NHS

Hull University Teaching Hospitals

NHS Trust

TRUST BOARD

TRUST BOARD

📅 11 July 2023

🕐 09:00 GMT+1 Europe/London

📍 The Boardroom, HRI

AGENDA

REFERENCES   Only PDFs are attached

📕 1 - Trust Board Agenda July 2023.pdf

Trust Board in Public
Tuesday 11 July 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 meeting held 9 May 2023** **4.1 Minutes of the meeting held 21 June 2023 (Accounts Approval)** Sean Lyons, Chair	Approval Approval		Attached Attached
	4.1 Board Work Programme 2022/23 Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.2 Board Development Framework Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.3 Matters Arising Sean Lyons, Chair			Verbal
	4.4 Action Tracker Sean Lyons, Chair	Approval		Attached
	Patient Story			
5	**Patient Story** Makani Purva, Chief Medical Officer	Assurance	09.10	Verbal
	Governance			
6	**CEO Report** Chris Long, Chief Executive Officer	Assurance	09.25	Attached
	6.1 Development Group Committees in Common Summary Sean Lyons, Chair	Assurance		Attached
	6.2 Audit Committee Summary Mike Robson, Audit Chair	Assurance		Attached
	6.3 Year-end Board and Committee Review Rebecca Thompson, Head of Corporate Affairs	Assurance		Attached
	6.4 Register of Gifts and Interests Annual Update Rebecca Thompson, Head of Corporate Affairs	Assurance		Attached
	6.5 Standing Orders Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	6.6 Health and Safety Annual Report Rebecca Thompson, Head of Corporate Affairs	Information		Attached

	6.7 Summary from the Charitable Funds Committee Tony Curry, Charitable Funds Chair	Assurance		Attached
	Strategy			
7	**7.1 Board Assurance Framework Q1 2023/24** Rebecca Thompson, Head of Corporate Affairs	Approval	09.40	Attached
	Quality			
8	**8.1 Quality Report** Makani Purva, Chief Medical Officer/Jo Ledger, Acting Chief Nurse	Assurance	09.50	Attached
	8.2 CQC Update Makani Purva, Chief Medical Officer	Assurance		Attached
	8.3 Infection Prevention and Control Annual Report Greta Johnson, Director of Infection Prevention and Control	Assurance		Attached
	8.4 Infection Prevention and Control Board Assurance Framework Greta Johnson, Director of Infection Prevention and Control	Assurance		Verbal
	8.5 Annual Review of the Quality Strategy Michela Littlewood, Associate Director of Quality	Assurance		Attached
	8.6 Summary from the Quality Committee Una Macleod, Quality Chair	Assurance		Attached
	Workforce			
9	**9.1 Workforce/People Strategy Update** Simon Nearney, Director of Workforce and OD	Assurance	10.30	Attached
	9.2 Trade Union Facility Time Reporting Requirements Regulations 2023 Report Simon Nearney, Director of Workforce and OD	Approval		Attached
	9.3 Freedom to Speak Up Fran Moverley, Head of Freedom to Speak Up	Assurance		Attached
	9.4 Guardian of Safe Working Report Mahmood Loubani, Guardian of Safe Working	Assurance		Attached
	9.5 Summary from the Workforce, Education and Culture Committee Una Macleod, Chair of Workforce, Education and Culture Committee	Assurance		Attached
	Performance			
10	**Performance Report** Ellen Ryabov, Chief Operating Officer **10.1 Elective Care Priorities** Ellen Ryabov, Chief Operating Officer **10.2 Finance Report** Lee Bond, Chief Financial Officer	Assurance Assurance	11.00	Attached Attached

	10.3 Premises Assurance Model Mark Green, Head of Information and Governance	Assurance		Attached
	10.4 Summary from the Performance and Finance Committee Mike Robson, Chair of Performance and Finance	Assurance		Attached
11	**Questions from the public relating to today's agenda** Sean Lyons, Chair		12.00	Verbal
12	**Chairman's summary of the meeting** Sean Lyons, Chair			Verbal
13	**Any Other Business** Sean Lyons, Chair			Verbal
14	**Date and time of the next meeting:** Tuesday 12 September 2023			Verbal

Attendance 2023/24

Name	09/05	21/06	11/07	12/09	14/11	13/02	12/03				Total
Sean Lyons	✓	✓									2/2
S Hall	✓	✓									2/2
T Zepherin	x	x									0/2
T Curry	x	✓									1/2
U MacLeod	x	x									0/2
M Robson	✓	✓									2/2
L Jackson	✓	✓									2/2
A Pathak	✓	✓									2/2
D Hughes	✓	✓									2/2
C Long	✓	✓									2/2
L Bond	✓	✓									2/2
M Purva	✓	✓									2/2
J Ledger	✓	✓									2/2
S Nearney	✓	✓									2/2
E Ryabov	x	x									0/2
I McConnell	x	✓									1/2
S Rostron	✓	x									1/2
S McMahon	✓	x									1/2
R Thompson	✓	✓									2/2

