compiling of 4 stillbirths and 4 neonatal deaths. A PMRT review has been commenced within two months of the reporting period in **100%** of cases.

B)

In Q4 the multidisciplinary review team have reviewed 7 cases from Q3, 1 case was joint with another trust and is currently in the report writing stage and the 6 remaining cases have been reviewed and had a written report completed and published. 2 of these cases were not completed within the 4 month time frame and 1 case which is joint with another trust remains outstanding from

Q3. There was 1 case from Q4 reviewed and currently in the report writing stage.
When removing the joint cases from the data, Hull Teaching Hospitals has demonstrated a compliance of **66.6%** for commencing and completing a review within 4 months due to 2 neonatal cases breaching the target. The 6 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 Q4 reporting period, the parents have been told that a review of their baby's death will take place, and the parents' perspectives and any concerns they have about their care and that of their baby has been sought. The bereavement midwife maintains contact with the parents through the PMRT review.

D)

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

6. Recommendations

The Trust Board is requested to:

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

Ainsley Belton and Sue Cooper
Bereavement Midwives

Director of Midwifery

April 2023

MATERNITY PMRT ACTION TRACKER FOR Q4 2022

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY PMRT ACTION TRACKER FOR FEBRUARY 2023

MBRRACE ID	ACTIONS	Lead	Due date	RAG
83553	Review guideline to ensure woman prescribed Aspirin when GDM diagnosed following booking HbA1c	AW	28/02/23	
83772	Ensure a Kleihauer is obtained postnatally for losses-publish in Labour Ward and PMRT newsletters	SC/ AB	31/03/23	
	Highlight change to GAP guideline to all obstetrician's, and in all area's newsletters, and PMRT newsletter	SC/ AB KS	28/02/23	
83851	Reminder via PMRT newsletter to staff regarding the need to risk assess all maternity patients for their requirement of aspirin	SC/A B	28/04/23	
	To ensure that women are appropriately seen in the pre-term birth clinic The capacity issues are recorded on the HUTH risk register.	UR	28/04/23	
85086	To ensure that women are appropriately seen in the pre-term birth clinic The capacity issues are recorded on the HUTH risk register.	UR	28/04/23	
	Reminder to staff via the PMRT newsletter and staff training of the DNA policy and follow up.	SC/A B	28/04/23	
Actions now completed (to be received at the PMRT meeting then removed from this tracker)				

Leads

SC – Sue Cooper
AB – Ainsley Belton
LD- Liz Davies
AW – Amanda Waterton
RB – Rebecca Barber
KS- Mrs Karthika Sivakumar
UR- Mrs Uma Rajesh

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	**Meeting Date**	
Title	**Perinatal Quality Surveillance Tool**				
Lead Director	Interim Chief Nurse				
Author	Lead Midwife Director of Midwifery				
Report previously considered by (date)	Quality Committee Q4 report				

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 4

January to March 2023

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

The ratings above are from our inspection in 2018.

An inspection for Maternity Services Safe and Well Led domains was undertaken on 15th March 2023. CQC inspectors visited all areas of the maternity services based at the Hull Women & Children's Hospital. They spoke to staff and women attending the service as well as conducting more formalised interviews with managers and clinicians.

Following the inspection a Letter of Intent was received on 17th March 2023 and an immediate action plan put in to place for 18th – 21st March 2023 to support systems and processes in the Antenatal Day Unit. This was followed up with a further, longer-term action plan and submitted to the CQC on Tuesday 21st March 2023.

Full feedback from the CQC and updated ratings for the visit have not yet been received.

3.0 HSIB REFERRALS

The following provides numbers of HSIB referrals made:

Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
1	1	1									

January: MI – 021372 – Attended with bleeding – abruption & dehiscence HIE / cooling

February: MI – 021900 – HIE / Cooling – case rejected

March: MI – 023882 – Concealed pregnancy, BBA. HIE / cooling – case rejected

4.0 DATIX INCIDENTS

The following provides the number of incidents reported:

Severity	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
Moderate	2	2	2									
Major	0	0	0									
Catastrophic	0	0	0									

SUI/2023/3017 Previous LSCS admitted with abruption and scar dehisense. Baby admitted to NICU – Cooled. HSIB Case MI-021372

W273222 Admitted unwell with Pneumonia – transferred to ICU following EM LSCS

SUI/2023/3522 Unexpected admission to NICU. Referred to HSIB but rejected

W275808 Unexpected admission to NICU following ventouse birth. Baby had large cephalohematoma

W277434 Concealed pregnancy, BBA. Baby cooled. Referred to HSIB but rejected.

W276844 Preterm birth capacity – delay in patient care.

Themes & Actions

No themes identified at present

5.0 SERIOUS INCIDENTS

Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
1	2	0									

SUI/2023/336 – G1P0 22 weeks pregnant. Maternal death due to cerebral venous sinus thrombosis

SUI/2023/3017 Previous LSCS admitted with abruption and scar dehiscence. Baby admitted to NICU – Cooled. HSIB Case MI-021372

SUI/2023/3522 Unexpected admission to NICU. Referred to HSIB but rejected

6.0 TRAINING COMPLIANCE

CNST Training Data PROMPT, Fetal Monitoring and Neonatal Resuscitation

PROMPT – Compliance at end of March 2023

Area	No of Staff	DAY 1 - REMINDER (10 MTHS)	Expired - Review (1 yr)	In date	% Perf	Shortfall	No.Staff Req'd to achieve 90%
Obstetric Cons, Ass Spec	15	6	2				
	15	6	2	13	87%	1	14
Obstetric Registrar	16	6	4				
Obstetric SHO	16	7	6				
	32	13	10	22	69%	7	29
Anaesthetic Consultant	8	1	1				
	8	1	1	7	88%	1	8
Anaesthetist	8	1	1				
	8	1	1	7	88%	1	8
Labour & Del. MW	45	12	6				
Community	50	9	5				
Specialist Senior Midwives	28	7	6				
Maple & Rowan Ward Core Midwives	39	7	2				
MLU Midwives	17	2	2				
Bank Midwives	9	3	3				
ANC - W&C Midwives	24	8	6				
	212	48	30	182	86%	9	191
Labour & Del. MW Assist	15	3	3				
Community MW Assistants	7	4	3				
Maple & Rowan Ward Midwifery Assistant	24	12	5				
MLU MW Assistant	14	1	1				
Bank Midwife Assistant	4	3	2				
ANC - W&C Midwives Assistant	11	2	0				
	75	25	14	61	81%	7	68
ODA-Ps	0	0	0				
Gynae Theatre Nurses	0	0	0				
	0	0	0	0	0%	0	0
Total No. Staff	350	94	58	292	83%	23	315

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.

Neonatal Resuscitation training – Compliance at end of March 2023

Neonatal Resuscitation

Area	No of Staff	DAY 1 - REMINDER (10 MTHS)	Expired - Review (1 yr)	In date	% Perf
Neonatal Consultant	8	6	1	7	88%
	8	6	1	7	88%
Neonatal Registrar ANNP	14	8	8	6	43%
Neonatal SHO	11	4	3	8	73%
	25	12	11	14	56%
Specialist Snr NICU Nurses	8	5	0	8	100%
NICU Nurses	102	54	36	67	66%
NICU Bank Nurses					0%
	110	59	36	75	68%
Labour & Del. MW	45	16	7	38	84%
MLU Midwives	19	7	5	14	74%
Community	48	21	8	40	83%
Specialist Snr Midwives	28	14	8	20	71%
Maple & Rowan Midwives	38	15	9	29	76%
Bank Midwives	9	3	1	8	89%
ANC Midwives	23	8	4	19	83%
	210	84	42	168	80%

Job Role	Number staff in group	Training completed to date	% compliance for CTG training
Obs Consultants	15	14	**93.3**
Obs Registrar	14	13	**92%**
Obs SHO	14	14	**100%**
Labour Ward MW	41	40	**95.6%**
MLU MW	29	26	
Maple/Rowan	36	21	
Specialist MW	27	22	
ANC MW	30	27	
Community MW	34	34	
Bank MW	9	7	

CTG Training

7.0 MINIMUM SAFE STAFFING LEVELS

Midwifery Staffing

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

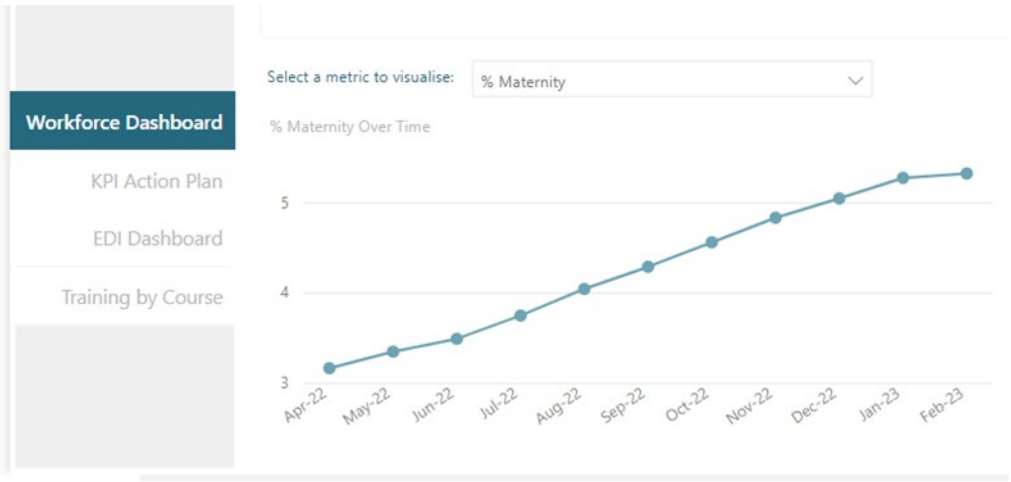
Ongoing workforce reviews are being undertaken to explore additional specialist and management roles to ensure on site senior operation support 24hrs a day 7 days a week.

Maternity Leave

The service has seen an increase in maternity leave amongst qualified midwives and is currently at 5.3%.

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



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 undertaken a number of recruitments:

Newly Qualified Midwives – we have offered jobs to 22 student midwives due to qualify in September 2023 equating to 17.6 WTE

Rotational Midwives – we have recruited 2 external rotational midwives equating to 1.8 WTE

Operational Matron Post –1.0 WTE interviews are 25 April 2023

Clinical Midwifery Educator – recruited 1.0 WTE

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 was successful in its bid for 10 international midwives. Recruitment is underway with a shortlist of 11 international midwives to move forward to interview.

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 – 14 red flags reported from January to March 2023:

- 2 delayed or cancelled time critical activity

- 1 delay between presentation and triage
- 1 of these were delay between admission for induction and beginning of process
- 8 were missed or delayed care
- 2 delay in providing pain relief

8.0 SERVICE USER VOICE FEEDBACK

On the 8th March 2023 the Hull & East Riding Maternity Voices Partnership undertook a Fifteen Steps review of maternity services.

The 15 steps for Maternity is a toolkit to look at maternity services from the perspective of the service users. It aims to identify any improvements that could be made based on first impressions of healthcare areas.

The areas visited were:

Women & Children's entrance
The Antenatal Day Unit
Scanning Areas
Labour and Delivery
The Fatima Allam Birth Centre
The Bereavement Suite
NICU
Postnatal Ward
Community Midwife Clinics

A report has been received from the team outlining the positive findings of the visit but also some recommendations for each area. The common themes for improvement were:

- Lack of signage in other languages and formats. More inclusive posters for BAME. LGBTQ etc. required
- Lack of representation of dads
- No reference or information about PALS or MVP displayed
- Lack of Perinatal Mental Health Information
- Lack of Baby Changing facilities and dedicated breast / infant feeding spaces
- Concern about the relevance and sensitivity of where and how some information is displayed.

The report will be reviewed and an action plan developed to move forward with these recommendations.

9.0 STAFF FEEDBACK

Feedback received from a Community Midwife:

I feel impelled to put a few lines together on behalf of myself and my colleague's in Wyke Community Team to highlight to you both just how fabulous your leadership team are.

I have examples, merely days apart of not only compassionate leadership, leading by example, but examples of true, woman centred care.
On Friday; Anna and Hannah themselves attended a homebirth for my team as there was no one else available. This woman had previously had a difficult experience in the hospital and very much wanted to birth at home.

Instead of telling her she would have to transfer in, Anna put out immediately for help and Hannah who was actually annual leave attended this beautiful birth with her. Both the woman and my team were thrilled that they did this.

Today, my second woman who was booked for a homebirth went into labour. Again; faced with the challenges of staffing levels, Hannah and Anna sprang into action again to put this woman's wishes first and managed to get workload covered to release my colleague Donna and Kay to attend her. Again, resulting in a beautiful homebirth and what was special today was this woman was part of a Student Midwife's caseload. Laura has attended almost all of this woman's care and was then able to be present and experience her homebirth.

Well, I have had a few tears of joy today.
I just wanted to share with you the positivity and the happiness we are feeling right now.
Times may be hard but we have the best team ever

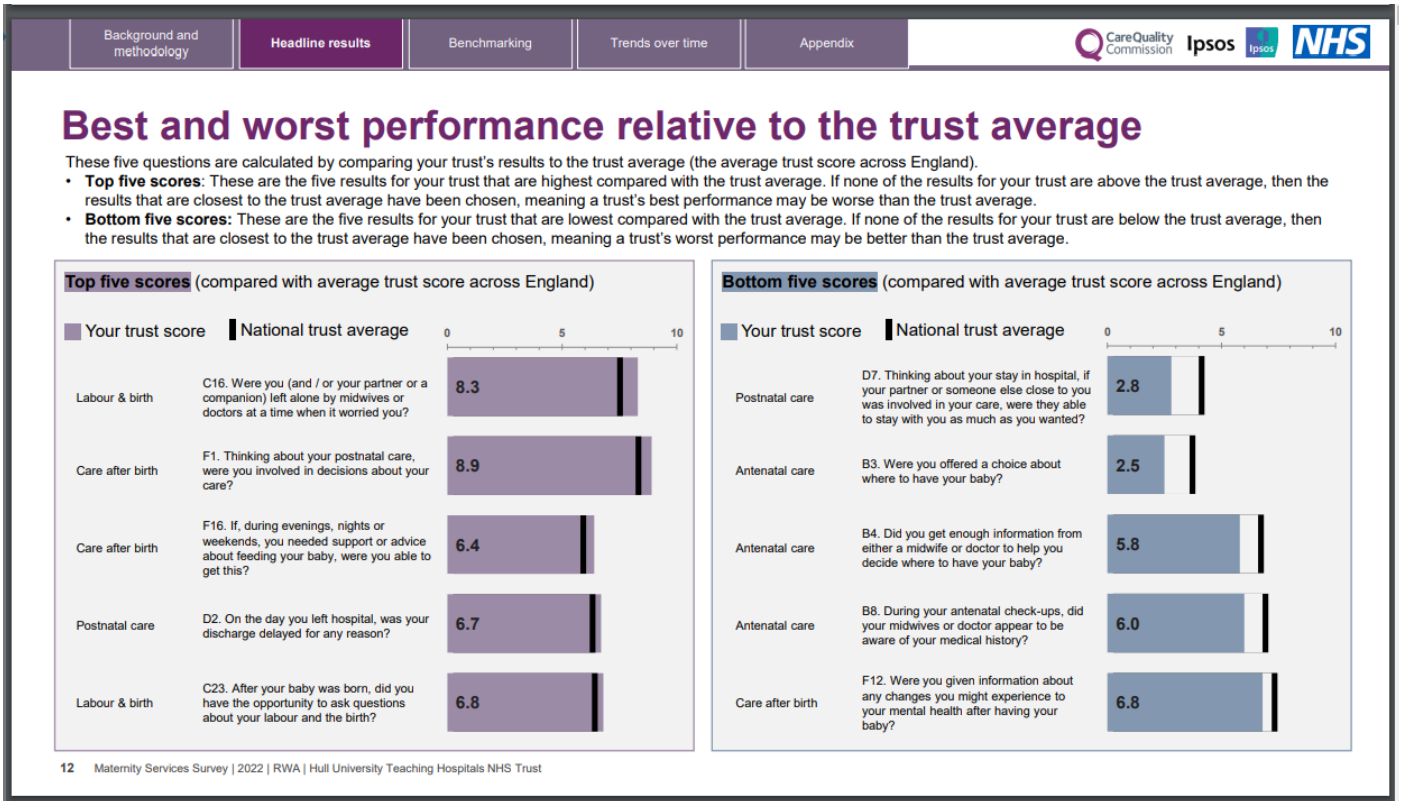
10.0 CORONERS

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

Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
0	0	0									

11.0 NATIONAL SURVEY RESULTS

Maternity Survey 2022 results



NHS Maternity Survey 2022

Results for Hull University Teaching Hospitals NHS Trust

Where mothers' experience is best

- ✓ Mothers (and / or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.
- ✓ Mothers being involved in decisions about their postnatal care.
- ✓ Mothers being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- ✓ Mothers discharge from hospital not being delayed on the day they leave hospital.
- ✓ Mothers having the opportunity to ask questions about their labour and the birth after the baby was born.

Where mothers' experience could improve

- o Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- o Mothers being offered a choice about where to have their baby during their antenatal care.
- o During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.
- o Midwives or the doctor appearing to be aware of mothers' medical history during antenatal check-ups.
- o Mothers being given information about any changes they might experience to their mental health after having their baby.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where mothers' experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where mothers' experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.

This survey looked at the experiences of individuals in maternity care who gave birth in February 2022 at Hull University Teaching Hospitals NHS Trust. Between April 2022 and August 2022 a questionnaire was sent to 385 individuals. Responses were received from 180 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

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

LMNS:	**Humber and NorthYorkshire**	**Programme Lead:**	Becky Case
Trust Name:	**Hull University Teaching Hospitals NHS Trust**	**Completed by:**	Julia Chambers, Lead Midwife
CQC Rating:	**Good (2018)**	**Date:**	March 2023

No of Serious incidents and HSIB reported	**Saving Babies Lives v2 compliance**	**Maternity Incentive Scheme**		**No of complaints/PALS - themes**
January 2023 – 1 SI (HSIB – Maternal Death) **February 2023 - 2 SI's (Both HSIB – cooled babies)** **March 2023 – 1 HSIB cooled baby (concealed pregnancy, BBA)**	Element 1: Compliant	Safety Action 1 (PMRT): Compliant	Safety Action 6 (SBL Care Bundle): Compliant	**January 2023** **4 complaints under investigation (3 unhappy with care received)** **February 2023** **2 complaints under investigation (unhappy with care received)** **March 2023** **2 complaints under investigation (unhappy with care received)**
	Element 2: Compliant	Safety Action 2 (MSDS): Compliant	Safety Action 7 (MVP): Compliant	
	Element 3: Compliant	Safety Action 3 (ATAIN): Compliant	Safety Action 8 (Core Competency Framework): Compliant	
	Element 4: Compliant	Safety Action 4 (Clinical Workforce Planning): Compliant	Safety Action 9 (Trust Board Oversight): Compliant	
	Element 5: Compliant	Safety Action 5 (Midwifery Workforce): Compliant	Safety Action 10 (HSIB & ENS): Compliant	

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/ Delay to Treatment	1/ Progress in labour not monitored on a partogram	1/ Clinical Assessment
2/ PPH>1.5 litres	2/ Ensure Asprin prescribed when GDM diagnosed	2/ Guidelines
3/ Unexpected Admission to NICU	3/ Appropriate review in the Pre-term clinic – follow up if DNA	3/ Communication
4/IN-utero transfer	4/ Kleihauer test not offered	4/ Escalation
5/ GAP – missed IUGR	5/ Risk assessment not documented at start of care in labour	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.

	Jan 2023	Feb 2023	March 2023
Early breast milk	67%	64%	
Thermoregulation	100%	91%	
DCC	67%	82%	
Intrapartum antibiotics	0%	75%	
Correct place of birth	100%	100 %	
Magnesium sulphate	100%	67%	
Antenatal steroids	67%	64%	

Perinatal - Key Themes from Incident Reviews	**Perinatal - Key Safety Interventions Implemented**
1/ Fluid Drug prescribing & administration in neonates	Introduction of @Druggles', discussion at daily huddles of any incidents with learning feedback
2/ Recently concluded neonatal SI – accidental arterial cannulation	Pay attention to pO2 on the gas taken from cannula. Check a gas for pO2 if cannulating at a vein anatomically close to an artery for early indication of accidental arterial cannulation
3/ Documentation of risks	3/ Ensure full documentation of discussion of risks when consenting patients

2

MVP Service User Feedback Themes
Fifteen Steps completed on 8th March 2023 with Hull & East Riding MVP. Lots of positive feedback and also some areas for improvement around engagement with our non-En sign posting etc..
Moments of Excellence / Good Practice Points
• Neonatal Resuscitation Simulation for unplanned birth on Antenatal Day Unit taken place – positive simulation with good engagement from MDT

Concerns
Community Midwifery issues with Entonox storage and transport now resolved – new SOP in place. CQC visit – immediate actions around triage /ADU. Action Plan in place and being implemented. Staffing continues to be challenging – high level of maternity leave impacting.
Suspensions of Service
None

MBRRACE ***Stabilised and Adjusted Mortality Rates per 1000 births***	**Still birth**	3.56
	Neonatal death - term baby <7 days	2.05
	Extended perinatal death	5.57

Appendix 2 – 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

REFERENCES

Only PDFs are attached

8.3 - Learning From Morbidity and Mortality - Q3 22-23 Final Draft.pdf

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item		**Meeting**		**Meeting Date**	
Title	Learning from Mortality and Morbidity Report – Q3 2022/23				
Lead Director	Dr Makani Purva – Chief Medical Officer				
Author	Chris Johnson – Effectiveness and Improvement Manager				
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 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 Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information
- Decide if any further information and/or actions are required

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
MORTALITY - LEARNING FROM DEATHS QUARTER 3 2022/23

1. PURPOSE OF THIS REPORT

The purpose of this report is to provide the Trust Board with a summary of mortality statistics and learning from deaths in line with the requirements set by NHS Improvement, outlined in the national framework. The data in this report is from Quarter 3, 2022/23, unless otherwise stated (broader timeframes are used in some instances for deeper statistics, for example, HSMR and SHMI.)

The report also aims to outline the plans for the upcoming year, detailing the positive direction taken by the Trust to enable a stronger focus on learning from mortality and morbidity during 2022/23 and beyond.

The content of these reports will now closely follow the proposed work plan and content of the monthly Trust Mortality and Morbidity Committee.
Information relating learning and actions taken are obtained from various sources including the Medical Examiner Office, Speciality M&M meetings and the Trust incident reporting system (Datix).

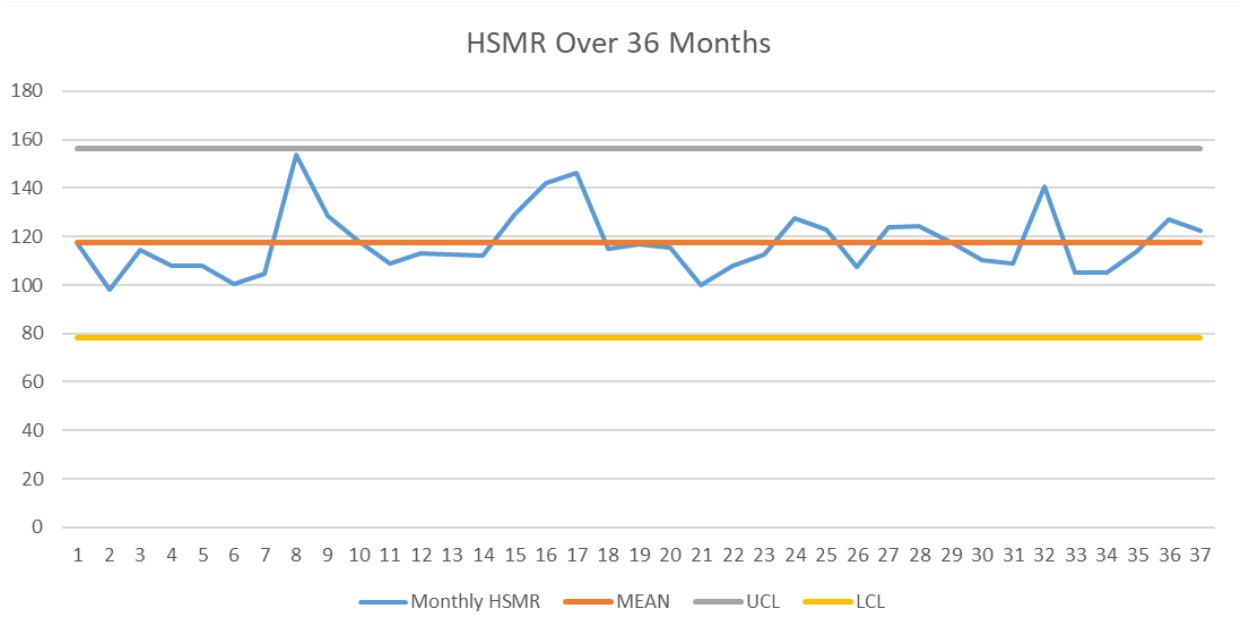
2. SUMMARY OF IN-HOSPITAL MORTALITY IN Q3 2022/23

The following table provides a breakdown of patient deaths that occurred within the Trust during Q3 2022/23, drawing comparison to last year. Please note, figures now include patients who died within the Emergency Department/ dead on arrival.

	Year for Comparison	Total number of In-hospital deaths
Q3	2021/22	Total of 732 deaths 675 were Inpatients 57 deaths within the ED, including dead on arrival
	2022/23	**Total of 746 deaths** 670 were Inpatients 76 deaths within the ED, including dead on arrival

2.1 HSMR (HOSPITAL STANDARDISED MORTALITY RATIO)

The following HSMR chart illustrates the most up to date data available for the Trust. HSMR data reflects that the Trust is currently within the Mean range.



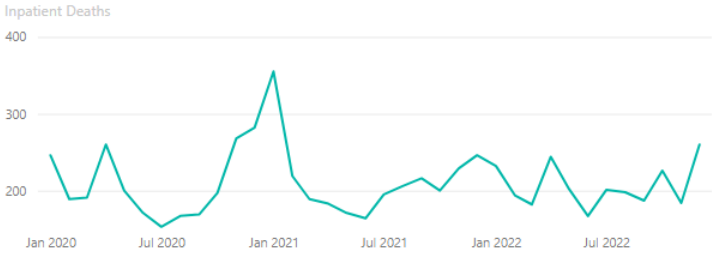
2.2 SHMI (SUMMARY HOSPITAL LEVEL MORTALITY INDICATOR)

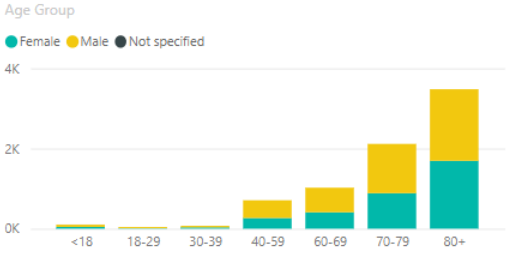
The latest Trust SHMI shows that the number of deaths are within the expected range and no longer outlying above the upper control limit.

Latest data (August 2022) shows expected deaths at 2675, with the observed deaths at 2960, putting the Trust within the “As Expected” banding.

2.3 IN-HOSPITAL MORTALITY DASHBOARD

The following crude mortality dashboard covers the last 36 months of inpatient mortality (excluding ED):

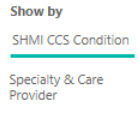




Month	2019/20	2020/21	2021/22	2022/23	Total
Apr		260	183	244	687
May		200	171	202	573
Jun		171	164	167	502
Jul		153	195	201	549
Aug		167	206	198	571
Sep		169	216	187	572
Oct		197	200	226	623
Nov		268	229	184	681
Dec		282	246	260	788
Jan	246	355	232		833
Feb	189	219	194		602
Mar	191	189	182		562
Total	**626**	**2,630**	**2,418**	**1,869**	**7,543**

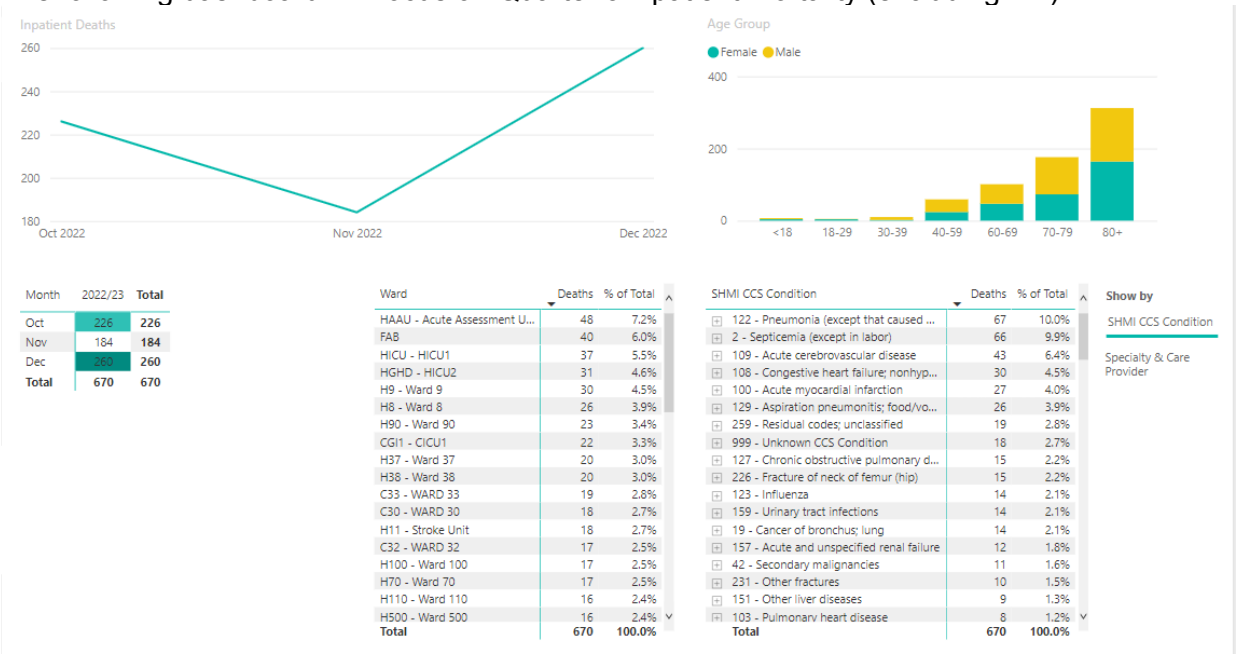
Ward	Deaths	% of Total
H90 - Ward 90	435	5.8%
H9 - Ward 9	356	4.7%
C30 - WARD 30	332	4.4%
HGHD - HICU2	326	4.3%
H8 - Ward 8	320	4.2%
H80 - Ward 80	309	4.1%
HAAU - Acute Assessment U...	301	4.0%
HICU - HICU1	300	4.0%
C32 - WARD 32	254	3.4%
H37 - Ward 37	249	3.3%
H110 - Ward 110	241	3.2%
H500 - Ward 500	236	3.1%
H100 - Ward 100	226	3.0%
C31 - WARD 31	208	2.8%
C33 - WARD 33	203	2.7%
H5 - Ward 5	196	2.6%
H38 - Ward 38	191	2.5%
CGI1 - CICU1	184	2.4%
Total	**7,543**	**100.0%**

SHMI CCS Condition	Deaths	% of Total
122 - Pneumonia (except that caused ...	829	11.0%
259 - Residual codes; unclassified	735	9.7%
2 - Septicemia (except in labor)	528	7.0%
109 - Acute cerebrovascular disease	502	6.7%
108 - Congestive heart failure; nonhyp...	271	3.6%
129 - Aspiration pneumonitis; food/vo...	234	3.1%
157 - Acute and unspecified renal failure	219	2.9%
100 - Acute myocardial infarction	211	2.8%
42 - Secondary malignancies	197	2.6%
19 - Cancer of bronchus; lung	191	2.5%
127 - Chronic obstructive pulmonary d...	160	2.1%
159 - Urinary tract infections	145	1.9%
233 - Intracranial injury	133	1.8%
226 - Fracture of neck of femur (hip)	117	1.6%
114 - Peripheral and visceral atherosci...	106	1.4%
115 - Aortic; peripheral; and visceral ar...	97	1.3%
153 - Gastrointestinal hemorrhage	93	1.2%
107 - Cardiac arrest and ventricular fib...	86	1.1%
Total	**7,543**	**100.0%**



As expected, 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 (as shown on the table above).

The following dashboard will focus on Quarter 3 inpatient mortality (excluding ED):



The top 5 most common SHMI diagnosis during Quarter 3, as shown above, are:

- Pneumonia – 67 deaths (10% of total)
- Septicaemia – 66 deaths (9.9% of total)
- Acute Cerebrovascular disease (stroke) – 43 deaths (6.4% of all deaths)
- Congestive heart failure, non-hypertensive - 30 deaths (4.5% of total)
- Acute myocardial infarction – 27 deaths (4% of total)

3. Minimal Criteria for Structured Judgement Review (National LFD Framework)

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

Criteria	Number of cases requiring SJR / other case note review	Outcomes / Update
Deaths where a concern was raised about the quality of care provision (including cases raised by ME)	13	These 13 cases were identified via the medical examiner service and are currently progressing through the review stage.
Patients who had Learning Difficulties or Severe Mental Illness	6	The Safeguarding Team, in addition to other trained reviewers, regularly undertake reviews on this cohort of patients.
Deaths where an alarm has been raised with the provider (mortality alert – Dr Foster)	Cases are regularly now reviewed for cohorts of patients from within the outlier diagnoses.	A review into a potential outlier status in relation to Major Trauma patients is underway, with initial findings presented in this report.
Number of deaths that underwent a Serious Incident Investigation and completed.	0	Any deaths deemed more likely than not to have been avoidable.
Further sample of deaths where the learning will inform a provider's quality	Target of 5% per cohort	The Trust aims to undertake reviews on further samples of patients including fractured neck of femur

improvement work		patients, sepsis, pneumonia and stroke related mortality.

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

4. SUMMARY OF CASE NOTE REVIEWS

The following table illustrates the number of SJR's and other case note reviews completed within Q3; including details on how many were escalated to Tier 2 and Triumvirate level.

	Total Number of SJR / other case note reviews completed	Cases escalated to Tier 2 Review	Cases requiring Escalation to Speciality Discussion	SJR cases escalated and declared as a Serious Incident
Q3	100 (55 relating to deaths from Q3 45 relating to deaths from Q1)	9	3	0

During the Structured Judgement Review, various aspects of the patient's hospital stay are judged and given a score to represent the quality of care that they received.
The care score works on a 1 to 5 basis, with 1 being very poor and 5 being excellent. The table below provides an overall summary of Structured Judgement review care scores that were completed during Quarter 3:

		Poor 1	2	3	4	5	Good 6
1. Phase of Care							
Admission & initial care (1st 24hrs)	3.5	3	7	15	19	11	
Care during a procedure	4.2		1		2	3	
End of life care	3.9		2	12	30	9	
Ongoing care	3.4	2	9	17	18	7	
Overall assessment of care	3.4	2	8	19	20	6	
Perioperative care	3.4		3	1		3	
2. Avoidability of death							
Avoidability of death judgement	5.2				2		3
3. Themed Analysis							
Ceiling of care	4.0				3		
Communication with patient/family	3.5		5	1	1	5	
Documentation	2.4	1	7	4	1		
End of life care	4.5			1	1	4	
Fluid balance	2.0	1	3	1			
Interventions	2.5	1	1	1	1		
Management plans	3.4	1	1	1	4	1	
Medication \ Prescribing	2.7		1	2			
Multi-disciplinary care	3.5		1	2	2	1	
Other	1.9	3	5	2			
Senior clinical involvement	2.8	2			1	1	
Sepsis management	2.0		1				

Although the number of SJR's that undertook the thematic analysis element of review in Q3 is relatively small, there are some potential themes of issues that have occurred over a broader period of time, including:

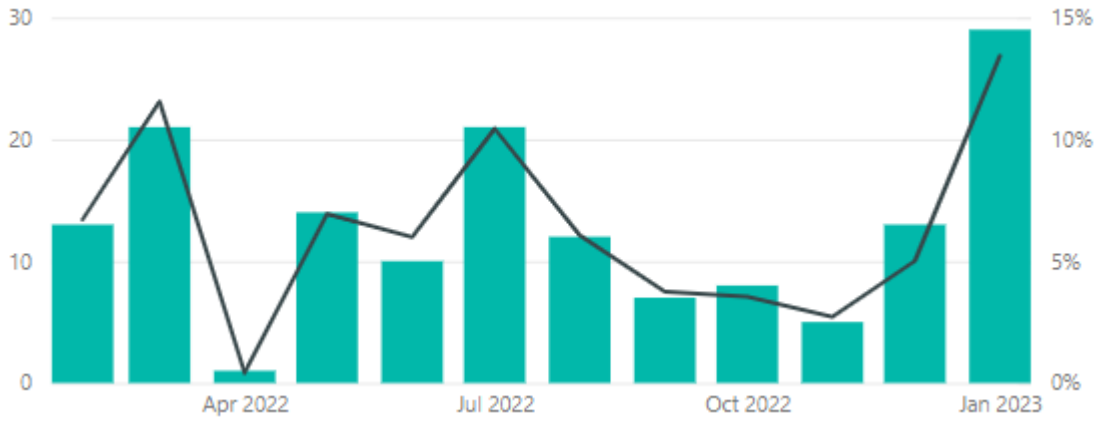
- **Fluid Balance** – support with hydration and nutrition was sub-optimal in 2 Stroke cases. Poor hydration resulted in hypernatremic dehydration and acute kidney Injury. A Quality Improvement Plan is currently in the planning stages to help address these issues, covered later in this report.
- **Documentation** –Lack of documentation relating to coherent patient plan with lack of senior reviews documented.
- **Sepsis Management** - When the criteria to treat sepsis were met (sign of infection + 1 or more red flags) sepsis does not appear to have been considered or identified at this time.