Attendance 2022/23

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

APOLOGIES AND WELCOME

Verbal

DECLARATIONS OF INTEREST

Verbal

REFERENCES

📕 4 - Draft Board Minutes May 2023.pdf

📕 4.1 - Minutes of the EO Board to approve the accounts June 2023.pdf

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board Meeting
Held on 9 May 2023

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice Chair
	Mr M Robson	Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Mr L Bond	Joint Chief Financial Officer
	Mrs J Ledger	Interim Chief Nurse
	Prof M Purva	Chief Medical Officer
	Ms J Mizon	Deputy Chief Operating Officer (from 12pm)
	Mrs S McMahon	Joint Chief Information Officer
	Mrs S Rostron	Director of Quality Governance
	Mr S Nearney	Joint Director of Workforce and OD

In Attendance:	Mrs L Cooper	Head of Midwifery
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies**	

Apologies were received from Mrs E Ryabov, Chief Operating Officer, Mr I McConnell, Joint Director of Strategy, Mr Paul Walker, Deputy Chief Operating Officer, Prof U Macleod, Non-Executive Director, Mrs T Zepherin, Non-Executive Director and Mr T Curry, Non-Executive Director

2   Chair's Opening Remarks
The Chairman welcomed the Board to the meeting.

3   Declarations of Interest
3.1 Changes to Directors' interests since the last meeting
There were not declarations made.

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

4   4.1 Minutes of the meeting held 14 March 2023
Page 2 item 5 – should read open heart surgery.
Dysfunctional was spelt incorrectly

4.1.1 Minutes of the meeting held 30 March 2023
The minutes of the meeting were approved as an accurate record.

4.1.2 Minutes of the meeting held 24 April 2023
Item 2, paragraph 9
Mr Nearney suggested that a vacancy monitoring process be put into place. This would be for non-clinical staff only due to the amount of clinical vacancies in the Health Groups.

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4.2 Board Work Programme
The Board reviewed the Work Programme. There were no changes made.

4.3 Board Development Programme
The Board reviewed the Development Programme.

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

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

5   Patient Story
The Board heard 3 patient stories, 2 related to patients with endovascular aneurysm repair and one related to a Endometriosis patient who had waited a long time for treatment and was not communicated to sufficiently during the wait. The patient was very complimentary about the service once seen. The patient also mentioned the lack of GP support relating to their care.

The Board discussed how patients were communicated with and how it improved once a named individual was assigned to them. Urgent patient pathways were much more efficient than the amber pathways.

Prof Purva advised that some patients would escalate themselves if they felt unwell but others would wait for their appointments. She added that harm reviews were being completed in each service and day case surgery were appropriate would help to clear the backlogs.

The Board agreed have a Board Development session to cover backlogs, the stratification process and how patients are communicated with whilst they are waiting.

Action: MP/RT to set up Board Development Session relating to backlogs.

6   6.1 Chief Executive Officer Report
Mr Long presented his report and highlighted the Trust Choir and their recent performance at the Coronation concert. He thanked the team for doing a fantastic job and being a credit to the Trust.

6.2 CQC Update
Mrs Rostron presented the update and advised that the ED urgent actions were well underway although the actions were taking time to embed. The Performance and Finance and Quality Committees were monitoring these actions.

There was a discussion around the overdue action which was the implementation of the Ground Floor model. Mr Long advised that there had been some opposition to the plans and these cultural issues were being worked through.

Action: The Board agreed to have a Board Development session to

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review the Ground Floor model progress and any issues.

HOB capacity had been opened in AAU and the digital work being carried out meant the data sets were being received. The Sepsis training trajectory was on track and patients were being consistently reviewed.

Mrs Rostron advised that the overall ratings were 'inadequate' for safe, and 'requires improvement' for Surgery and Medicine. There was a lot of work to do and this would be monitored at the Quality Committee.

Mrs Rostron reported that following the Maternity inspection the Trust had received a section 31 letter of intent. The service had also been visited by the National Maternity Team. Feedback was expected by the end of the week, but would mean conditions be added to the Trust's registration.

There were 4 actions for well-led which would be monitored at the Quality Committee. The August Quality Committee will be dedicated to just the CQC actions and progress and Mrs Rostron invited any Trust Board member to attend.

The mandatory training compliance and appraisals target had been changed from 90% to 85% which was in line with the national target. Resuscitation and Safeguarding training compliance had reduced, but actions were in place to address both issues.

Mrs Rostron mentioned the QSIR training and quality improvement work and how the Trust was performing well in these areas.

Assurance visits would be stepped up with Mrs Ledger leading maternity and ED and Mrs Rostron leading Family and Women's and Surgery. The Chief Executive would chair the Safety Oversight Group to hold leads to account. Mrs Rostron had developed an inspection training package to allow members of staff to help with the assurance visits.