These issues were shared with the responsible specialties to be discussed at the M&M meeting, and where required, a Tier 2 review undertaken.

The latest figures show that the Trust undertook SJR's on an average of 10% of all monthly deaths towards the end of Quarter 3, into Quarter 4. Quarter 4 has begun strongly, with almost 15% of the deaths occurring in January 2023 receiving an SJR. Add to this a further 5% of SJR's undertaken on paper (outside of the Lorenzo form) and this shows a positive upwards trend in SJR completion

This is a result of improved engagement from Clinicians around the SJR process, in addition to the mandate of SJR training that is easy to access via the online portal.

SJR Rate (percentage of all in-hospital deaths reviewed)



As of 1st February, 2023, there have been a total of 389 ST5+ Clinicians undertake the online SJR training module. This number will continue to grow throughout Quarter 4 of 2022/23 and will enable more SJR's to be completed, in line with Trust policy.

5. LEARNING FROM MORBIDITY AND MORTALITY

This section of the report aims to collate and expand upon the agreed work plan and topics of discussion that took place in the Trust M&M Committee's that took place during Q3, 2022/23.
Learning is broken down into Health groups and Specialties, as per the M&M Committee work plan.

There are 3 main areas covered in this report, these relate to:

- Family and Women's Health Group – Child Death Peer Review
- Sepsis
- Elevated Mortality – Trauma (TARN)

5.1 Family & Women's Health Group

In December 2022, the National Child Mortality Database published "The Sudden and Unexpected Deaths in Infancy and Childhood" report. This report draws on data from the National Child Mortality Database (NCMD) to investigate sudden, unexpected and unexplained deaths in both infants and children and young people, and to draw out learning and recommendations for service providers and policymakers.

Key Findings in National Report Brief

Of all 6,503 infant and child deaths occurring between April 2019 and March 2021 in England, 30% (n=1,924) occurred suddenly and unexpectedly, and of these 64% (n=1,234) had no immediately apparent cause.

Infant deaths (under 1 year)

There was a link between unexplained deaths of infants and deprivation. A significantly larger proportion of unexplained deaths were of infants living in the most deprived neighbourhoods (42%) than those in the least deprived neighbourhoods (8%).

There was a strong link between sudden, unexpected infant deaths and sleeping arrangements.
Where it was known, 98% (n=124/127) of unexplained deaths occurred when the infant was thought to be asleep, and of those, 52% (n=64/124) of deaths occurred while the sleeping surface was shared with an adult or older sibling. Of the 64 deaths where the sleeping surface was shared, for 60% this sharing was unplanned and at least 92% were in hazardous circumstances e.g., co-sleeping with an adult who had consumed alcohol or on a sofa. Of the 124 deaths that occurred during apparent sleep, at least 75% identified one or more of the following risk factors related to the sleeping arrangements: put down prone (face down) or side; hazardous co-sleeping; inappropriate sleeping surface when sleeping alone; inappropriate items in the bed.

Unexplained deaths among infants were more common in males (64%) than females (36%), and were strongly associated with low birth weight, prematurity, multiple births, larger families, admission to a neonatal unit, maternal smoking during pregnancy, young maternal age, parental smoking and parental drug misuse.

Child deaths (1-17 years)

Both explained and unexplained deaths in this age group were associated with a history of convulsions. Where data were available (n=30), there was a history of convulsions recorded in 27% of children whose deaths remained unexplained in this age group. This incidence was similar to children whose deaths went on to be explained.

Sudden and unexpected child deaths in this age group were highest in the most deprived neighbourhoods.

For sudden and unexpected deaths that occurred during 2020 and had been fully reviewed by a CDOP (n=204), 84% went on to be explained by other causes.

There were at least 32 unexplained deaths in 2020 of children in this age group.

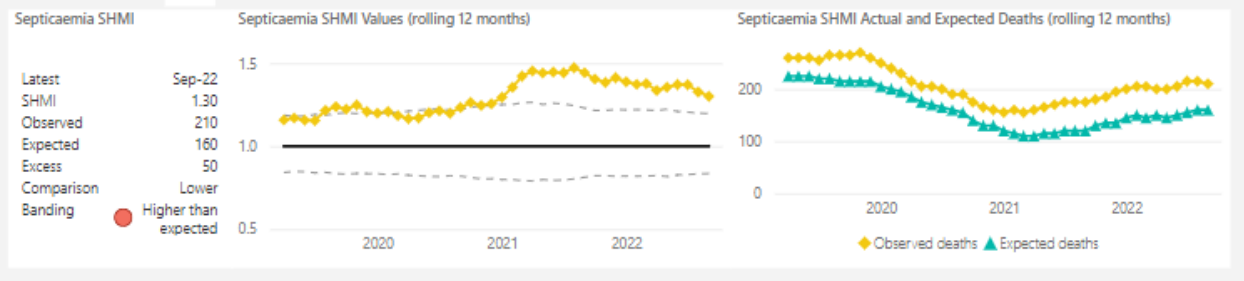
Trust Response

In response to this report, the Trust will be discussing this report and findings at the Child Death Overview Panel for Hull and East Riding, as well as being presented at the Paediatric Audit meeting.

The Trust is also planning a peer review that is set to commence in February 2023 to assist in the assessment of the current care practices and outcomes.

5.2 Sepsis

The following graph shows the most recent SHMI data for Sepsis.



The expected number of deaths is 160; the observed number of deaths within the Trust is 210, higher than expected, however, the rolling 12 month graph does show an overall positive decline in the number of observed deaths, heading down towards the upper control limit..

Sepsis remains a key area of focus for the Trust and its small but dedicated Sepsis team, who have helped develop a powerful tool for measuring and monitoring the care standards that are associated with Sepsis throughout the Trust. The Sepsis Audit aims to assess and monitor compliance of care standards that occur during the first hour from the initial Sepsis trigger.

The following dashboard shows a snapshot of Sepsis audit undertaken over the last 12 months for patients who had one or more of the following: Sepsis, Suspected Sepsis and Septic shock:

Question	Yes Results	No Results	% Compliance
Escalation within 15 minutes of a NEWS2 score	77	76	50.3%
Evidence of a documented assessment by a doctor in response to escalation	87	63	58.0%
30 minutes or continuous monitoring for 7+	32	70	31.4%
1 hourly for 5-6	47	65	42.0%
Escalation to critical care to manage hypoxia if required and suitable	6	20	23.1%
Escalation to critical care to manage hypotension if required/suitable	16	21	43.2%
Fluid balance chart commenced and consistently maintained	33	136	19.5%
Blood cultures obtained within 1 hour	49	3	47.6%
Urine sample ordered within 1 hour and consequently sent	22	64	25.6%
CXR ordered within 1 hour if suitable	51	36	58.6%
Sufficient investigation for the infection source	119	53	69.2%
Lactate within 1 hour	96	75	56.1%
Was Lactate repeated if initial result >2mmols/L	14	48	22.6%
Coagulation screen within 1 hour	62	106	36.9%
CRP within 1 hour	123	49	71.5%
U and E within 1 hour	123	49	71.5%
FBC within 1 hour	123	49	71.5%
Oxygen when required	60	3	95.2%
Resuscitation fluids administered within 1 hour	85	26	76.6%
Antibiotics prescribed within 1 hour	45	45	50.0%
Antibiotics administered within 1 hour	32	58	35.6%
Antibiotics prescribed according to HUTH guidelines?	104	64	61.9%

Care standards with a higher than 70% compliance rates include: Sufficient investigation of infection source, CRP within 1 hour, U and E within 1 hour, Oxygen (when required), resuscitation fluid within 1 hour, FBC within 1 hour.

Care Standards requiring Improvement

- **Antibiotics within 1 Hour (32 out of 58 patients compliant)**
  This is an essential care standard that can have a direct impact on patient outcome.

- **30 minutes/continuous monitoring for NEWS score of 7+ (32 out of 70 patients compliant)**
  A high score (NEW score of 7 or more) should prompt emergency assessment and continuous monitoring by a clinical team/critical care outreach team with critical-care competencies and usually transfer of the patient to a higher dependency care area.

- **Fluid balance chart commenced and consistently maintained (33 out of 136 patients compliant)**
  A recurring theme from SJR and Sepsis audit relating to incomplete/poorly maintained fluid balance charts.

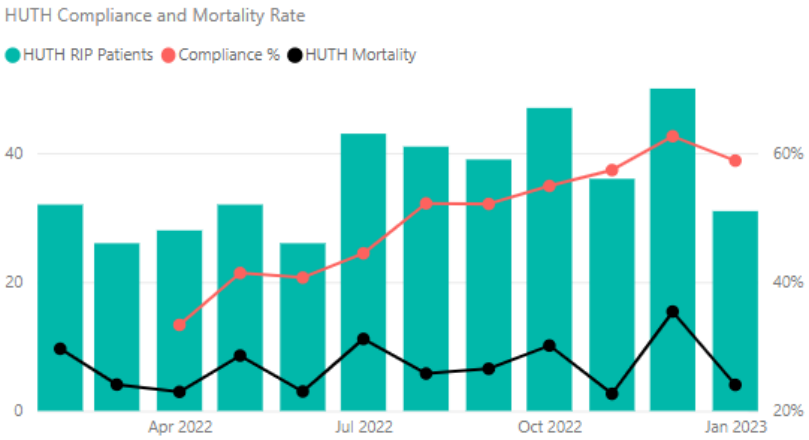
  Outcome Comparisons for Sepsis 6 Compliance
  The following table compares compliance rates for each care standard, broken down into best and worst outcomes, showing the difference in percentage between deaths and survivors compliance rates:

Sepsis Care Standards	WORST OUTCOME • Deaths with unresolved infection • Suspected sepsis, sepsis & septic shock n=74	% difference between deaths and survivor compliance rates	BEST OUTCOME • Survivors • Suspected sepsis, sepsis & septic shock • Discharged with no repeat infection related admissions within 30 days n=43
30 min monitoring for NEWS >7	19%	25%	44%
Abx administered within 1 hour	28.6% (note: Abx prescribed within 1 hour: 50%)	21.4%	50% (note: Abx prescribed within 1 hour: 64.3%)
Consistent fluid balance	13.7%	8.3%	22%
Abx within HUTH guidelines	56.2%	12.1%	68.3%
Sufficient investigations for the infection source	62.2%	7.6%	69.8%
1 hourly monitoring for NEWS >5	38.3%	5.5%	43.8%
Blood cultures	53.5%	2.1%	55.6%
IV Fluids (if indicated)	77.6%	-13.6%	64%
Urine sample	28.9%	-10.7%	18.2%
Lactate	58.1%	-12.9%	45.2%
Oxygen (if indicated)	100%	-20%	80%
CXR (if indicated)	68.4%	-26.7%	41.7%

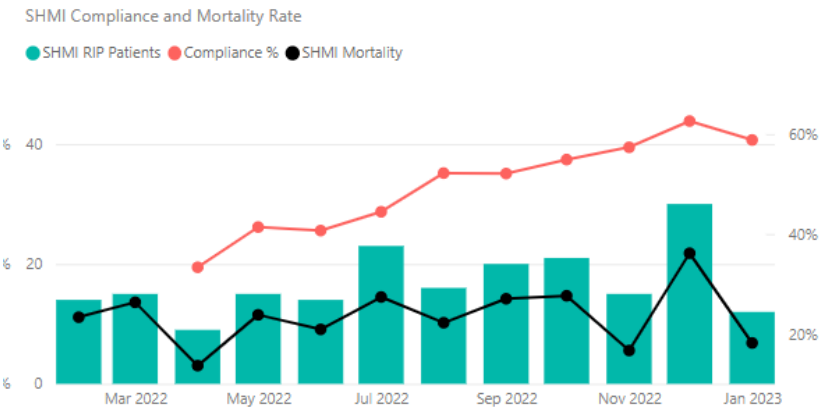
The table clearly shows that there are 2 care standards that have the highest impact on patient outcomes, these are:

- 30 Minute monitoring for patients with a NEWS2 of 7+
- Antibiotics prescribed within 1 hour / within HUTH Guidelines

The following graph shows HUTH mortality rates versus compliance rates:



The following graph shows SHMI mortality rates versus compliance rates:



There has been an overall rise in compliance rates between May 2022 to December 2022, rising from 39% to 62%.
The highest compliance rates were for those patients who were most in need of Sepsis screening and management. The lowest compliance rates were the most likely to result in infection related re-admissions within 30 days of discharge.

As time progresses, the information that is gathered form the Sepsis audit will make it easier to measure for improvement, as currently the audit is still in its infancy and it is still at the data gathering stage.

Actions Taken
There are currently a number of positive actions being taken to further improve the care delivered to patients who have, or are suspected to have, Sepsis.

Sepsis Quality Improvement Plan
The Sepsis Team are empowering clinicians, especially junior doctors, to embrace the Trusts strategy of driving quality improvement through meaningful and measurable quality improvement plans.
There are 3 main areas of Sepsis care that require improvement, which are currently being suggested to clinicians to allow for them to choose an area that they feel they would like to be involved with in relation to driving improvement.

The 3 suggested areas for improvement are:

- **Monitoring**
  - Reduce the amount of overdue observations for NEWS2 score 5+
  - Improve consistent fluid balance monitoring for patients with NEWS2 score 5+

- **Investigations:**

- Improve rates for the identification of infection source
- Good quality blood cultures sent within 1 hour before Antibiotics
- treatment
- Urine samples ordered and consequently sent
- Improve times between sample ordered/obtained and sample time received by lab

- **Management**
  - Antibiotics prescribed and administered within 1 hour
  - Escalation of the deteriorating patient (NEWS2 5+) within 1 hour
  - Increase use of Sepsis screening tool for all NEWS2 5+
  - Reduce time between prescribing and administering antibiotics

There are several things to consider for those who are undertaking the quality improvement work. Including:

- What knowledge do you need before undertaking the project?
- Will improvement make a difference to pateitn care and outcome?
- Is it sustainable?
- Will you need a team?
- Who are the key stakeholders?
- Will you need specialist support (e.g. Information/I.T)?
- Is the timeframe realistic?
- Cost implications
- Does is require authorisation?
- How will improvement be measured?

In addition to the launch of the Sepsis QIP's, other improvements include:

- Mandatory Simulation training for Nurses & Doctors
- Electronic Sepsis Pathway
- Introduction of the MicroGuide for Antibiotics prescribing guidelines
- Team meetings and process mapping workshop

Nerve Centre Sepsis Screening and Management Tool
Until very recently, the only way of collecting Sepsis six related data was to manually scrutinise paper based records. There was no way of knowing in real time, which patients were diagnosed with Sepsis. The paper pathway was the only source of support and guidance. The creation and implementation of the Nerve Centre tool (currently used in ED) will change, for the better, the way we collect this important data and respond to Sepsis.

Improvements on HRI Ground Floor
The ED has now introduced an escalation Doctor who has made a big difference in the timely response of care for patients with suspected Sepsis. Safety huddles in the ED now reinforce and remind the importance of the Sepsis Nerve centre tool.

5.3 TARN Outlier Status for Trauma related Mortality
The Trauma Audit & Research Network (TARN) measures and monitors process of care and outcomes to demonstrate the impact of these initiatives, providing local, regional & national information on trauma patient outcome. As part of the TARN outlier Policy, as agreed by the TARN Board, they annually review case mix standardised outcomes (the major trauma excess survival rate or percentage- the "Ws" outcome statistic) and the standard deviations together with data quality for all trauma receiving hospitals.

Historically patients who are transferred out of a Trust for on-going acute care have been excluded from the Ws statistic, this is referred to as "right censorship". However, to account for the differing number of transfers a Trust may treat compared to their peers and the potential impact of transfers in, out or both on Ws, the following groups are now all considered as part of the Outlier review process.

Right censorship: In deriving a hospital specific Ws the outcome of transferred patients is solely allocated to the final hospital in the acute trauma transfer pathway.

Left censorship: In deriving the hospital specific Ws the outcome of transferred patients is solely allocated to the initial hospital in the acute trauma transfer pathway.

Full censorship: In deriving a hospital specific Ws the outcomes of all transferred patients

are excluded.

After these 3 censorship models were reviewed, during the period between April 2019 and March 2021, Hull Royal Infirmary was identified as being a potential Negative Outlier.

Right censorship model:
Ws is 3 standard deviations (lower than) the norm at -2.5 (CI: -3.6 to -1.3).

Left censorship model:
Ws is 2 standard deviations (lower than) the norm at -1.4 (CI: -2.6 to -0.2).

Full censorship model:
Ws is 3 standard deviations (lower than) the norm at -2.1 (CI: -3.3 to -0.9)

Trust Response and Actions Taken
In response to this outlier alert, a TARN mortality review was planned to allow the Trust to identify any potential issues that may have contributed to this alert.

A bespoke proforma was developed to be used to aid in the review, in addition to a structured judgement approach for evaluating the care that was delivered to the patient.

The review is currently underway at the time of writing this report, therefore, the results and finding will be available in a separate report in the future.

In addition to the TARN mortality review, a cross-section of SJR's were analysed relating to patients who suffered a neck of femur fracture and died within the hospital, as these patients often form part of the overall trauma patient cohort, and it was also a cohort of patient that show a potential elevated mortality SHMI diagnosis.

The following table provides a breakdown of the care scores, in addition to thematic analysis, for the 12 completed Neck of Femur SJR's:

		Poor 1	2	3	4	5	Good 6
1. Phase of Care							
Admission & initial care (1st 24hrs)	4.4			1	11	8	
Care during a procedure	4.2			4	6	8	
End of life care	4.2			4	9	7	
Ongoing care	3.8		2	7	5	6	
Overall assessment of care	3.7		2	6	9	3	
Perioperative care	4.2			2	7	4	
2. Avoidability of death							
Avoidability of death judgement			1	2		1	
3. Themed Analysis				2	1	1	
Ceiling of care	3.3			2			
Communication with patient/family	3.8				1	1	
Documentation	3.0		2	3			
End of life care	4.5			1			
Fluid balance	2.6			1			
Interventions	3.0			1		1	

There was 1 SJR which required a Tier 2 review, which highlighted required learning around fluid balance issues.