Mrs Rostron had asked RSM the internal auditors to check compliance with the CQC action plans as part of the 2023/24 programme.

The Board discussed training needs for the clinical governance leads within each service and Mrs Rostron advised that the central governance team were working with the leads and a Teams channel as well as training had been developed. Mrs Jackson expressed her concern regarding the Maternity Service actions that had not been implemented and Mrs Rostron advised that further support was being given.

Action: Quality Committee in August invite to be extended to all Board members.

6.3 Audit Committee Annual Report
Mrs Thompson presented the report which highlighted the work of the Audit Committee in 2022/23. There were no gaps in governance to report. The report would form the Audit section of the Trust's Annual

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Report.

6.4 Audit Committee Summary

Mr Robson presented the summary and advised that RSM had carried out a pre-CQC Maternity Review which had been given reasonable assurance and 11 recommended areas for improvement had been agreed.

The Counter-Fraud Service had been brought back in-house from 1st5 April 2023 and was now managed by Northern Lincolnshire and Goole NHS Foundation Trust.
The Annual Accounts had been presented as had the Draft Annual Governance Statement. Mr Bond stated that it was important to reference any areas or concerns related to the internal governance review.

6.5 Trust Self-Certification

Mrs Thompson presented the report and advised that at the time of writing the compliance statements were a true reflection. Mr Lyons asked that the CQC sections be re-visited following the current inspections and subsequent ratings. He added that caveats should be added for transparency.

Resolved: It was agreed that the statements would be reviewed off-line and aligned to the Annual Governance Statement.

6.6 Fit and Proper Persons

Mrs Thompson presented the report and advised that all Board members met the Fit and Proper criteria.

Resolved: The Board approved the report following a number of slight alterations to the declarations.

6.7 Eliminating Mixed Sex Accomodation

Mrs Ledger presented the statement which highlighted a breach in January 2023. The breach reflected the capacity issues at the time January breach as well as the HOB strict discharge criteria.

Mrs Ledger added that the Duty of Candour was carried out.

Resolved: The Board approved the EMSA statement.

6.8 Board Assurance Framework

Mrs Rostron presented the Q4 Board Assurance Framework and reported that on the whole the Trust did not achieve the target risks although the finance and capital targets were met.

Mrs Rostron proposed that the risks be extended for 6 months due to the Group Model although the risks would be monitored and presented to the Committees and Board as the current process.

The Board discussed the timings of an aligned BAF and agreed it was not the priority in the next 12 months. Mrs Rostron suggested that the 2023/24 BAF be scoped and presented to the Board Committees for review and then to the Board for approval. The Board also discussed

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having a Board Development session related to the BAF in Q2.

Action: Board Development Session to cover the 2023/24 BAF to be organised in Q2.

6.9 Updated Code of Governance for Boards/Division of Responsibilities
Mrs Thompson presented the updated Code of Governance and advised that she would further update the Board if any changes were required.

She also presented the Division of Responsibilities for the Chairman and Chief Executive Officer.

Mr Long pointed out that 4.1.5 stated that the Trust Secretary's line management was shared by the Chair and the CEO but this was not the case. All members of the management structure report either directly or indirectly to the Chief Executive as stated in 3.1.2. It was agreed that section 4.1.5 would be removed.

Resolved: The Trust Board received both reports and the Chair and CEO approved the Division of Responsibilities once section 4.1.5 was removed.

6.10 Standing Orders
Mrs Thompson presented the paper which set out the use of the Trust Seal since the last report.

Resolved: The Trust Board retrospectively approved the use of the Trust Seal.

7.1 Digital Strategy
Mrs McMahon reported that Nerve Centre was rolled out and work was getting close to a single patient admin system but this was challenging.

Mrs McMahon also talked about linking the clinical programmes, cyber security incident reporting and Information Governance mandatory training. Patient Knows Best, the Lab information system and Baginet were also being implemented and developed.

Work was ongoing regarding staff retention and the staff survey. Southern organisations were offering higher salaries and remote working, so staff were taking these opportunities. Mrs McMahon advised that it was key that staff were engaged and agile with the new systems so they become embedded quicker.

The Board discussed virtual hospitals and aligning the EPR across the entire ICS in the future. Mrs McMahon advised that she met regularly with the other CIOs in the ICS but having a fully standardised system was a way off yet. She added that the virtual ward programme was also transformational. Mr Robson added that having a shared sense of direction and standardised systems would help patient care greatly.

7.2 Research and Innovation Annual Report

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The report was presented for information to the Board. Mr Lyons highlighted the Research Celebration Event and how it was a very uplifting day with lots of great work being carried out.

Mr Bond asked about the Joint working with NLAG and the level of ambition involved. Prof Purva advised that there was more to do but that there was huge potential. She added that a level of investment was required to elevate R&I to the next level.