Fluid Balance Issues
Fluid balance has been noted as potential issues in 4 of the 12 SJR's completed for patients who had a neck of femur fracture. In addition to these 4, other SJR's outside of the fractured neck of femur cohort have also commented on issues relating to fluid balance.

A Tier 2 Neck of Femur fracture SJR made the following comments:

- It's often not clear if/when a patient should be on a fluid balance chart and for how long.
- For example, the next few days, perioperative period, the whole admission? Doctors must be very specific.
- Its then not clear what being on fluid balance chart actually means, for example, recording
- Input? Input and output? Do they need a catheter? Should it be hourly? Can the patient record it themselves? What should trigger a medical review?
- Its then not clear that everyone knows how to find the fluid balance chart on the various nebulous IT systems.
- Its then not clear doctors/nurses know how to interpret them, what is normal? if it's not normal what should be done next. There is little point in having all of the data if it's not reviewed and acted on appropriately

As a starting point it would probably be very helpful if the reason a fluid balance chart was being requested was made clear in the notes. If people know why they are doing it and what they are aiming for, the outcomes might improve.

For example, “this patient has decompensated heart failure and is fluid overloaded. We are aiming to remove about 10 litres of fluid over the next week. A fluid balance chart is needed to make sure this patient remains fluid restricted and in a negative fluid balance during that time.”

“This patient is nil by mouth because of bowel obstruction but also has AKI, they need to be volume resuscitated with IV fluids, correct their electrolyte abnormalities and maintain an acceptable urine output (at least 35ml/hour).”

Fluid Balance Quality Improvement Plan
Initial data collection is currently underway to help direct a quality improvement plan that will aim to assist in the identification of issues, along with possible improvements, relating to fluid balance. The initial data gathering will include identifying SJR’s that were completed over the last 36 months that mention Fluid balance as a potential issue. From here, a small sample will be selected of 10 cases, for which a patient care map will be undertaken by a qualified clinician or nurse, identifying and recording any issues as they go.

Any issues identified will be shared with key areas, such as Nephrology and Renal, which would also provide an adequate area to undertake trials of any system changes, SOP changes, new tool implantation etc.

7. MEDICAL EXAMINERS UPDATE
Scrutiny was undertaken on 97% of deaths that fall under the remit of the Medical Examiners office (n=742), including 158 referred to coroner and 76 taken for investigaton.

19/742 (3%) referred for SJR

35/742 (5%) referred for M&M review

Dove House Hospice: 74 deaths in Q3, all scrutinised.

Turnaround time for MCCDs and cremation forms for Q3 2022/23

- Target: 3 days
- Average Turnaround Time = 2.92 days
- Median Turnaround Time = 3 days
- Range: 0 to 11

The service is now recording a breakdown of reasons for delay/ case – data to be available for Q4

The priorities for the next quarter are as follows:

- Continue to ensure the service is delivered in line with the statutory requirements by April 2023
- Pilot community scrutiny in selected GP practices and PCNs.
- Complete process mapping exercise for all deaths, coronial and non-coronial, with stakeholders across HUTH, GP and both local authorities.
- Agree plan of work within inter-agency steering group.
- Triangulation of data to inform the scrutiny and learning. Request to BI to develop dashboard

- Continue to raise awareness of the medical examiner service and its role across the Trust and with relatives and carers

- Continuation of QI work to reduce delays, new drive to involve junior doctors in the project

- Work with Mortuary and Bereavement services to review/ agree the key roles of each area

9. RECOMMENDATIONS

The Trust Board is recommended to receive this report and:

- Decide if this report provides sufficient information
- Decide if any further information and/or actions are required

Chris Johnson
Effectiveness and Improvement Manager
February 2023
Additional contributions by: Laura Davis, Donna Gotts, Dr Fiona Thomson & Dr Kate Adams

SUMMARY FROM THE QUALITY COMMITTEE

REFERENCES

Only PDFs are attached

8.4 - Quality Committee Summary April23.pdf

Report to the Board in Public
Quality Committee
April 2023

Item: CQC Report	Level of assurance gained: Limited

The CQC report shared the good progress in ED delivering the actions and the impact of those improvements were now showing. There were four actions being monitored which were shared and one overdue which was discussed and an update would be provided by the Deputy Chief Operating Officer at the next meeting.

Action plans for Trust Wide, ED and Medicine were shared following submission to the CQC with Surgery being granted an additional two weeks to submit.

Following the Maternity CQC inspection the Trust submitted an action plan to the address some immediate concerns raised by the CQC, following an internal assurance visit by the Trust it was highlighted that some actions were not visible and a further meeting was arranged with the leadership to discuss.

A full programme of assurance visits were being developed which would include executives and non-executives.

Item: Board Assurance Framework	Level of assurance gained: Reasonable

The year end was presented to the committee and advised that BAF risk 3.1 and 3.2 had not met the target risks. BAF risk 6 has also not met the target due to investment required not yet realised.

Overall there were 2 risks that had achieved their target risk ratings, the in-year finance risk (BAF 7.1) and the capital risk (7.3), however this was subject to audit.

Highlighted were the Risk Maturity Assessment results and advised that the action plan would be reviewed at the Audit Committee and managed operationally at the Operational Risk and Compliance sub-committee.

The Board is being asked to consider extending the current risks for 6 months to align them with any changes due to the Group Model and strategy changes. If this is agreed BAF risks will still be managed in the same way by reviewing them at the Committee and Board quarterly.

Item: Quality Strategy Update	Level of assurance gained: Reasonable

The update was presented to the committee following a review sharing the main aspects and the next steps;

- Increasing the from six harms to seven and adding Sepsis
- Changing 'YOUnique' to simply 'staff as patients' following feedback
- Expanding on Year 2 outcomes
- Moving PSIRF narrative and replacing with approved PSIRP
- Adding the requirement for Health Groups to have a minimum of 3 work-streams associated with the Quality Strategy
- Adding the quarterly review meetings with allocated Board members and work-stream leads
- Adding the relevant Non-Executive Directors to each quality priority

Item: Fundamental Standards	Level of assurance gained: Reasonable

The Nursing and Midwifery Fundamental Standards audits were presented for the biannual update to the committee, good progress has been made since last presented and the report highlighted achievements and areas for focused attention.

There are 4 areas with wards receiving red ratings, which were Nutrition, IPC, Tissue Viability and Patient Centred Care.

An additional fundamental standard will be introduced later in the year for Falls, which has been written by the specialist team.

There are two wards which have received outstanding ratings and maintained for over a year, the good practice on these wards is being shared across the Trust.

Item: Quality Accounts	Level of assurance gained: Substantial

The quality accounts is on schedule for publication, the quality priorities have been agreed and are linked to the Quality Strategy;

- Mortality & Morbidity - EFFECTIVE AND LEARNING
- Mental Health Triage in the Emergency Department – FOCUSED
- Learning from Incidents – PATIENT SAFETY
- Medication Errors – SAFE CARE
- Sepsis – SAFE CARE

The final version will be signed off at Quality Committee on the 26th June following Board delegating authority to Quality Committee.

Item: CNST Maternity	Level of assurance gained: Reasonable

The committee received the quarter four reports for the four key areas for CNST;

- Perinatal Mortality Review Tool
- Avoiding Term Admission into NICU (ATAIN)
- Growth Assessment Protocol (GAP)
- Perinatal Quality surveillance Report

The reports also provided overview of what actions were being taken and highlighted concerns.

Item: Quality Indicator Report	Level of assurance gained: Reasonable

The committee were advised that the Trust is now working to PSIRP and within the new framework, future reports would reflect that going forward and the closure of SI's under the old framework. A thematic review was being undertaken in ED following incidents to identify learning.

In complaints there was significant improvement seen but the backlog was still acknowledged. The introduction of Early Resolution has had an impact on reducing complaints.

Pressure Ulcers and Falls were still an issue and deep dive presentations to future meetings were scheduled. We have now introduce a virtual wards for multiple fallers so the team can ensure support and actions completed. Staff allocation overnight is also be reviewed.

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

The strategy updated shared the headline position and successes at the end of 2022-23:

- There were 7,244 participants recruited onto 163 National Institute Health Research (NIHR) portfolio adopted studies, which is 67% above the target set by our clinical research network (Yorkshire and Humber)
- Our overall portfolio recruitment for 2022-23 ranked the Trust third in terms of Teaching Hospital Performance in Yorkshire and Humber.
- Commercial activity is also ranked third highest in the network with 39 studies, showing a commitment to delivering the CRN 'Managed Recovery' for the Life Sciences Industry post-pandemic.
- Respiratory Diseases was the top recruiting specialty in the Trust's portfolio with the 'Hull Lung Health' and a broad range of interventional drug studies.
- In the annual Participant in Research Experience Survey (PRES) 98% of our research participants feel that they are fully prepared for their research experience by our research staff and feel valued when taking part in our research. 100% of our research participants feel they are always treated with courtesy and respect by staff and 96% would take part in further research trials.
- Renal Research leads national trial: The STOP ACEi Trial led by Professor Sunil Bhandari, is a long awaited landmark RCT trial funded by the NIHR and sponsored by Hull University Teaching Hospitals NHS Trust that completed in 2022-23.
- Paediatric Research Team successful recruitment to vaccine study: The team were extremely proud to be running the Trust's first paediatric commercially funded RSV vaccine trial in 2022-23 and exceeded target recruitment.

Item: Effectiveness Quarterly Update	Level of assurance gained: Reasonable

The paper provided an overview of progress against national audits, National Confidential Enquiry into Patient Outcome and Death (NCEPOD), local clinical audit plan, Getting It Right First Time (GIRFT) and Operational Improvement.

The Trust is participating in all national audits with the exception of Inflammatory Bowel Disease (IBD) Registry, Perioperative Quality Improvement Programme (PQIP) and the National Comparative Audit of Blood Sample Collection and Labelling.

The Trust is an outlier in four national audits and updates were provided.

There are currently two NCEPOD studies for Testicular Torsion and Endometriosis.

GIRFT has restarted and the Trust has taken part in two deep dives, Respiratory and Rheumatology and further visits are scheduled for Acute & General Medicine and Gynaecology Gateway Review.

Several key operational improvement projects have taken place across the trust. Outcomes of these programs are largely reported to the Performance and Finance Committee and escalated to Board as appropriate.

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

OUR PEOPLE REPORT

REFERENCES

Only PDFs are attached

9.1 - Trust Board - Our People 09.05.23.pdf

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	09.05.23
Title	Our People				
Lead Director	Simon Nearney - Director of Workforce and Organisational Development				
Author	Simon Nearney - Director of Workforce and Organisational Development				
Report previously considered by (date)	This report has not been received at any other meeting.				

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

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

Hull University Teaching Hospitals NHS Trust

Trust Board

9th May, 2023

Our People

1. Purpose

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

2. Background

At the previous Board meeting in February, 2023 the Trust had 35 Covid-19 inpatients. As at 2nd May, 2023 the Trust have 13 Covid-19 inpatients. The Trusts key challenge remains the number of 'No Criteria to Reside' patients in a hospital bed which is currently 167 patients which affects the number of surgical patients that can be seen and treated. The Trust's Emergency Department also remains under extreme pressure and the flow of patients through our acute assessment areas and wards. This pressure continues to have an adverse impact upon staff morale and staff feeling they are providing sub-optimal care.

3. Key Issues

The total staff sickness absence for the financial year 2020-21 was 3.91%. The total absence including sickness and Covid-19 for 2021-22 was 6.71%. The Trust attendance target for attendance is 96.1% (sickness not to be greater than 3.9%).

The Trust total sickness and Covid-19 absence is currently 4.4%. This is an increase from 3.5% as at the last Board meeting in February 2023.

4. Employee Services

Hull and North Yorkshire (HNY) Covid Programme

The HNY Covid Vaccination Programme Bank team have been tasked with retaining the vaccination workforce for the Spring and any Autumn booster programmes. Each vaccinator has been called to discuss their intentions in relation to the next phase and to encourage them to remain on the bank. This has been a successful piece of work with approximately 150 staff members committing to remaining on the bank.

Industrial Action/Pay Awards

Staff employed on Agenda for Change terms and conditions are to receive a pay rise in June 2023 after the majority of health unions backed the below pay deal.

Part One – 2022/23 Non-Consolidated/Non-Pensionable Pay Award

This consists of two *one-off payments* on top of the 2022/23 pay award:

- A 2% payment.
- An additional 'backlog bonus' the specific value of this payment is dependent on staff's own pay band. The average value across all pay bands would be 4%.

Part Two – 2023/24 Consolidated/Pensionable Pay Award

This would be a *permanent* salary uplift for all staff:

- All staff would receive a 5% pay uplift.
- Further investment will provide a 0.4% pay uplift for staff in Band 1 and at the entry point of Band 2. This will see the entry level pay in the NHS increase to £11.45 per hour.

Part Three – Non-Pay Measures

The agreement also included a number of non-pay measures to support the NHS workforce to include

- Improving career development and support.

- Supporting specific challenges for nursing staff.
- Developing a national evidenced-based policy framework building on existing safe staffing arrangements.
- Considering measures to reduce agency spend.
- Reviewing the NHS pay setting process.
- Tackling violence and aggression.
- Removing pension abatements.
- Considering a cap for redundancy payments.

Notably, The Royal College of Nursing was one of the unions which rejected the above deal and has warned it will continue to pursue strike action, however, will need to carry out another ballot of its members as its six-month mandate has expired. The RCN is expected to start balloting members in the coming weeks, with a result due in June 2023. Previously the RCN, along with many other unions were not successful in achieving a mandate for strike action with HUTH, however, unlike last time the RCN is holding a national ballot rather than a series of local workplace ones. Unite, who also did not achieve a mandate for strike action within HUTH, still has a mandate for local strikes within some ambulance services and a few hospitals.

Junior Doctors are on a different contract so are not affected by the above pay agreement. The Health Secretary is meeting the BMA on Tuesday 9th May 2023 to see if the two sides can agree a way forward in the relation to the junior doctors pay dispute which has led to strike action within HUTH and the wider NHS in both March and April 2023.

Through the Industrial Action Group the Trust will continue to plan for any impact on its services of ongoing or new strike action.

5. Staff Vacancies

The Trusts overall vacancy position as at 31st March 2023 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1461.8	1382.5	59.1	20.2	1.4%
Add Prof Scientific and Technical	368.6	340.7	2.1	25.8	7.0%
Administrative and Clerical Staff	1640.7	1644.9	12.6	0.0	0.0%
Allied Health Professionals	519.0	502.1	4.4	12.5	2.4%
Estates and Ancillary	622.9	541.9	5.5	75.5	12.1%
Healthcare Scientists	188.8	158.6	1.9	28.3	15.0%
Medical & Dental - Consultant	512.8	480.0	16.0	16.8	3.3%
Medical & Dental - SAS	71.2	56.0	0.2	15.0	21.1%
Medical & Dental – Trainee Grades	722.8	696.0	23.6	3.2	0.4%
Nursing and Midwifery Registered	2492.2	2482.0	42.3	0.0	0.0%

Trust Total	8600.7	8285.7	167.2	147.8	1.7%

Overall the Trust vacancy position is 1.7%. The Consultant vacancy rate has reduced to 3.3%. The vacancy rate for Registered Nursing and Midwifery is currently 0% across the organisation, however this includes 51 international registered nurses who are currently taking their OSCE exam and will be working in a ward area shortly.

6. Communications and engagement

Group Model

We are continuing with the recruitment process for our Group Chief Executive to lead both Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS FT. The advert closed on Thursday 27 April 2023. Interviews are being held in May, which involve the Board, internal and external stakeholders.

Following discussions with Health Groups and at the Workforce Transformation Committee a draft Culture Transformation plan has been developed. We have identified eight key areas to focus on in 2023/2024: clear narrative for staff on the trust strategy for the next few years, civility and staff charter review and relaunch of PACT training, review of leadership programmes, strengthen change management process, simplified appraisal system, active promotion of home working and flexible working options, shifting of culture around breaks and annual leave, development of a set of golden rules for staff and managers.

A revised staff charter is with networks and the Workforce Transformation Committee for consideration, prior to sign off at the WTC, JNCC and LNC.

7. Staff Support

Occupational Health Services remain the main route for staff to access support and help for a wide range of mental and physical challenges at work. The staff support service continues to work alongside our Occupational Health Service and offers an email and telephone hotline service. The Trust is promoting and advertising the Humber, Coast and Vale Resilience Hub widely for staff to access support. The Trust continues to support staff via Focus Counselling, Occupational Health Team, Clinical Psychology, Coaching Services and the Pastoral and Spiritual Care Team for general mental wellbeing support. The 24/7 staff support hotline continues to be available and is run by the Pastoral and Spiritual Care team. The OD team continue to monitor and signpost staff through the hyp-tr.staff.support@nhs.net email address.

Well Being Update:

- Staff Support Psychology team are running a rolling training programme via HEY 24/7 with a different subject each month, In April they delivered Stress Management training and in May they are delivering How to Sleep Well. All the sessions are delivered via teams and are repeated throughout the month.
- OD has started to deliver REACT MH training across the trust face to face. (REACT MH is mental health risk assessment for staff to have meaningful supportive conversations with colleagues to help identify staff that need further support or just need to know that what they are experiencing is not unusual) We have 8 trainers in the Trust. So far 19 staff have been trained. 6 more events are available via HEY 24/7 between June and December.
- TRiM Update: we have had 16 TRiM incidents so far since we have been offering this service. We now have 9 managers trained and 44 practitioners
- 90 staff have been trained in Breaking Bad News
- 57 staff have been trained in Advanced Communication with a further 50 booked in
- 26 staff have been trained in Emotional Intelligence with 10 booked in
- Health and Well Being Lead started her role in April.
- Supporting research by Essex University in to well-being and resilience amongst Medical staff

8. Learning and Organisational Development
Leadership Development Programme Update

- The Clinical Administration Service Leadership Team – CAS Leaders began undertaking an enhanced 90-Day Challenge both as a leadership development offer and opportunity to further gel as a leadership team. Each leader is undertaking a leadership challenge of their own design, most aligned to improving patient safety, access and retention rates
- ½ Day Bitesize Introduction to Project Management – This 4 hour course is introduces the QSIR 6 Stages of Project management, enhancing it with proven mixed methodology drawing on complementary principles and practices (e.g. The Go MAD Results Framework, PRINCE 2, Agile). Bespoke resources have been developed aligned to HUTH, our values and our strategic pillars
- Supervisors+, our 6-month leadership development programme is being reviewed and refreshed to condense the timeframe for completion and introduce content in line with our values, strategic pillars and the emerging national NHS Framework for Managers
- Evaluation begins with two of our flagship programmes Be Remarkable and Rise and Shine. We will be assessing KPIs and ROI measuring inputs, outputs and outcomes against the LDF and relevant measures
- The 90-Day Challenge pilot moves to standard offer following the completion of 3 successful cohorts

- Development and implementation of the SAS Leadership offer is underway having begun with a survey of SAS doctors serving as a training needs analysis
- Flagship programmes Be Remarkable and Rise and Shine have enjoyed a renewed uptake to pre-pandemic levels with cohorts currently fully booked in advance

OD Update (Bespoke Work)

- The coaching network has been very busy so far this year with 15 coaching relationships started since January, compared to 18 in the whole of 2022.