Mr Hall highlighted and commended that fact that recruitment for last year was 68% above target.

Quality Report
Mrs Rostron presented the report and advised that PSIRF had gone live on 1st April 2023 and other Trusts were interested in learning from the programme and processes.   Mrs Rostron offered support to Northern Lincolnshire and Goole NHS FT should they require it.

Mrs Rostron was keen to inform the Board that although Serious Incidents were no longer declared there were still processes in place for unexpected deaths and Never Events.

Mrs Ledger advised that there had been an increase in pressure ulcers with many being related to devices. A development video had been launched and would be shared with relevant staff during May 2023.

Mrs Ledger reported that although falls numbers were reducing there had been 8 patients who had suffered harm due to falls and resulting in fractured neck of femurs. Training was being stepped up across all disciplines but data was suggesting that the majority of falls related to patients with cognitive impairment. Different ways of working were being reviewed as was changing visiting times to ensure patients could have someone with them for longer. Prof Purva added that falls training had now been made mandatory for Junior Doctors.

Mrs Rostron advised that a new Model Complaints Standards Group had been developed and the 90 complaints overdue was now down to 36. A review of the process had been undertaken and more complaints were being managed using the early resolution process.

Mrs Rostron added that the Quality Accounts had been out to stakeholders and the priorities were set.

Resolved: The Board approved delegating authority to the Quality Committee to sign off the Quality Accounts in June 2023.

Maternity Update
Mrs Cooper presented 4 reports the first was perinatal mortality national reporting standards and the Trust was reporting 100% compliance for Q4 with the indicators.

The second was Avoiding Term Admissions into NICU. The Trust was reporting 2.5% per 1000 births in Q4. The national standard was less than 6% per 1000.

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The report relating to monitoring growth restriction highlighted 5 true missed cases and work was ongoing with the sonographers to review these cases.

Action: An update regarding the missed cases to the September 2023 Trust Board.

The forth report highlighted midwifery staffing. Mrs Cooper advised that the vacancy rate was 10.37% and there were a large number of staff on maternity leave.

There were 22 new starters commencing in September 2023 and 11 candidates were being interviewed from overseas as part of the International Recruitment programme.

Mrs Cooper advised that the service had carried out a successful 15 steps programme which included some fathers, Mr Curry and BAME representatives.

The CQC recommendations were being reviewed and actions implemented and monitored at the Maternity Incident Review Oversight Group.

Mr Lyons offered the Board's support to Mrs Cooper and the service adding that it was important to help get the teams and service into a better place.

8.3 Learning from deaths
Prof Purva presented the report and highlighted that SHIMI was improving and the Trust was no longer an outlier. There had been further improvements in Sepsis, Pneumonia and Stroke services and Subject Judgement Reviews were ongoing and slightly higher than usual.

Quality Improvement projects and interventions relating to Sepsis were in place and the Trust had invested in additional sepsis nurse support to assist with training and the steering group.

There was also a Quality Improvement project to review trauma mortality data and the common themes, one being fluid balance issues.

The Medical Examiner service was improving along with the completion of death certificates.

Mr Bond asked when the programme outcomes and results would be expected and Prof Purva advised that the data was now available to tracking it would be much easier. Changes seen over the next 6 months would be key before the winter pressures arrived.

8.4 Quality Committee Summary
Mr Robson advised that Prof Macloed was now Chair of the Committee and he had joined as the NED.

Mr Robson advised that the Committee had discussed the Consultant cover in ED during the Junior Doctor strike and how this had impacted

on patient flow due to quick and efficient decision making. Mr Long advised that it was key to balance JD training and consultant input and Prof Purva reminded the Board that elective work had been cancelled during the strike which also had an impact.

9.1 Our people
Mr Nearney presented the report and advised that sickness absence had reduced from 6.7% to 4.4%.

The Agenda4Change one off pay award and increase would be going through although the Junior Doctor pay increase was still being discussed. This meant more strike action was likely.

The vacancy position was at 1.7% and this included international nurses.

The Group CEO interviews were being held 16 May 2023.

Mrs Rostron advised that the 90 Projects programme was working really well and was going to incorporate the Human Factors training in the future.

Prof Purva advised that a Junior Doctor Quality Improvement event was being held in May 2023.

9.2 Workforce Education and Culture Summary Report
Mr Nearney presented the report and advised that the key issue discussed was the Staff Survey results. An 8 point action plan was in place and the issues were being tackled on both the North and South bank.

Mr Nearney spoke of the e-rostering programme and how some doctors were still using paper methods. Mr Bond asked how long it would be before the programme was completed and Mr Nearney advised that it would take a year. Mrs McMahon expressed her concern regarding the length of the programme and Mr Nearney advised that a cultural shift was also required which took longer.