New OD interventions:

- Paediatric Dietetics: Adapting and Connecting communication workshop using Insights
- Surgical Dietetics: Adapting and Connecting communication workshop using Insights
- Ward 120: Team development
- NICU Leadership team: Leadership supervision
- Future commissioned work with Infectious diseases service with regards systemic coaching
- Future commissioned work with Pharmacy with regards leadership development for operational management team.

Apprenticeships

The apprenticeship levy came into effect in May 2017, requiring employers with annual pay bills in excess of £3m to contribute 0.5% of their total wages to funding apprenticeships. Our apprenticeship budget for 2022/23 is around £1.75m with an overall current levy funding balance of £3.6m. This year our spend will be £1.11m with a predicted underspend of £640k. The levy can be used over a 2 year period before it expires. This spend was the result of the following actual apprenticeship activity:

Apprenticeship Completions	60
Continuing on programmes started prior to FY2022/23	111
Apprenticeship Starts	71

We have a wide range of apprenticeship opportunities currently in our Trust including:

- Senior Healthcare Support Worker
- Occupational Therapist (integrated degree)
- Nursing Associates
- Registered Nursing Degree
- Creating and Digital Media
- Physiotherapist (integrated degree)

- Healthcare Science Practitioner (integrated degree)
- Pharmacy Technician

To support the wider community we have engage with 19 different healthcare providers, including GP Surgeries to facilitate apprenticeship levy transfers and the total value of our current transfers is £270k with plans to support more providers in the next financial year. This ensures that minimise waste on expiring levy and allows us to support with key roles such as community based Advanced Care Practitioners which benefit the whole patient pathway.

SPARK

The SPARK (Simulation Partnership for Advancing Regional Knowledge) has been relaunched, this is chaired and led by the Simulation team in Hull and currently members represent Hull, NLAG, York and Scarborough Teaching Hospitals. The group will be holding its relaunch conference at Scarborough Hospital on 5th September 2023. The group are currently working together on joint bids, mapping resources and identifying areas for future collaboration including making better use of virtual reality and creating tours of the hospital sites for use at inductions, to support returning trainees after time out and student orientation.

Human Tissues Licence Granted to HUTH subject to paperwork review

The Surgical Skills Centre were audited in December 2022 and had been asked to submit additional paperwork in March 2023. This has been submitted and we are now awaiting the final review of documentation. We expect the centre to have the licence in place by June 2023. This will improve income generation for the Trust as the centre will be the only in the region that will be operating on a business model, attracting prestigious courses. The centre have interest from several companies who want to run their activities within. Once the licence is granted, the centre will have an official relaunch event.

9. Equality, Diversity & Inclusion (EDI)

Two positive action programmes have been commissioned for delivery across autumn 2023. Both programmes are targeted towards Black, Asian and Minority Ethnic (BAME) staff and staff with lived experience of a disability and/or long-term health conditions within HUTH. Both programmes aim to support the re-energising of careers through the focus on recognising personal strengths and developing leadership skills and putting them into practice. Advertising and recruitment of cohorts will take place from May across summer.

- Firstly, the With:Stand Leadership Programme will run a second cohort for BAME staff members between bands 5-7 and will be delivered this year. This four day programme will be offered to 45 members of staff. The programme offers the group exploration and exposure to tools and strategies that help staff to navigate their experiences of the environment, recognise their talents and to recognise career ambitions.
- The Disability Leadership Programme will focus on supporting 12 staff members with lived experience of disability and/or long-term health conditions to increase in their confidence, motivation and self-belief through recognising personal strengths and developing their leadership skills. The participants will collectively build a 'Disabled Inclusive Leadership Charter' which will map out the specific inclusive behaviours that should be adopted by all staff and those who line manage.
- Both programmes will also offer an opportunity for participants to take part in a 90 Day Leadership Project and also will aim to identify mentoring relationships.

A task group designing an Inclusivity Academy have been shaping the creation, development and overview of a suite teaching modules covering various topics around Equality Diversity and Inclusion, which are in line with the Trust's Equality, Diversity and Inclusion Strategy. This aims to raise the awareness around protected characteristics, discrimination within the workplace and expected support structures and expected compassionate and inclusive behaviour. The modules will be aimed at all staff members but also those with line management responsibility.

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

Officer to contact:
Simon Nearney
Director of Workforce and OD

SUMMARY FROM THE WORKFORCE, EDUCATION AND CULTURE COMMITTEE

REFERENCES

Only PDFs are attached

9.2 - WECC Summary Apr 23_UM.pdf

Report to the Board in Public
Workforce, Education and Culture Committee April 2023

Item: Gender Pay Gap Report	Level of assurance gained: Substantial
The Trust mean gender pay gap has reduced to 29.14%, the median gender pay gap has increased to 20.63%. The Trust have implemented a menopause steering group and "Itchy Feet Clinics" to aid staff retention. The clinical excellence awards scheme was delivered on an equal distribution basis for 2022/23 whilst the Trust develop an in-house system. Further options to explore to reduce the gender pay gap include flexible working at senior grades.	
Item: Equality Delivery System 2022 (EDS 2022)	Level of assurance gained: Substantial
A mapping session against the EDS 2022 standards was held although there was no mandatory requirement, the Trust scored as developing. Engaging key stakeholders will be a focus to support the development of equality objectives. EDS 2022 will be a standing agenda item on the Trust's Wellbeing Steering Group agenda. The Health Inequalities steering group was set up 6 months ago and will provide a report to Trust Board.	
Item: Guardian of Safe Working Q3 Report	Level of assurance gained: Substantial
Surgery Health Group received the highest number of exception reports in Q3 especially in Plastic Surgery where a rota was found to be non-compliant. ECGs continue to be an issue in wards 6/60 and ward 7, the Guardian of Safe Working is liaising with the Matrons to resolve this issue. The Guardian of Safe Working was asked to present an annual report to the Trust Board.	
Item: Medical E-Rostering (Project Update)	Level of assurance gained: Reasonable
The Head of HR Services provided an update on the medical e-rostering project. The scope of the project to move all Junior Doctors onto e-Rostering was extended to include ACPs. The trial Neurosurgery tier 1 roster was successful, the next area to trial is Neonates. The first year of the project centred on Clinical Support and Surgery. Clinical Support wanted to test the use of electronic rostering on one rota to gain assurance that it would work. The next areas of concentration are Family and Women's and Medicine.	
Item: National Staff Survey Results	Level of assurance gained: Limited
The Director of Workforce & OD presented the findings from the National Staff Survey 2022. Overall, these are very disappointing results with a reduction in experience reported in most questions. All HR Business Partners will discuss the results with their services and challenge management behaviours. A change management process is being formalised. Manager briefings to all Band 7+ staff will take place in May/June 2023. A Take a Break campaign will be launched to encourage all staff to take breaks.	
Item: Freedom to Speak Up Guardian Report	Level of assurance gained: Substantial
The Speak Up Champions network has been implemented, 17 staff have been trained with a further 10 due to complete their training in the next few months.	
Item: People Strategy Performance Report	Level of assurance gained: Substantial
The Director of Workforce & OD shared that the current Trust vacancy rate is 4% and retention is 11.9%. Mandatory training is currently at 84%, SN proposed a mandatory training target of 85% for 2023/24. Any new requests for training to become mandatory have to be approved at Workforce Transformation Committee	

Item: Covid and Flu Vaccination Progress Report	Level of assurance gained: Substantial
The Trust had a 61.5% vaccination rate for Covid, further vaccinations are expected however no further information has been received yet. The Trust had a 62.9% vaccination rate for Flu.	
Item: Board Assurance Framework	Level of assurance gained: Substantial
Due to the Staff Survey results, the committee agreed to increase the Culture target risk rating to 4 x 4 = 16. It was agreed that the staffing risk rating target would be increased to 4 x 4 = 16.	
Item: Nursing and Midwifery Staffing Report	Level of assurance gained: Substantial
The Interim Chief Nurse shared that the amount of CHPPD has reduced as a result of additional wards that are open to support operational pressures. Currently, the Trust has 57 WTE registered nurse vacancies. The non-registered vacancy position has improved due to the mass recruitment event in conjunction with the Job Centre. The hybrid roles for the NCTR facility are currently out to advert. Recruitment with Hull University has been completed including 154 Adult nurses, 22 Midwives and 17 Paediatric nurses.	
Item: Apprenticeship Programme	Level of assurance gained: Reasonable
The Head of Learning & OD shared that the apprenticeship budget for 2022/23 is anticipated to be £1.59m with an overall current levy funding balance of £3.62m. The actual spend (up to the end of Q3) is £1.02m with an additional projected spend of £290k in Q4. In 2023/24, the Trust is planning to commission over £1.7m worth of apprenticeship activity, over £1m of which will potentially be on nursing programmes. The Trust has engaged with providers across the ICB patch to facilitate levy transfers including ACP roles and GP practices.	

PERFORMANCE REPORT

REFERENCES

Only PDFs are attached

10 - PerformanceReport_April23_Final.pdf

Agenda Item		**Meeting**	**Trust Board**	**Meeting Date**	**09.05.23**
Title	Performance Report				
Lead Director	Ellen Ryabov – Chief Operating Officer				
Author	Louise Topliss – Assistant Director of Operations (Operational Performance)				
Report previously considered by (date)					

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

Key Recommendations:

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

Performance and Activity Report

March 2023 Performance

February 2023 for Cancer data

Produced April 2023

Table of Contents

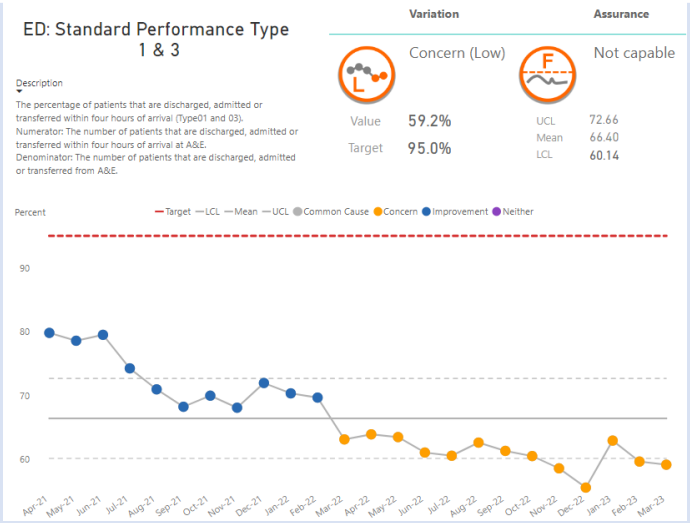
1. Executive Summary

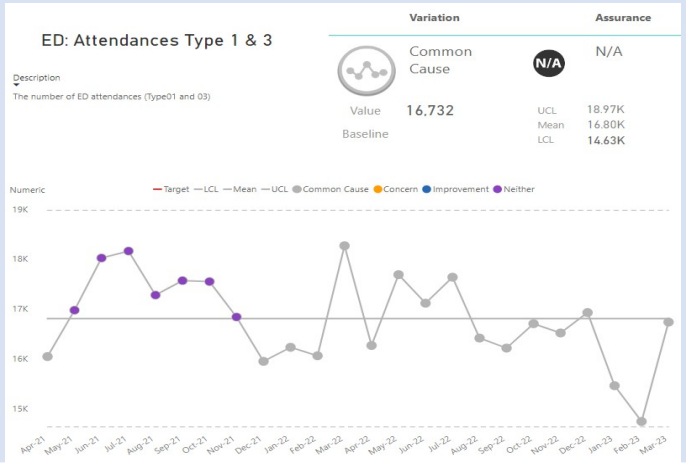
Areas requiring improvement	
Urgent Care performance – ED and Ambulance handovers	• For March 2023, the Ambulance handover position remained highly challenged and deteriorated from the February position due to the number of lodged patients within ED. While the number of delayed handovers increased from February the average, handover time reduced from 1:06hr to 53 minutes. • 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 as HUTH take on responsibility for cohort staffing and management between the hours of 08:00 to 20:00 from 10th April 2023. • The number of patients in February 2023 with No Criteria to Reside continues to be the single largest factor affecting performance with a daily average of 207 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. In February there was a small decrease in the number of 2WW referrals received. • The Trust continues to achieve 3 of 9 cancer-waiting times' national standards were achieved (2ww and 31-Day Drug and combined Faster Diagnosis Standard (FDS). • The number of patients on the 62-day Cancer PTL remained at ~1,300 and in itself is not monitored but used as the denominator when considering the scale/proportion of patients who fall into the +63 day backlog metric. From January 2023, in line with the required Cancer Waiting Times guidance, the Trust began reporting patients on the 62-day PTL from referral to treatment, 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 +63 and +104 days, and the recovery trajectory to 31 March 2023. The Trust did not achieve the recovery trajectory requirement of 130 patients by 31 March 2023 as the impact

	of surgical cancellations, NCTR volumes in hospital beds, industrial action and significant and ongoing delays to radiotherapy treatment dates. • The Trust has been informally advised that due progress on the +63 day backlog and continued achievement of the Faster Diagnosis Standard, we will be stepped down to Tier 2 for cancer (we are already Tie 2 for long waits) which requires regional rather than national assurance. • Internally the 2/52 meetings with the top 4 tumour sites (colorectal, Gynae, urology and lung) are well established; chaired by the DCOO (Elective Recovery & Cancer) and attended by DGMs and the Trust Lead Cancer Manager. The focus of this meeting has shifted to patients earlier in the pathway (i.e. 28 – 62 days) to identify opportunities to expedite their next steps and reduce the number of 62 day RTT breaches. • The 23/24 trajectory for patients +63 days is 148; trajectories have been set at Trust and tumour site level to monitor progress towards achievement. A number of tumour site improvement plans are in place with non-recurrent funding from the Cancer Alliance to support. • Late inter-provider transfers (IPTs) from within the HNY ICS primarily have an adverse effect on urology and lung; discussions with referring Trusts. The Cancer Alliance for HNY is leading on the improvement work to support more timely transfers and improved experience/outcomes for patients.
Recovery of elective activity	• Recovery of elective activity in March 2023 did not achieve the plan in any POD except for follow ups at 99% of plan. Ordinary elective activity was 92% of plan, which is an improvement on previous months. • The 22/23 operational plan also includes a reduction of outpatient follow-ups by 25% by March 2023. In March 2023, follow up activity was 132% of baseline and 99% of plan. There is on-going analysis and improvement projects linked to outpatient pathways to support this operational requirement, and a range of performance discussions at HG level related to the comparison to the GIRFT standards in 15 specialities. Many of the HUTH pathways have a discharge rather than follow up, so a reduction and/or transfer to PIFU would not be appropriate. • For 23/24 operational plan the 25% OPFU reduction still applies, however, this now only applies to follow ups without a procedure – work is underway to extract all FUs with a procedure to develop a new baseline.

	• Outpatient new activity delivered 87% of plan and baseline. • Day case activity delivered 92% of plan. • Ward C9a will be functional as a 5-day ward for orthopaedics from week commencing 17 April 2023, moving to 7-days in early May 2023; this should reduce the risk of recovery for orthopaedics and neurosurgery. • Mutual aid (both NHS and out-sourcing) 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). • At the end of March 2023, the Trust reported 2 x 104 week waits. The breaches reported were in Ophthalmology corneal transplants which were mandated by NHSE to move to a reportable RTT pathway, however donor material was not available to complete the patient 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. • 4,092 patients have waited more than one year for their appointment/procedure, this is below the trajectory of 5,312. • Mutual aid continues to be progressed in challenged specialties.
Reducing the delays in people leaving acute setting	• In March 2023, there were 207 (average) patients per day with NCTR, an increase of 1 per day from February 2023. This is 19% of the total general & acute beds, and 31% of the beds at HRI (total G&A beds 672 HRI/397 CHH). NCTR patients who should be receiving appropriate care elsewhere with the support of other partner organisations or settings. • • From April the DCOO (Urgent & Emergency Care) has a daily meeting with Health Groups to reduce delays for patients on Pathway 0 with NCTR; good progress meant that 2 of the 4 Health Groups were stood down from this process wef 11 April 2023.

2. Emergency Care Standards – 4 hour Performance





What the chart tells us

The 4-hour performance delivery remains fairly static, although is significantly below the required standard. In March 2023, performance was 59.2% for all attendance types.

Intervention and Planned Impact

- Boarding (HUTH version of Bristol model) is in daily operation and has been expanded to a second round of admissions to take place that will see a further 10 patients moved from ED between 10:00 and 14:00, with planning from May 2023 for a further 10 between 14:00 and 16:00.
- A working group to improve the utilisation of Ward H36 will explore which patient pathways would be appropriate for a short stay assessment area, patients awaiting longer investigations (June 23).
- From the 6th April 2023 improved Standardisation of the EPIC/RAT roles particularly in relation to long waits overnight began and being monitored through the Health Group.
- From April 2023 Surgery Health Group to focus on reduction of lodged time for patients in ECA, freeing up consulting rooms.
- Return to pre-Covid pathways in paediatric ED to improve treatment times
- The above actions are planned to improve performance across the whole department to 51% end April 2023, 54% end May 2023 and 59% by end of June 2023.
- Mental Health Streaming facility to open by end of May 2023, expecting to reduce breaches by 1 per day but significantly improve the patient experience.

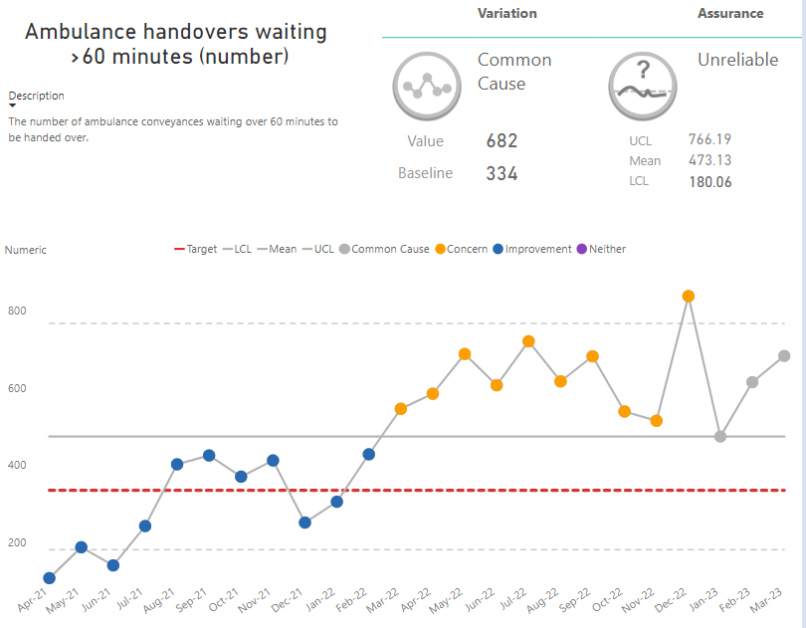
Risks / Mitigations

- 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.
- Staff recruitment for the new NCTR build may prevent the release of Ward 36 in June 2023.

A&E trajectory for 2023/24

April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
51%	**55%**	**59%**	**63%**	**67%**	**71%**	**74%**	**77%**	**75%**	**75%**	**76%**	**76%**

3. Ambulance Handovers waiting over 60 minutes



What the chart tells us

Ambulance handover waits over 60 minutes have been increasing since February 2022. There were 682 waits over 60 minutes reported in March 2023, which equated to 23.0%.

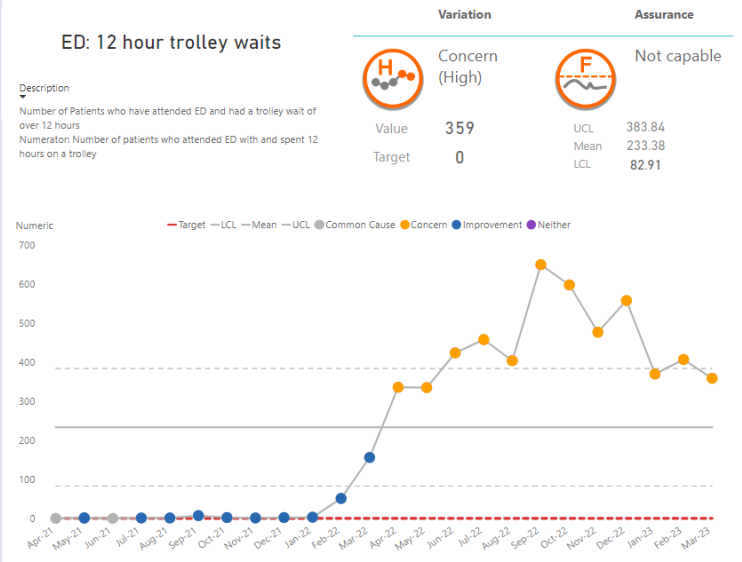
Intervention and Planned Impact

- From 10th April 2023 day-time cohorting staff will be provided by HUTH which will enable the YAS cohort crew to return to the community work.
- From 10th April 2023, a 2nd Nurse has been allocated to work in Initial Assessment to be able to take concurrent handovers.
- An initial meeting was held on the 27th March 2023 to agree a joint Rapid Programme Improvement supported by both YAS and HUTH QI teams. Date currently being agreed to commence 8 week observation period followed by a 5-day workshop in June/July 2023.
- A trajectory of improvement has been agreed for the percentage of Ambulances released within 30mins of arrival; the target for April 2023 is 53.5%.

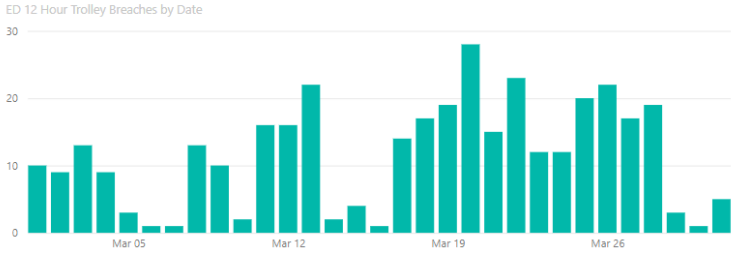
Risks / Mitigations

- 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.
- YAS are unable to use the EPR to capture the early handover of Resus 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)	1,490	1,395	1,730	1,693	1,661	1,201	1,269	**10,439**
ED 12 Hour Trolley Breaches	68	37	53	33	46	62	60	**359**
ED 4 Hour Standard Performance (Type 01)	43.2%	44.8%	46.6%	48.1%	44.0%	40.2%	45.9%	**44.9%**



What the chart tells us

There were 359 x12 hour trolley wait breaches in March 2023 with the longest wait from Decision to Admission (DTA) of 29 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 March 2023 was that 12.4% of patients (1,298 patients) waited over 12 hours against a national tolerance of 2%.

Intervention and Planned

- Boarding (HUTH version of Bristol model) is in daily operation and has been expanded to a second round of admissions to take place that will see a further 10 patients moved from ED between 10:00 and 14:00, with planning from May 2023 for a further 10 between 14:00 and 16:00.

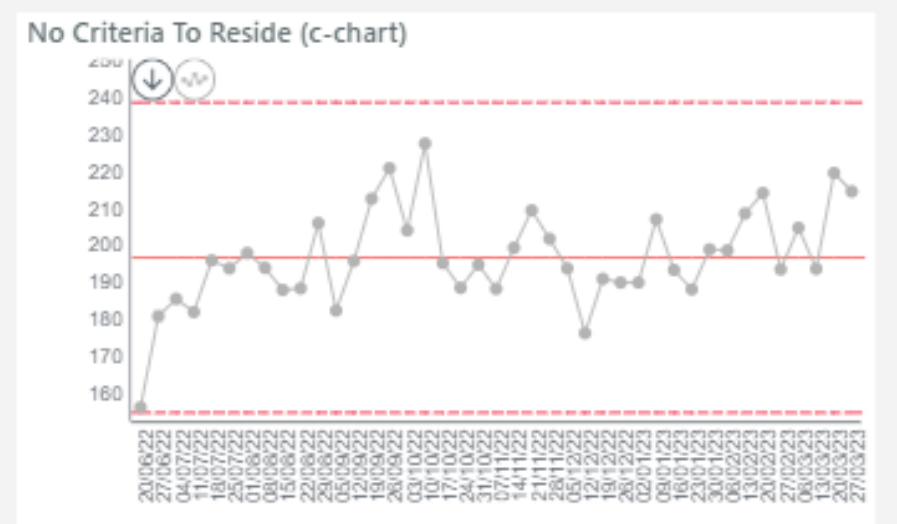
- Mental Health Streaming facility to open by end of May 2023, will allow patients waiting for transfer to be in a dedicate MH area.

Risks / Mitigations

- High numbers of No Criteria to Reside patients, outside of the NCTR bed base are occupying acute beds reducing for acute work.

- Opening of the Paragon Intermediate Discharge Suite (PIDS) by the end of June 2023 with c.60 beds to collocate patients with No Criteria to reside.

5. No Criteria to Reside



What the chart tells us

On average, there were 207 patients per day with No Criteria to Reside in March 2023. There was an average impact of 4 days increase on Length of Stay due to the NCTR.

The NCTR accounted for 4,229 lost bed days in March 2023, which is an increase on the previous month.

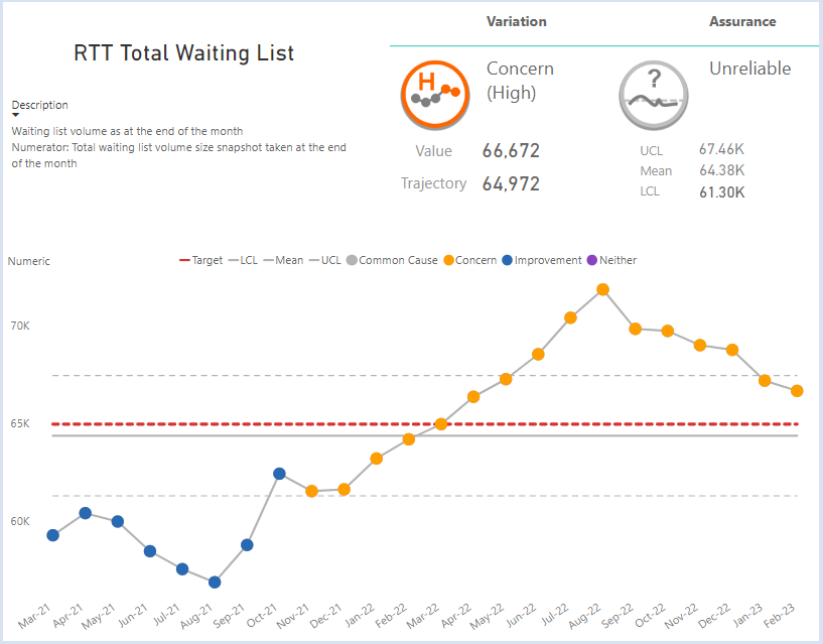
Intervention and Planned Impact

- System leaders are focused on reducing the number of NCTR patients to sub-100, with a system trajectory agreed to 100 (including in the new build) by March 2024.
- PSC have been commissioned by the system to provide project support for delivery of a Discharge to Assess (D2A) process. Working groups have begun and are currently exploring current issues for prioritisation.

Risks / Mitigations

- Domiciliary capacity remains lower than demand.
- Recruitment challenges due to competition from retail sector
- infections (Flu/D+V/Covid) closing community care 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 March 2023, the current unvalidated position is 68,087, this has been reducing since August 2022. The total WLV is above the trajectory of 63,453.

Overall, referrals in 22/2023 were 5.5% down on the previous year; the operational plan for 2022/23 assumed no further increase in referrals.

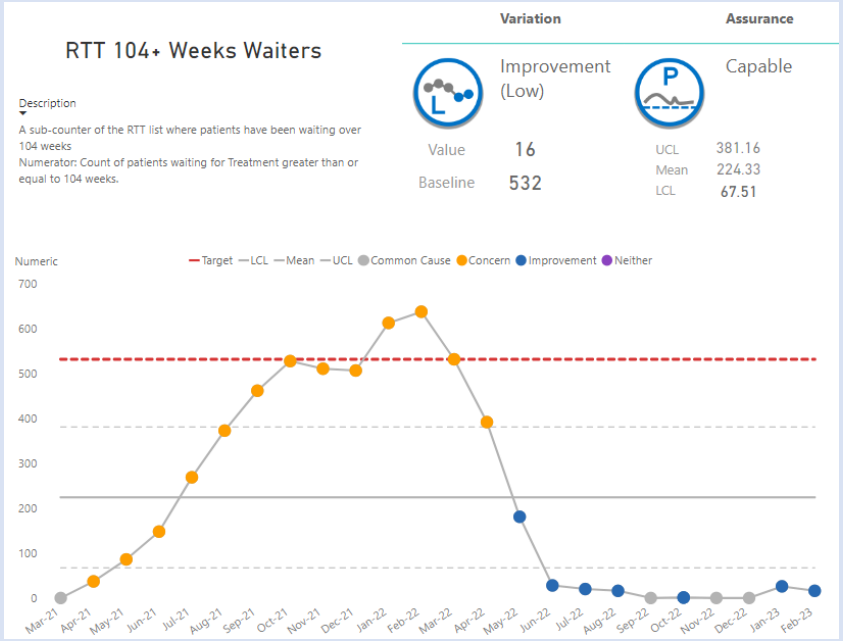
Intervention and Planned Impact

- Targeted HG & speciality meetings continue to reduce waiting times – Trust internal milestone of no patient waiting more than 70-weeks at 31 March 2023; a position of 755 patients was achieved which is a significant improvement of 82% (reduction of 3,428) since January 2023.
- Additional internal milestone: Zero +52 week non-admitted waits at 31 March 2023. This initiative will progress reductions on the Total WLV. The position at the end of March was 2,201 a reduction of 4,193, an improvement of 66%.
- Mutual aid/in-sourcing and out- sourcing to support the total WLV reduction.
- Capacity alerts in x6 pressured specialities are live – monitoring arrangements to consider the effectiveness and impact (5x specialities – referral rate reducing, with ENT referral rate flat)
- Additional support for Gynaecology was prioritised with capacity on-stream in March 2023.
- Text validation 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.

Risks / Mitigations

- Increase in GP referrals – referral triage and A&G in place to mitigate
- Orthopaedic bed base reduction (-12) – now available to orthopaedics, and will be open as a 5-day ward from week commencing 17 April 2023
- 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 March 2023, the Trust reported 2 x 104-week waits. Both of these are corneal transplant patients awaiting NHSBT to provide donor material.

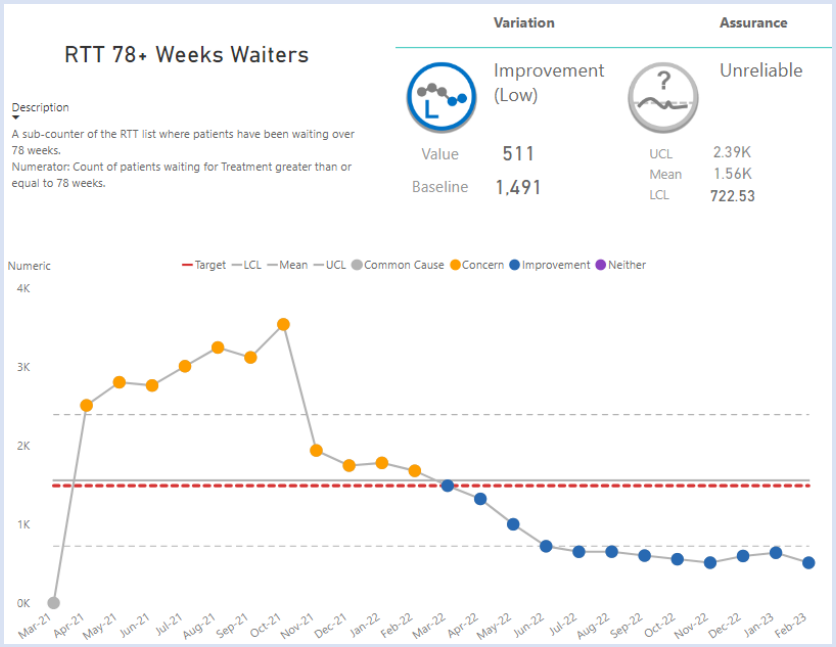
Intervention and Planned Impact

- 104-week patient risks largely eliminated as a result of interventions delivered – zero tolerance approach adopted
- Continued focus corneal transplant patients reliant on scarce donor material.

Risks / Mitigations

- BI reports and governance processes detect and manage any "pop-ups"
- Corneal transplant (unmatched) pathways previously managed by HUTH as planned were mandated to RTT ticking pathways by NHSE
- April 2023 (at 12/4/2023) risk of 104-week breaches currently x2 patients, both are corneal transplants and have confirmed dates in April 2023.
- Junior Doctor industrial action

8. 78 Week Waits & Planned Trajectory



What the chart tells us

At the end of March 2023, the Trust reported 104 x breaches of the 78-week target, against a forecast position 126, of which 11 were corneal transplants with the majority of other breaches in gynaecology.

The current position (at 12.4.23) is 261 total 78 week patients to treat by the end of April 2023. 57% of these have an appointment/TCI date booked before the end of April 2023; progress has been impeded by the Easter weekend followed by planned industrial action.

The current risk assessment is 110 patients without a confirmed plan to treat.

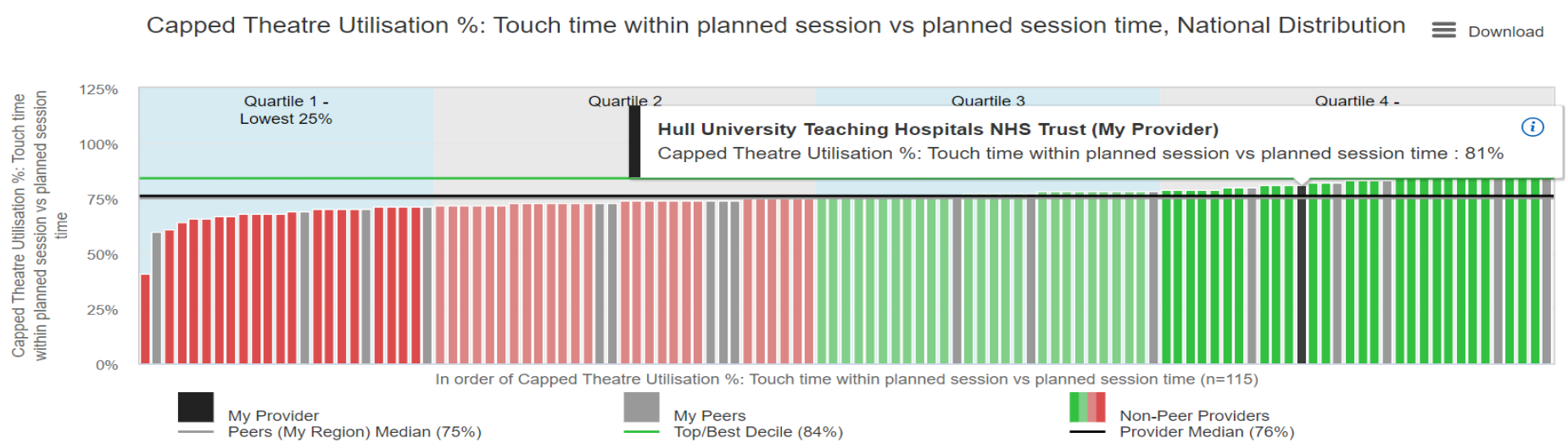
Intervention and Planned Impact

- Continued focus at speciality level of patients dated and/or risks now focussed to achieve zero 78-week waits by the end of April 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
- 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
- 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
- Impact of BMA industrial action during April 2023
- Speciality capacity risks:
  - Gynaecology (capacity and obstetric clinical prioritisation)
  - Plastic Surgery (immediate DIEP demand)
  - 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 (at 26.2.23) shows capped theatre utilisation at 81% and in Quartile 4 nationally, this is an improvement on the last reported position. This is the latest available position due to Model Health making some technical changes to their website.

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.

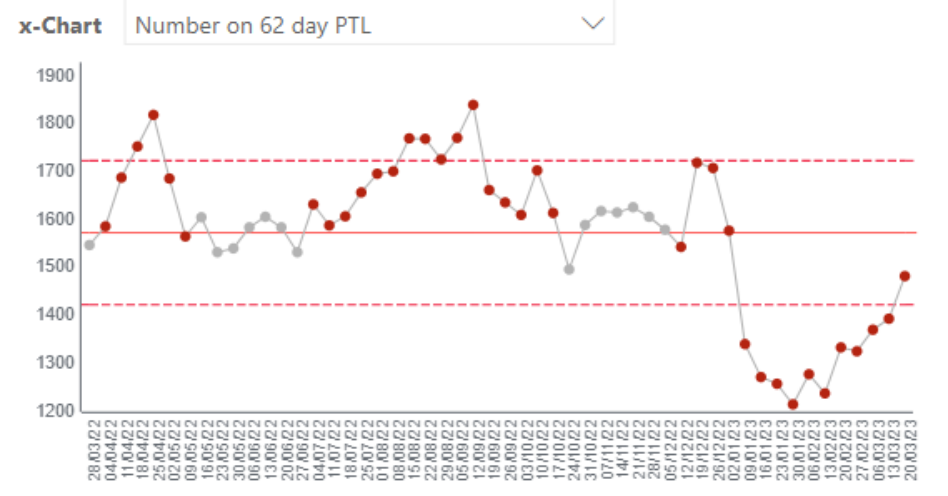
Intervention and Planned Impact

- 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 implemented from March 2023.
- 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 reduced to **1,325** at the end of February 2023 compared to 1,700 at the end of December 2022. This was a small increase that recorded in January (1,256).