Ms Mizon joined the meeting

10   Performance Report
Ms Mizon advised that work was ongoing to meet the trajectory of the 4 hour delivery target, the Trust had been stepped down from Tier 1 to a Tier 2 for elective and cancer recovery.

Outpatient follow up work was developing and transformational and the Day Case Surgery Unit at Castle Hill was commencing well.

Ms Mizon advised that she was working with the Hull PLACE director to review Primary Care delivery and support.

10.1 Finance Report Month 12
Mr Bond advised that the draft accounts were now being prepared and

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that the Trust had ended the year with a surplus of £68k.

Mr Bond added that the main concern was the underlying position of £52.1m which was made up of non-recurrent CRES and additional in-year pressures.

The Month 1 financial position was showing a £1.5m deficit which was made up of £600k for the Junior Doctor strike and £900k of Health Group unidentified CRES.

10.2 Performance and Finance Summary
Mr Robson presented the summary and advised that the items had been covered off during the meeting.

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**
	There was no other business discussed

14	**Date and time of the next meeting:**
	Tuesday 11 July 2023, 9am – 12pm

Hull University Teaching Hospitals NHS Trust
Minutes of the Extra Ordinary Trust Board to approve the Annual Accounts 2022/23
Held on 21 June 2023

Present:	Mr S Lyons	Chairman	
	Mr S Hall	Vice-Chair	
	Mr T Curry	Non-Executive Director	
	Mr M Robson	Non-Executive Director	
	Dr A Pathak	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	
	Mr S Nearney	Director of Workforce and OD	
	Mr I McConnell	Joint Director of Strategy	
	Mr J Johal	Joint Director of Estates	

In attendance:	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies:**	

Apologies were received by Mrs T Christmas, Non-Executive Director, Prof U Macleod, Non-Executive Director, Mrs S Rostron, Director of Quality Governance, Mrs E Ryabov, Chief Operating Officer, Mrs S McMahon, Joint Chief Information Officer

2   Declarations of Interests
2.1 Changes to Directors' interests since the last Meeting
There were no declarations made.

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

3   Audited Accounts 2022/23
3.1 Audit Findings Report (Mazars)
Mr Bond presented the Audited Accounts and findings report from Mazars, the Trust's external auditors.

He advised that turnover had increased to £846m, the adjusted deficit of £7m meant the Trust had a surplus of £74k with £53m in the bank and there had been significant investment of £44m relating to fixed asset additions.

There was £39m of PFI obligations remaining with last year's unitary payment being £13m. There was a 9 to 13 year commitment left of PFI payments.

Mr Bond added that the £425 provision to NHS Resolution had reduced to £323m.

Mr Robson reported that the Audit Committee had accepted the Accounts and recommended approval by the Trust Board. He added

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that there were final checks being carried out and requested that the Board delegated authority to Mr Bond to make any final changes to the Accounts.

Mr Hall asked about 2023/24 preparations and Mr Bond advised that provisions were being made for any known issues. He added that there would be financial pressures relating to the pay and non-pay awards in 2023/24.

Mr Lyons asked about the misstatement extrapolation techniques and Mr McConnell advised that this was a popular crude technique to test the confidence level of the Auditors.

Mr Bond advised that the External Auditors had added an opinion as part of the Value for Money section of their statement relating to the risks around the CQC inspection, the section 31 letter and the inadequate rating for safe. He reported that this was consistent with the Annual Governance Statement.

Mr Robson advised that the Annual Governance Statement had been presented by the Chief Executive Officer at the Audit Committee, had been reviewed by both sets of Auditors and was recommended for approval by the Board.

Resolved:
- *The Board approved the accounts and agreed to delegate responsibility to Mr Bond to make any final changes necessary. This would not include major changes to the Accounts.*

- *The Board approved the Annual Governance Statement*

4   Letter of Representation
Mr Bond presented the letter of representation. He advised that the letter was drafted by the External Auditors and was standard to all Trusts.

Mr Robson advised that the Audit Committee had recommended approval of the letter.

Resolved: The letter of representation was approved by the Board.

5   Annual Report 2022/23
Mrs Thompson presented the annual report and advised that subject to any changes following the Accounts audit, the Annual Report would be prepared for publication on the Trust's website.

Subject to minor typo corrections, it was agreed that the report could be taken forward to the next stage ready for publication.

The Board agreed that the Annual report was a great showcase for the Trust and was reflective of the challenges and the extensive investments in the last year. He thanked all contributors for their hard work.

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6   Any Other Business
There was no other business discussed.

3

REFERENCES

X 4.2 - Trust Board Work Programme 2023.xlsx

REFERENCES

📕 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								
June 2023				BAF 3.2: Patient Harm/Recovery	BAF 4: Risks to recovery plan				Staff Survey
August 2023		BAF 1: Board Leadership/ Leadership and culture						BAF 7: Financial sustainability	Board Assurance Framework
October 2023			BAF 2: Staffing	Waiting list ensuring patient safety - MP		BAF 5: ICS			IPC
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

📄 4.5 - Action Tracker July 2023.pdf

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

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
May 2023						
01/05	Patient Story	Patient backlog Board Development session date to be agreed	MP	October 2023		
02/05	CQC Update	Ground Floor model Board Development session date to be agreed	SL/RT	August 2023		
		Quality Committee CQC focus meeting invite to all Board Members	RT	August 2023		
03/05	Board Assurance Framework	BAF development session to be held at the August Board Development session	RT	August 2023		
04/05	Maternity Update	Monitoring growth restriction missed cases – update to the Board	LC	September 2023		
COMPLETED						
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		

Actions referred to other Committees

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

1

REFERENCES

📄 2023 07 04 Chief Executive report July 2023.pdf

Hull University Teaching Hospitals NHS Trust

Trust Board

11th July 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:	Day Surgery Centre, rehab plan for Covid patients, external visitors to solar field	

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

1

Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 11ᵗʰ July 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 opens new ultra-modern Day Surgery Centre
In May the Trust was delighted to announce the opening of our state-of-the-art Day Surgery Centre. The £10 million Centre will support our elective recovery programme in addressing the challenges posed by the backlog of surgical cases resulting from the Covid-19 pandemic.

Located at Castle Hill Hospital, the facility marks the first phase of expansion, introducing four new cutting-edge theatres into operation, enhancing the Trust's capacity to deliver high-quality care and expedite surgical procedures for patients with surgery as a day case as the default.

The Centre will provide additional theatre capacity at for patients across Hull and the East Riding and beyond, who need a planned procedure. The Centre includes pre-assessment facilities ensuring a seamless transition for patients requiring day case surgery, reducing waiting times and improving overall patient experience from booking to recovery.

The four new theatres have been designed to provide an optimal environment for both patients and medical professionals, incorporating the latest advancements in medical technology and patient care. The theatres will open on a phased basis – phase one ENT & MaxFax; phase two Breast & Vascular; phase three orthopaedics and phase four neurosurgery. This will be done on a rolling two-week programme with patients already booked in to receive their pre-assessments.

Phase one of the Day Surgery Centre is part of a comprehensive expansion plan, with the second phase set to further bolster the Trust's surgical capabilities with 10 theatres.

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

2

RESEARCH, DEVELOPMENT AND INNOVATION

New research trial shows rehab plan for patients recovering from Covid-19 improves physical and mental health
A research trial has been completed by the University of Hull, Hull York Medical School and Hull University Teaching Hospital NHS 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.

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.

HUTH IR Consultants travel to India to share skills

In a significant collaboration, a team of IR consultants from the Trust and the Christian Medical College in Vellore recently led an Interventional Radiology (IR) advanced practice course on vascular interventions in India.

This pioneering initiative provided postgraduate trainees in IR with the opportunity to enhance their knowledge and skills in the field. The course marked a crucial milestone in advancing IR practices and fostering international cooperation in medical education between the two healthcare providers.

HUTH and CMC Vellore have a long and well-established relationship with teaching visits which began in 1998 to encourage further development of IR and higher studies in diagnostic imaging. Across India, IR is still a very new specialty and there is notable under provision of services except in major centres.

IR is a rapidly evolving field that employs minimally invasive techniques to diagnose and treat a wide range of medical conditions including stroke, pulmonary embolism and aortic aneurysms. It involves using image-guided procedures to perform therapeutic interventions within the body, eliminating or reducing the need for traditional open surgeries. The benefits of these techniques include reduced patient trauma, shorter hospital stays, quicker recovery times, and improved outcomes overall.

The collaboration between our Trust, which enjoys one of the best reputations in the UK for IR and the CMC brought together experts from both organisations, to facilitate the sharing of knowledge, expertise and best practices, to enrich the educational experience for participants.

ZERO30

Visitors welcomed for fact-finding mission
Colleagues from our estates and capital teams welcomed a very special set of visitors to Castle Hill Hospital during June.

3

Representatives of Reckitts and the Oh Yes! Net Zero collaborative visited Cottingham to see our solar field and learn from our experience of setting it up.

The Trust joined the Oh Yes! Zero (OYNZ) collaborative just over a year ago as an outward demonstration of our commitment to sustainability issues and in order to share learning and best practice. OYNZ is made up of businesses and organisations from across the Hull and Humber region, public and private sector, working together to reduce carbon emissions and promote positive change.

Alex Best, Marc Beaumont, Nick Harrison and Tom Wilson from the Trust were on hand to share our learning from the solar field construction, including bidding for funding, cleaning and maintenance, supply chain issues and the additional challenges which Covid-19 brought about.

A team of Reckitts' estates and engagement staff joined their Global Public Policy & Stakeholder Management Director, Peter Edwards, on the visit, which took in both solar fields A and B plus a look behind the scenes in the inverter rooms.