At week ending 14 April 2023, the PTL size was **1,588**, this increase can be explained by the two Easter Bank Holidays (Friday and Monday) which are the primary PTL tracking days. There will be a lag in updating each patient pathway and therefore the PTL is likely to remain higher than it was in January/February 2023 for a few weeks.

The focus nationally, and through the Tier 1 meetings remains on long waiting patients rather than PTL volume which has reduced from 255 at the end of February 2023 to **197**. At the beginning of April 2023 the number of patients was **202**.

Skin continue to demonstrate good progress in reducing their respective cancer recovery backlog trajectories achieved the end of year trajectories. During February 2023, Gynae-oncology has sustained reductions in PTL volume; this can be attributed to improved histology turnaround 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 static but significantly off-track – partly due to late inter-hospital transfers. Further input and reinvigoration of the actions are required to deliver improvement in Q1 2023/24.

Gynae-oncology – ongoing review and revision of pathways, which is consultant led, will begin to have positive effects into Q1 2023/24

Colorectal met the backlog trajectory at the end of December 2022 which was maintained with further improvement in February 2023 and within trajectory. At the beginning of April 2023 the backlog increased and did not achieve the end of year trajectory. A couple of factors can explain this increase; an ongoing increase in referrals with March 2023 being a new high with 550 referrals received. Secondly, whilst there is a triage process in place the vast majority of patients will require a colon examination and therefore will remain on the PTL until after the test has taken

	place. Lung beginning to see a reduction in the backlog but remained off track for the end of year trajectory. Late IPTs continue to be a factor in regards to poor performance which requires joint transformation work with NLAG. A meeting with York will be scheduled at a later date if appropriate. 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. In February 2023 there was good improvement in performance however, remains significantly lower than the target and is not expected to improve before December 2023.
	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 **approximately 10 days** compared to 10-weeks in June 2022; which has supported the improvement of the colorectal PTL. This change is supporting month on month improvement in Faster Diagnosis Standard in the colorectal pathway (January 2023 31.9% & February 2023 51.6%). **Histology capacity/delays** – focus on histology turn-around times remains, however there has been a significant improvement in skin & Gynae-oncology, resulting in PTL reductions. 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 commenced January 2023 and continues to add value to the MDT meeting • 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 post continues to add value in the department and in particular has been of most benefit in Gynae-oncology and Skin

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
- Maternity leave due back to work in July and September 2023.
- Clinical Oncology workforce shortages remains a challenge with actions underway both regionally and nationally; improvement funding from Cancer Alliance for 23/24 will support a consideration of new models of care

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. February 2023 performance made a good improvement at 53.9% (34.5% in January); however, subsequent treatment with chemotherapy/drug (e.g. hormones) exceeded the standard (98%) with a 99.1% performance in February 2023.

Mutual aid has been pursued across a range of providers to assist improvement but without much success to date.

Transformation Opportunities

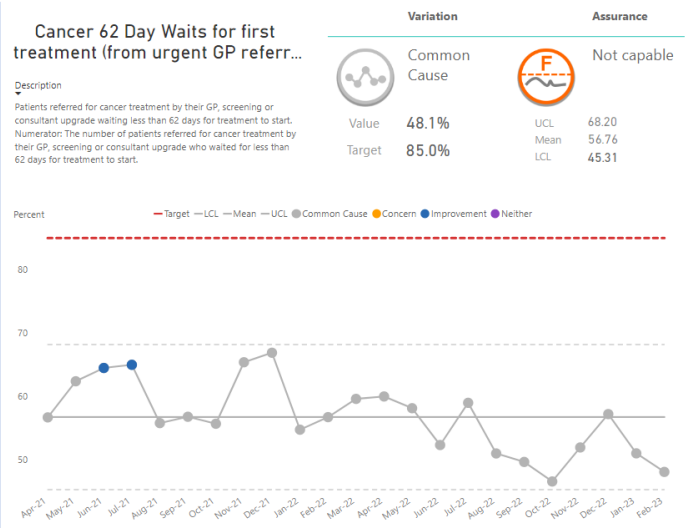
- Improvement in the Lower GI triage processes will shorten the pathway and lead to performance improvement – non-recurrent funding in place; will need recurrent support from the 23/24 & 24/25 growth for cancer – plans have been developed and submitted to the Cancer Alliance awaiting funding approval
- Increasing numbers of 2WW referrals received with a FIT test result will enable more patients to be effectively triaged; locally at 72.1% in February 2023 which continues to be monitored and on-going discussions with primary care planned to further improve uptake by GPs. Practice and individual GP information has been provided to the cancer commission lead as requested to support ongoing improvement/compliance
- Gynae-oncology – the improved PMB pathway has been approved and ready for implementation which should begin to show improvement in performance against the Cancer Waiting times for patients by the end of Q1 2023/24
- Urology action plan developed and agreed with the service and was gaining traction; progress has stalled and engagement is being reinvigorated
- Upper GI – newly introduced steps at the beginning of the pathway to improve timeliness (patients now have CT scan on the same day as endoscopy if the results of the endoscopy indicates a likely cancer). Data is being analysed to determine if the process has shortened the time to MDT discussion. The encouraging results of the pilot were shared with the Cancer Operations Group for discussion. It was agreed to widen the scope of the pilot to all patients with a likely malignancy regardless of how they entered the pathway. In addition, consideration is being given to whether the process can be transferred to failed colonoscopy patients, e.g. patient to have a CTC on the same day; this would benefit suspected colorectal cancer patients and reduce the number of visits to the hospital as well as expedite their pathway.
- Head and Neck – test bundling has been reviewed and confirmed that this is now implemented. Performance in Q1 2023/24 will be monitored for progress.
- Actions form part of the overall Cancer Transformation programme of work

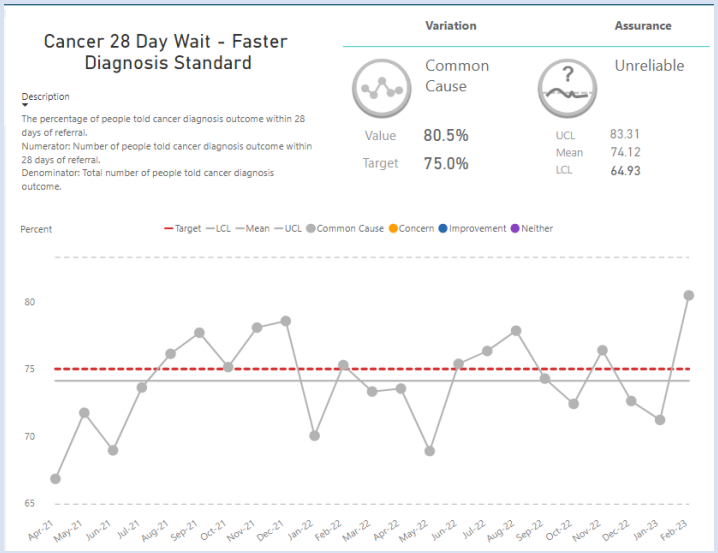
Risks / Mitigations

- 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 - recent Bowel Screening TV campaign has coincided with an spike in colorectal 2WW referrals and the increase continues with the highest number seen in March 2023 (550 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 February 2023 was 48.1% which demonstrates a deterioration; performance has not been achieved for some time.

The Faster Diagnosis Standard (combined) February 2023 achieved 80.5%.

Intervention and Planned Impact

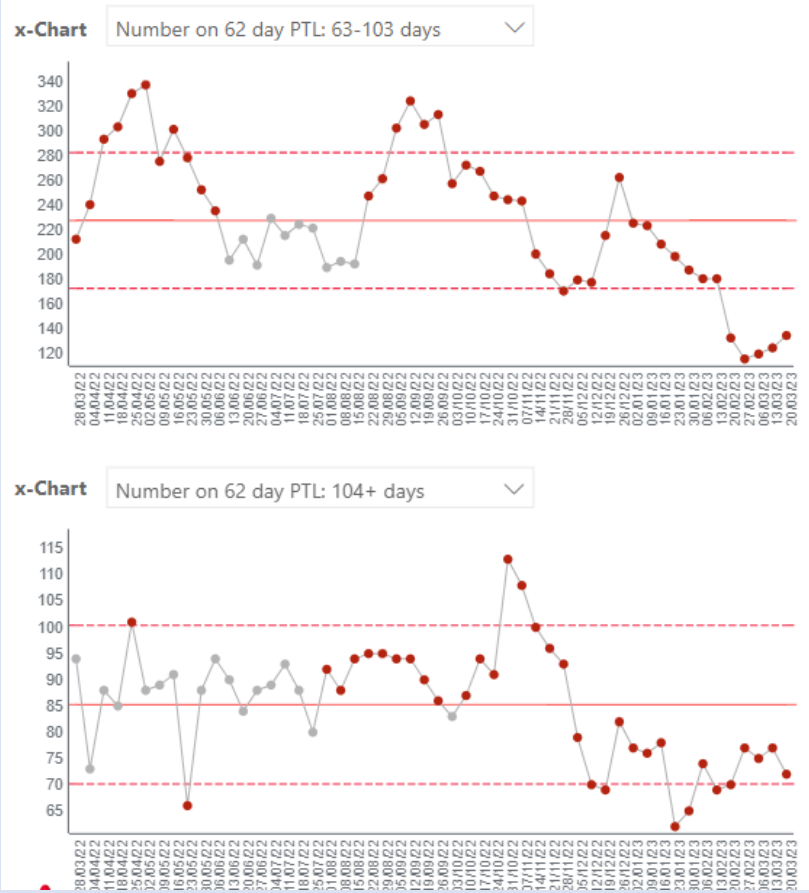
Largely the same as Section 8. Above.

- Administration processes continue to be reviewed and actions implemented as appropriate
- Discussion with pharmacy colleagues to improve despatch times of bowel preparation will support CTC slots being fully utilised to realise the improved waiting times
- Improved access to CT Colon internally should have a direct impact on FDS performance for colorectal.
- 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, revisions and implementation. FDS performance made good progress in February 2023 – 43.9% (January 29.7%)
- FDS for tumour sites not achieving the target under review and process improvements being considered for implementation. Lung met the standard in February 2023 following intervention my MDT Lead Clinician

Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times; referrals continue to be high in certain tumour sites
- Colorectal referral increase is sustained due to Bowel Screening Campaign (PTL volume increase; further demand/pressure on CTC/colonoscopy)
- Staff gaps (vacancies and absence) further impact on diagnostic capacity, radiotherapy & waiting times)
- 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 specifically related to FIT with referral (Lower GI), teledermatology (Skin) and npMRI (urology).

Intervention and Planned Impact

Skin has maintained an improved position and achieved the trajectories in PTL numbers, 63+ and 104+ days backlog – the provision of dermatoscopes to GP practices in Hull and East Riding means that 2WW referrals with image are contributing to this performance, there is further work for the Cancer Alliance to support.

Urology backlog continues to remain static – access to npMRI is outside the best practice timed pathway and an areas of focus for the improvement actions.

- 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. Progress against this plan is stalled however, clinical engagement is good and further sessions are planned to ensure improvement initiatives are implemented.

Colorectal – 2WW referrals with a FIT test/result are at 70%; there is work for the Cancer Alliance to support to increase the rate to a target of 80%.

- LGI Nurse led triage, currently in development, is intended to remove 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.

Risks / Mitigations

- Additional tracking resource for LGI, funded by the Cancer Alliance, demonstrated benefits as the primary PTL was reducing; recent increase in referrals has impacted on recovery. The Trust backlog does not exceed 170 by 31 March 2023
- Urology service improvement action plan has been developed and agreed to address gaps and delays
- Urology – additional Haematuria capacity, funded by the Cancer Alliance, to reduce the backlog and reduce the PTL volume whilst ensuring patients are on the correct clinical pathway (or discharged). New clinics being organised April/May to continue to reduce the backlog.

13. Elective Recovery Fund

	Target	104%	104%	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	Feb-23	Mar-23	Q4 Total	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	3,924,243	4,344,698	12,644,497	49,613,644
	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	5,185,752	5,987,846	16,695,844	55,001,717
	Actuals	3,617,701	4,536,981	4,183,067	4,396,023	3,900,946	4,404,168	4,517,577	4,877,993	3,919,529	4,480,405	4,370,736	4,704,228	13,555,369	51,909,356
	Baseline 19/20 %	89%	107.2%	104%	100%	100%	106%	102%	119%	107%	102%	111%	108%	107%	105%
	Plan %	93%	108%	96%	100%	92%	95%	109%	109%	100%	81%	84%	79%	81%	94%
	Indicative Gain/Loss	(441,193)	103,054	5,731	(136,898)	(127,031)	54,397	(53,850)	448,728	76,618	(52,630)	217,142	139,307	303,819	233,375
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	5,397,750	5,976,080	16,850,037	68,242,980
	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	6,197,399	6,508,800	18,880,743	74,240,989
	Actuals	4,159,135	5,031,179	5,117,440	5,016,301	4,656,149	4,943,458	4,900,591	5,601,753	4,917,525	4,180,539	5,161,581	5,447,110	14,789,231	59,132,761
	Baseline 19/20 %	78%	92%	88%	87%	89%	87%	80%	92%	85%	76%	96%	91%	88%	87%
	Plan %	73%	82.3%	85%	81%	74%	78%	78%	88%	82%	68%	83%	84%	78%	80%
	Indicative Gain/Loss	(1,061,782)	(508,501)	(719,584)	(741,054)	(592,001)	(741,765)	(1,104,303)	(556,278)	(803,580)	(1,136,038)	(339,059)	(576,010)	(2,051,106)	(8,879,954)
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	2,578,963	2,855,280	8,228,875	32,605,455
	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	2,893,269	3,201,676	9,059,399	35,060,395
	Actuals	2,654,211	3,119,167	2,830,223	2,864,128	2,750,510	2,774,726	2,887,656	3,312,916	2,509,340	2,996,897	2,880,047	2,806,058	8,683,001	34,385,877
	Baseline 19/20 %	101%	113%	106%	97%	116%	100%	96%	120%	103%	107%	112%	98%	106%	105%
	Plan %	102%	109.6%	101%	99%	96%	92%	97%	106%	87%	101%	100%	88%	96%	98%
	Indicative Gain/Loss	(69,127)	187,060	45,540	(157,094)	206,071	(85,070)	(185,551)	339,520	(17,925)	67,859	148,444	(122,575)	93,728	357,153
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	2,584,931	2,861,888	8,403,097	32,680,913
	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	2,925,968	3,336,539	9,296,750	36,409,921
	Actuals	2,863,730	3,203,297	3,011,158	2,948,237	3,019,936	3,058,896	3,048,896	3,528,729	2,918,424	3,421,393	3,140,425	3,801,811	10,363,628	37,964,931
	Baseline 19/20 %	112%	116%	116%	101%	125%	111%	100%	126%	120%	116%	121%	133%	123%	116%
	Plan %	105%	106%	102%	98%	100%	96%	100%	110%	98%	113%	107%	114%	111%	104%
	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	1,219,362	1,350,008	3,929,297	15,416,225
	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	1,087,490	1,217,731	3,419,172	13,142,965
	Actuals	1,016,644	1,210,762	1,076,333	1,091,463	1,113,930	1,177,643	1,154,931	1,305,291	1,045,625	1,212,705	1,143,048	1,286,843	3,642,596	13,835,217
	Baseline 19/20 %	84%	92%	91%	78%	92%	92%	82%	100%	90%	89%	94%	95%	93%	90%
	Plan %	104%	112%	103%	104%	106%	104%	102%	111%	97%	109%	105%	106%	107%	105%
	Indicative Gain/Loss	(177,581)	(115,479)	(115,890)	(278,602)	(110,570)	(113,723)	(238,449)	(43,237)	(121,807)	(151,213)	(93,817)	(87,874)	(332,904)	(1,648,242)
	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	15,705,249	17,387,954	50,055,803	198,559,217
	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	18,289,878	20,252,594	57,351,907	213,855,989
	Actuals	14,311,421	17,101,385	16,218,221	16,316,152	15,441,470	16,358,892	16,509,652	18,626,682	15,310,442	16,291,939	16,695,836	18,046,050	51,033,825	197,228,142
	Baseline 19/20 %	91%	103%	99%	93%	102%	98%	92%	109%	99%	96%	106%	104%	102%	99%
	Plan %	90%	99%	95%	93%	88%	89%	94%	101%	91%	87%	91%	89%	89%	92%
	Indicative Gain/Loss	(1,749,683)	(333,866)	(784,203)	(1,313,648)	(623,530)	(886,161)	(1,582,154)	188,743	(866,694)	(1,272,022)	(67,269)	(647,152)	(1,986,463)	(9,937,669)

Activity data up to	26/03/2023		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
			*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											
Indicative Activity Requirement (% of baseline):			104%	104%	104%	104%	104%	104%	104%	104%	104%	104%	104%	104%
Ceiling target for follow up activity (% of baseline):			75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
TRUST TOTAL	New	Baseline	17,637	17,096	16,632	18,386	14,792	17,746	18,482	17,249	15,263	16,653	16,590	15,019
		Plan	14,229	16,146	15,726	16,348	16,183	17,259	17,044	18,072	16,388	17,022	16,558	18,550
		Actual*	14,280	16,995	15,526	15,573	15,413	15,955	16,468	18,435	14,128	17,362	16,283	16,147
		Plan %	100%	105%	99%	95%	95%	92%	97%	102%	86%	102%	98%	87%
		19/20 Baseline %	81%	99%	93%	85%	104%	90%	89%	107%	93%	104%	98%	108%
	Follow Up	Baseline	33,158	37,048	34,967	38,951	32,800	35,396	40,453	36,572	31,595	38,860	34,897	29,737
		Plan	30,529	35,206	34,395	34,371	34,910	37,462	35,973	37,893	34,517	35,376	33,882	39,765
		Actual*	34,134	38,212	36,075	35,660	36,736	37,101	37,168	41,925	33,945	40,249	38,110	39,284
	(minimise)	Plan %	112%	109%	105%	104%	105%	99%	103%	111%	98%	114%	112%	99%
	(minimise)	19/20 Baseline %	103%	103%	103%	92%	112%	105%	92%	115%	107%	104%	109%	132%
	Day Case	Baseline	6,080	6,198	5,817	6,488	5,948	6,167	6,688	6,244	5,702	6,600	6,009	4,996
		Plan	5,800	6,369	6,594	6,741	6,505	7,118	6,175	6,775	5,888	7,268	6,640	7,942
		Actual*	5,596	6,820	6,273	6,633	6,183	6,590	6,697	7,098	5,906	6,812	6,419	7,334
		Plan %	96%	107%	95%	98%	95%	93%	108%	105%	100%	94%	97%	92%
		19/20 Baseline %	92%	110%	108%	102%	104%	107%	100%	114%	104%	103%	107%	147%
	Ord Elect	Baseline	1,203	1,276	1,296	1,341	1,177	1,275	1,403	1,383	1,244	1,300	1,259	1,078
		Plan	1,175	1,266	1,244	1,296	1,314	1,326	1,316	1,338	1,259	1,294	1,288	1,378
		Actual*	888	1,049	1,072	1,067	973	1058	1,008	1,208	1,022	895	1,096	1,261
		Plan %	76%	83%	86%	82%	74%	80%	77%	90%	81%	69%	85%	92%
		19/20 Baseline %	74%	82%	83%	80%	83%	83%	72%	87%	82%	69%	87%	117%

What the chart tells us

Recovery of elective activity in March 2023 against the operational plan delivered:

- New Activity 87%
- Follow up Activity 99%
- Day Case Activity 92%
- Ordinary Elective Activity 92%

The indicative activity requirement of 110% of 19/20 baseline was not delivered in any POD.

Overall financial position delivered 89% of the plan and 102% of baseline in March 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 until mid-April 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.

Junior Doctor Industrial Action impacted overall on March and April 2023 activity.

Day case delivered 92% of plan (activity) in March 2023 (147% of 19/20).

OP 1st attendances (activity) achieved 87% of the plan in March 2023 and 108% of 19/20 baseline.

OPFU (activity) continue to over-perform at 99% of the plan and 132% of the 19/20 baseline, income is capped at 85% of 19/20 baselines; further information received in regard to the 2023/2024 planning round will see follow ups with a procedure removed from the requirement to reduce by 75%, which will likely improve the achievement of this metric for HUTH.

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 June 2023

14. Non-Elective Activity

26/03/2023		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
		*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%	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	4,285	3,977
	Plan	3,934	5,059	4,897	5,249	5,439	5,447	5,818	5,631	5,818	5,818	5,255	5,818
	Actual*	3,678	5,028	4,715	5,139	4,766	4,675	4,994	5,151	5,258	5,259	4,646	5,193
	Plan %	93%	99%	96%	98%	88%	86%	86%	91%	90%	90%	88%	89%
	19/20 Baseline %	78%	102%	102%	108%	105%	103%	103%	109%	110%	110%	108%	131%

What the chart tells us

Non-elective activity in 22/2023 was higher than the baseline of 19/20.

Intervention and Planned Impact

-

Risks / Mitigations

-

FINANCE REPORT

REFERENCES

Only PDFs are attached

10.1 - Finance Report Month 12.pdf

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	09.05.23
Title	Finance Report – 2022/23 - Month 12				
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:

The Trust Board is asked to note the following:

a) The delivery of the financial plan for 2022/23 with a reported £68k surplus.

b) The underlying deficit of £52.1m.

FINANCIAL UPDATE 2022/23 – MONTH 12

1. Purpose of Paper

To update the Trust Board on the financial position at month 12.

2. Month 12

The table in appendix 1 shows the month 12 reported position against the NHSI plan, at health group level.

The Trust is reporting a financial performance surplus of £68k at month 12, slightly better than plan. The surplus is broken down as follows:

	£000
Net Deficit	(808)
Adjustments	
Donated Assets	867
DHSC PPE Stock Movements	9
Financial Performance (Surplus)	68

There may be below the line changes to this position, reflecting impairments, once the Trust receives the asset valuation from Cushman and Wakefield. This should not change the position.

Income

The Trust position shows income is £10.2m above plan, an additional £4.4m above the forecast at Month 11. The Trust received additional funding in month 12 from Cancer Alliance (£1.3m), NHSE for 78 weeks (£1.0m), NHSE for excluded devices (£1.0m), NHSE for Breast/Gender/Trauma (£0.5m), CDC (£0.3m), other (£0.3m).

The £10.2m can be broken down as follows:

	£m
Capacity Funding	2.0
NHSE Underspend	1.3
Cancer Alliance	1.3
NHSE 78 weeks	1.0
NHSE Devices	1.0
Capital Charges	0.7
NHSE Devices	1.0
Wards H13/130	0.5
Other NHSE	1.4
Total	10.2

Education income is also above plan (£1.0m), 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 received £11.2m of income to cover the cost of the original 2022/23 pay award. This covers the full initial award.

The Trust has received additional income of £15.1m in March 23 for the proposed non-consolidated pay awards announced in March 23. The Trust has accrued anticipated costs of £16.5m against this. NHSE have said Trusts will receive no additional funding above the level issued. These entries have both been transacted through reserves as they have not yet been agreed.

The Trust is £1.5m 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 did not happen in 2022/23. This does not affect the Trust reported performance position.

Expenditure

Health groups and corporate areas are reporting that they have a deficit of £7.6m at month 12. This is £2.2m above month 11 position and £1.0m above the forecast at month 11.

The Trust delivered its CRES plan for 2022/23 as per the table below. Over delivery in Estates, Facilities and Development due to a non-recurrent rates rebate offset shortfalls in the Health Groups. £4.4m of this is non-recurrent, unchanged from previous month.

	Annual CRES Target £'k	CRES Achievement £'k	CRES Variance £'k	% Forecast	Recurring CRES achievement £'k	Recurring CRES Variance £'k	% Forecast
Medicine	1,825	1,825	0	100%	**622**	-1,203	34%
Emergency Medicine	397	297	-100	75%	167	-230	42%
Surgery	3,070	2,768	-302	90%	2,563	-507	83%
Family & Womens Health	1,814	1,533	-281	85%	873	-941	48%
Clinical Support Services	2,150	2,003	-148	93%	1,346	-804	63%
Corporate	1,709	1,709	0	100%	1,275	-434	75%
Estates, Facilities & Development	865	1,680	815	194%	**552**	-313	64%
Energy	5,149	5,149	0	100%	5,149	0	100%
Central	357	357	0	100%	357	0	100%
TOTAL	**17,336**	**17,321**	**-16**	100%	**12,904**	**-4,432**	74%

Surgery Health Group overspent by £0.9m in month, an increase of £0.5m on forecast. These additional costs related to increased drug costs (£0.2m), deep cleaning costs (£0.1m), minor works & IT (£0.1m) and bowel screening (£0.1m),

Medicine Health Group overspend increased by £0.6m in month, with £0.3m of this being above month 11 forecast. The additional costs were driven by increased spend

on insulin pumps and home ventilation monitors. There was also £0.1m expenditure on medical repairs.

Clinical Support Health Group increased by £0.1m in month, slightly above forecast. This related to consumables in Radiology.

Family & Women's Health Group overspent by £0.2m in month due to levels of Wet AMD injections. This was in line with forecast.

Pass through drugs overspend increased by £0.4m in month.

Corporate and Estates, Facilities and Development positions were both in line with forecasts.

3. 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 12 was £11.4m. This would be £1.9m above the revised target and £0.4m above the Trust initial plan. Increased usage on junior doctors and staff grades (£1.3m) has been partially offset by reduction on Consultant spend (£1.0m). AHPs have also increased by £0.1m.

NHSE has set a target for Trusts to spend no more than 3.7% of the total pay bill on agency in 2023/24. The Trust currently spends 2.4%.

4. 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 (£4.4m) and additional in-year pressures has moved this to a position of £51.2m.

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

The SOFP and SOCF for month 12 are not yet complete and will be presented to Audit Committee on 27th April 23.

Capital

The reported capital position at month 12 shows gross capital expenditure of £45.6m (incl PFI/IFRIC12 impact) against an initial plan of £34.9m. The revised total includes confirmed PDC schemes totalling £19.8m, including NCTR ward (£3.8m); CDC (£3.4m); EPR (£2.9m); Lung Health Check (£1.2m) and early drawdown Phase 2 Day

Surgery (£6.6m). In addition, the Trust has included £0.7m relating to CDEL slippage from within the ICS (York & NLAG). The Salix Grant scheme (£10m) did not take place in 2022/23.

The main areas of expenditure relate to the Equipment; NCTR Ward; Theatres; Day Surgery Scheme and PFI lifecycle costs

Cash

The Trust's liquidity position remains healthy with a cash balance of £58.5m at the end of March, £3m above forecast. The Trust has paid 95.5% by volume and 84.4% by value of non-NHS invoices within best practice terms. In March, the figures were 96.6% and 89.1% respectively

Stocks

Stock levels are at £16.6m, an increase of £0.6m in month and £0.7m higher than the same period last year.

Health Group	Mar 22 £000	Feb 23 £000	Mar 23 £000	Change from March 22 £000
Clinical Support	7,178	7,408	7,725	546
Surgery	4,489	4,726	4,894	405
Medicine	2,326	2,002	1,842	(483)
F & WH	1,096	1,115	1,174	79
Other	434	442	642	207
PPE Stock	345	345	335	(9)
Total	15,867	16,038	16,613	745

Clinical Support stocks have increased by £0.5m during the year. Pharmacy stocks are £0.4m of this due to increase in ward stocks of CT contrast to avoid unsafe shortages. Pharmacy are reviewing the levels with the services. Excluded devices from NHSE have also transferred to the 'visible cost' model, which means that the Trust now purchases the stock rather than NHSE. This has increased the value by £0.1m.

Surgery stock has increased by £0.4m. £0.3m of this relates to move to 'visible cost' model and £0.1m relates to purchase of stock for the new Day Surgery Unit.

Other stock increase related to purchase of oil stocks to increase resilience in case of anticipated energy disruptions.

Debtors

The Trust currently has £3.3m of debt that is over 90 days, a reduction of £0.8m from month 11. The main debtors are as follows:

Debtors Over 90 Days	February 23	March 23	Change
	£	£	£
Northern Lincolnshire And Goole Nhs Ft	850,056	301,486	-548,570
York & Scarborough Teaching Hospitals Nhs Ft	144,860	179,139	34,278
Fresenius Medical Care Renal Services Ltd	459,332	114,340	-344,991
Alliance Medical Ltd	0	93,101	93,101
Humber Teaching Nhs Foundation Trust	94,374	79,017	-15,357
East Riding Fertility Services Ltd	71,710	65,995	-5,715
Nhs Humber And North Yorkshire Icb	55,620	63,890	8,271
Crawford & Company Adjusters (Uk) Ltd	60,720	60,720	0
Nhs England	2,561	57,050	54,489
Ge Healthcare	51,962	51,962	0
Astrazeneca Ltd	61,225	27,641	-33,584
Other	2,253,138	2,204,370	-48,768
Total	4,105,558	3,298,711	-806,847

Both NLAG & Fresenius made large payments in month. The team are liaising with NLAG to reduce the balance further. Reminders have been sent to York re the outstanding balances that relate to Pathology and they have confirmed there are no issues and will look to clear. The invoices for Crawford and Company and GE Healthcare relate to the same issue (MRI downtime) and only one should be payable. The Health Group is working with the companies to agree who should be paying but a provision has been included in the accounts to reflect the expected cancellation of one of them.

Recommendations

The Trust Board is asked to note the following:

a) The delivery of the financial plan for 2022/23 with a reported £68k surplus.

b) The underlying deficit of £52.1m.

Stephen Evans
Operational Finance Director
April 2023

APPENDIX 1

Financial Year 2022/23 Month 12

	Annual Budget £000	Budget £000	Actual £000	Variance £000	Month 11 £000	Change In Month £000	Month 11 Forecast £000	Change In Month £000
Nhs Contract Income	651,689	651,689	661,934	10,245	3,818	6,427	5,812	4,433
ERF Income	19,589	19,589	19,589	0	0	0	0	0
Nhs Other Clinical Income	209	209	223	14	13	1	14	0
Education + Training Income	21,556	21,556	22,601	1,045	886	159	973	72
Other Income	2,320	2,320	2,074	(246)	(47)	(199)	(51)	(195)
Donated/Grant Income	10,460	10,460	520	(9,940)	(9,332)	(608)	(9,992)	52
Total Income	**705,823**	**705,823**	**706,941**	**1,118**	**(4,662)**	**5,780**	**(3,244)**	**4,362**
Surgery	(154,219)	(154,219)	(158,068)	(3,849)	(2,940)	(909)	(3,393)	(456)
Medicine	(96,356)	(96,356)	(97,956)	(1,600)	(963)	(637)	(1,295)	(305)
Clinical Support Services	(108,584)	(108,584)	(108,108)	476	532	(56)	573	(97)
Pass through drugs	(72,699)	(72,699)	(74,154)	(1,455)	(1,042)	(413)	(1,138)	(317)
Family + Womens Health	(94,356)	(94,356)	(95,608)	(1,252)	(1,073)	(179)	(1,194)	(58)
Corporate Directorates	(82,003)	(82,003)	(81,960)	43	224	(181)	41	2
Reserves	20,190	20,190	15,483	(4,707)	(346)	(4,362)	(1,438)	(3,269)
Pay Award	11,200	11,200	11,200	0	0	(0)	0	0
Other Operating Expenditure	(6,802)	(6,802)	(6,151)	651	427	224	475	176
Emergency Care Health Group	(19,567)	(19,567)	(19,729)	(162)	(82)	(80)	(139)	(23)
Estates Facilities & Developmt	(56,932)	(56,932)	(57,427)	(495)	(473)	(22)	(499)	4
Unaddressed Risk	0	0	0	0	0	0	0	0
Total Operating Expenditure	**(660,128)**	**(660,128)**	**(672,478)**	**(12,350)**	**(5,735)**	**(6,615)**	**(8,007)**	**(4,343)**
Donated Asset Income	(10,460)	(10,460)	(520)	9,940	9,332	608	9,992	(52)
EBITDA	**35,235**	**35,235**	**33,943**	**(1,292)**	**(1,065)**	**(227)**	**(1,259)**	**(33)**
Depreciation	(22,161)	(22,161)	(22,154)	7	0	7	0	7
Interest Payable	(6,236)	(6,236)	(6,395)	(159)	(215)	56	(162)	3
Interest Receivable	217	217	1,485	1,268	1,084	184	1,182	86
Pdc Dividends	(8,195)	(8,195)	(8,195)	0	0	0	0	0
Loss on Disposal of Assets	0	0	(50)	(50)	0	(50)	0	(50)
Gain on Disposal of Assets	0	0	38	38	0	38	0	38
Total Non Operating Expenditure	**(36,375)**	**(36,375)**	**(35,271)**	**1,104**	**869**	**235**	**1,020**	**84**
Net Surplus/Deficit	**9,320**	**9,320**	**(808)**	**(10,128)**	**(9,528)**	**(600)**	**(10,231)**	**103**
Donated Asset Adjustment (NEW)	(9,320)	(9,320)	867	10,187	9,558	629	10,231	(44)
Adjusted Financial Performance before Profit/Loss Adjustment	**0**	**0**	**59**	**59**	**30**	**29**	**0**	**59**
Adjustment to exclude stock movement on PPE consumables	0	0	9	9	0	9	0	9
Adjusted Financial Performance Surplus/Deficit	**0**	**0**	**68**	**68**	**30**	**38**	**0**	**68**

SUMMARY FROM THE PERFORMANCE AND FINANCE COMMITTEE

REFERENCES

Only PDFs are attached

10.2 - PAF Summary May 2023.pdf

Report to the Board in Public
Performance and Finance Committee
April 2023

Item: ED Performance	Level of assurance gained: Limited

The 4-hour performance delivery remains fairly static, although is significantly below the required standard. In March 2023, performance was 59.2% for all attendance types.

- Boarding (HUTH version of Bristol model) is in daily operation and has been expanded to a second round of admissions to take place that will see a further 10 patients moved from ED between 10:00 and 14:00, with planning from May 2023 for a further 10 between 14:00 and 16:00.
- A working group to improve the utilisation of Ward H36 will explore which patient pathways would be appropriate for a short stay assessment area, patients awaiting longer investigations (June 23).
- From the 6th April 2023 improved Standardisation of the EPIC/RAT roles particularly in relation to long waits overnight began and being monitored through the Health Group.
- From April 2023 Surgery Health Group to focus on reduction of lodged time for patients in ECA, freeing up consulting rooms.
- Return to pre-Covid pathways in paediatric ED to improve treatment times
- The above actions are planned to improve performance across the whole department to 51% end April 2023, 54% end May 2023 and 59% by end of June 2023.
- Mental Health Streaming facility to open by end of May 2023, expecting to reduce breaches by 1 per day but significantly improve the patient experience.

Item: Financial Report Month 12	Level of assurance gained: Good

The Trust has achieved a £68k surplus at year-end. The Annual Accounts will be submitted on 27 April 2023 for auditing.

The underlying position remains challenging (£51m deficit) and capital had achieved its Capital Departmental Expenditure Limit (£45m).

Item: Performance	Level of assurance gained: Limited

The Trust's total waiting list volume (WLV) has reduced marginally. At the end of March 2023, the current un-validated position is 68,087, this has been reducing since August 2022. The total WLV is above the trajectory of 63,453. Overall, referrals in 22/2023 were 5.5% down on the previous year; the operational plan for 2022/23 assumed no further increase in referrals.

On average, there were 207 patients per day with No Criteria to Reside in March 2023. There was an average impact of 4 days increase on Length of Stay due to the NCTR.

Ambulance handover waits over 60 minutes have been increasing since February 2022. There were 682 waits over 60 minutes reported in March 2023, which equated to 23.0%

The ED 4 hour target remains challenged but a number of initiatives such as a non-clinical EPIC, ward 36 being used as a CDU and Surgery Health Group focus on lodged patients were in place to improve the flow through the department.

The Committee discussed external planning and the capacity of Domiciliary Care in the Community.

Item: Revenue Planning 2023/24	Level of assurance gained: Reasonable
The Financial Plan 2023/24 was approved by the Board on 24 April 2023 and assumes a planned deficit of £16.7m. There was also an increase in the level of efficiencies required from 2% - 6.9%.	
Item: Capital Planning 2023/24	Level of assurance gained: Reasonable
The Trust's Capital plan for 2023/24 is £20.6m. The plan was approved by the Board and endorsed by the Performance and Finance Committee.	
The following reports were also shared: • Board Assurance Framework – Year-end 2023/24 The following contracts were approved; • Contract for Hearing Aids and Consumables	

QUESTIONS FROM THE PUBLIC RELATING TO TODAY'S AGENDA

Verbal

CHAIRMAN'S SUMMARY OF THE MEETING

Verbal

ANY OTHER BUSINESS

Verbal

DATE AND TIME OF THE NEXT MEETING:

Tuesday 11 July 2023, 9am - 12pm