2.   MEDIA/SOCIAL MEDIA ACTIVITY
In May there were 47 articles published/broadcast about the Trust, with a target of 80% positive coverage:
- 36 positive (88%)
- 1 factual (2%)
- 4 negative (10%)

Social media
Facebook
Total "reach" for Facebook posts on all Trust pages in May – 237,363
Hull Women and Children's Hospital – 72,220

Castle Hill Hospital – 57,458
Hull Royal Infirmary – 86,788
Hull University Teaching Hospitals NHS Trust – 20,897

Twitter @HullHospitals
380,000 impressions in May 2023
10,899 followers
Tweets with highest number of impressions related to the opening of our junior doctors mess and the retirement of Pat Watts, midwifery assistant, after 66 years' service

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REFERENCES

📄 6.1 Joint Development Group CIC Summary to the Board.pdf

Report to the Board in Public
Group Development Committees in Common
held on 31 May 2023

Item: Humber Acute Services Review update	Level of assurance gained: Reasonable
The HASR was at a critical stage and that the consultation would be in either July or September 2023. The proposals would be presented to the ICB Board in June and July for consultation approval. He added that the consultation was not a provider led but a commissioner led programme. Key risks: Delays in the progress due to the General Election	
Item: Progress with the Humber Clinical Collaboration Programme	Level of assurance gained: Reasonable
There were still 10 fragile services and the governance structures, which had multiple layers, were being reviewed. There would be a focus on Cardiology and Neurology to ascertain what went well and any to capture any learning. ICS clinical networks also had a part to play regarding local and system performance. Both CMO's were working with their consultant bodies to keep the momentum going and encourage the joint working arrangements.	
Item: Development of the Group Leadership Model	Level of assurance gained: Reasonable
The Committee discussed the Group Leadership Model and the work relating to the Governance workstreams. The new Committees in Common structure was discussed and it was agreed that rather than having two separate Audit Committees there would be one.	

AUDIT COMMITTEE SUMMARY

REFERENCES

📄 6.2 - Audit Committee Summary to the Board - June 2023 - Public.pdf

**Report to the Board in Public
Audit Committee June 2023**

Item: Audited Annual Accounts 2022/23	Assurance: Good
The audited Annual Accounts for 2022/23 were received, with the main changes to the draft accounts highlighted to the Committee but also noting that the overall financial position had not changed from the draft accounts. The Chief Financial Officer drew out the headlines including the fact that the Trust's turnover had increased again this year. The audited Annual Accounts were endorsed by the Committee for recommending approval/formal sign off to the Trust Board meeting taking place immediately after the Audit Committee meeting on 21 June 2023.	

Item: Audit Completion Report / Letter of Representation 2022/23	Assurance: Good
The Trust's External Auditor gave an unqualified opinion, without modification, on the Trust's financial statements for 2022/23. One VFM significant weakness was reported in relation to the 2022 CQC Inspection findings, and the External Auditor recommended that the Trust needs to fully address the issues identified by the CQC. The Committee were content to endorse the Management Letter of Representation for formal signing by the Chief Executive.	

Item: Annual Governance Statement 2022/23	Assurance: Good
The final version of the Annual Governance Statement (AGS) was presented by the Chief Executive. No further comments were received and the Committee approved the AGS for inclusion in the Trust's Annual Report.	

Item: Annual Internal Audit Report inc. Head of Internal Audit Opinion 2022/23	Assurance: Good
The draft Annual Internal Audit Report was presented to the Committee, with three reports requiring finalisation (currently at draft report stage). The final Head of Internal Audit Opinion (HOIAO) remained unchanged from the draft received at the April Audit Committee meeting – namely, a positive opinion (adequate and effective framework for risk management, governance and internal control, with further enhancements identified to ensure it remains so).	

Item: Trust Annual Report 2022/23	Assurance: Good
The Trust's Annual Report 2022/23 was received by the Committee and advised that it was virtually complete, had been reviewed by the Auditors and would be sent to the Communications Team for formatting / publication in due course.	

REFERENCES

Only PDFs are attached

📕 6.3 -Year end Governance Review 202223 - SR comments.pdf

📕 Appendix 6.1 Committee Effectiveness 2022 23.pdf

📕 6.3.2 - NED roles March 2023.pdf

📕 6.3.3 - Stat and Mand Roles July 23.pdf

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	11.07.23
Title		Board and Committee Year-End Review			
Lead Director		Suzanne Rostron, Director of Quality Governance			
Author		Rebecca Thompson, Head of Corporate Affairs			
Report previously considered by (date)		This report to be considered by the Board annually			

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

Key Recommendations to be considered:

The Trust Board is requested to:
- review the contents of the report and request any further information or assurance as required.

Year-End Board and Committee Review

1. Purpose of the paper

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

2. Board Committee Review

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

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

The minutes of each of the Committees are reviewed by the Audit Committee at each meeting to ensure that all Committees are discharging their responsibilities in line with their Terms of Reference. There have been no issues raised at the Audit Committee in 2022/23.

2.1 Quality Committee

The Quality Committee had a discussion around assurance at its May 2023 meeting and the Chair raised concerns that the committee was not effective due to the changes in priorities, such as the recent CQC inspections, and needed to consider how to become more effective and reactive with the correct assurance.

Following this discussion an in-depth review of effectiveness, highlighting reports received at the Quality Committee as well as the Board and other Committees was presented to the June 2023 Quality Committee.   It was requested that there was a focus on what the Quality Committee knew about maternity and ED and what was escalated to Board. This is summarised in the table below:

The following table shows what we knew and discussed in 2022/23.

ED	Maternity	Surgery
Enhanced monitoring (NHSEI) for Quality in relation to Urgent and Emergency Care since May 21 with regular updates to Quality Committee. These meetings stopped whilst the ICB were building their structures. Risk of overcrowding in ED raised to 25 in October 2022 – the only risk on the risk register to have this rating. HUTH's version of the Bristol Model was the immediate response to this. A cluster of SIs in ED in October 2022 demonstrating harm caused by failure to monitor the deteriorating patient. Consistent non-achievement of A&E targets. 12 hour breaches following years of this never happening.	NSHEI external review of Ockenden actions positive – however an action arising from this was the implementation of BSOTS via Badgernet. This has been delayed on a number of occasions. Quarterly reports (as required for CNST and Ockenden) detailing PMRT outputs. All maternity SIs to the Trust Board. East Kent presentation to QC and Board (Oct and Nov 22) – clearly showing similarities in some areas. Maternity Thematic Review presented to QC in November 2022 – again with the action to implement BSOTS. IVF footprint agreed to be used to separate ADU and triage – lengthy delays due to being a PFI building	Enhanced monitoring (NHSEI) for Quality in relation to elective recover since May 21 with regular updates to Quality Committee. These meetings stopped whilst the ICB were building their structures. 7 Never Events Thematic review of Never Events to QC. Negative internal assurance visit. Lowest staff survey results since 2015 (which then deteriorated further)

ED	Maternity	Surgery
Between 170-200 no criteria to reside patients continuously. Lowest staff survey results since 2015 (which then deteriorated further) Whistleblower to the CQC August 2022	Medical staffing challenges regularly raised with a plan to address over a number of years – the ask was for 12 additional consultants which could not be met immediately. Board approval to pause continuity of carer due to patient safety and not enough midwives to run the service. Poor patient survey. Lowest staff survey results since 2015 (which then deteriorated further) High profile case striking a midwife off the register highlighting the cultural challenges in the department. Whistleblower to the CQC (October 2022) Cultural programme and leadership development in response to cultural concerns	

The Committee was asked what further information or changes in presentation could be made going forwards. This discussion resulted concluded the following:

- Escalation to the Board: whilst this had occurred, it could be strengthened. For example, the East Kent gap analysis provided clear examples of similarities and differences with HUTH. However, the assurance rating was on the process that had been undertaken rather than on the findings. This is something the Committee and Chair will review.
- A suggestion was made that further detail on the risk register would be useful, particularly for high risks. Whilst the Committee was aware that the overcrowding in ED was the only risk rated 25 and that the Trust was under enhanced monitoring since May 21 with the then CCG and NHSEI prior to the ICB forming, it agreed that more time to discuss this risk could have been helpful.
- On reflection the Committee concluded that the ED CQC findings were not unexpected but despite receiving a significant amount of maternity information and the key findings of the CQC being included in these reports the S31 was not expected. A discussion was held about highlighting key parts of the reports to help distil this information.

The Trust's standard effectiveness questionnaire and scores was also presented which showed that, onthe whole, the Quality Committee was effective. However, it was agreed that 2 hours was no longer sufficient to cover the agenda. This has been extended to 2.5 hours in the first instance.

In response to the feedback received, a number of actions were agreed. The actions were:
- Papers to be received at least 5 days before the meeting to give members time to read them
- Information packs to include the monthly Quality Report and any detail behind the deep dives (e.g. Quality Improvement Plan and any associated reports to other committees)
- CQC report to be presented as the presentation to the Quality Improvement Group. This will incorporate the deep dives related to the CQC for that month (again the full

report and appendices will be provided but will be taken as read with the presentation highlighting key issues and committee members expected to ask questions)
- Expectation that all Committee members liaise with their Executive sponsor with responsibility for their area as to what their report/presentation should contain when asked to present information or prepare a deep dive

The paper received by the Quality Committee is attached at the appendices.

The Quality sub-committees are the operational committees and relevant information is escalated for assurance to be gained.
The Sub-Committees are:
- Operational Risk and Compliance Committee
- Patient Experience
- Patient Safety and Effectiveness Committee
- Non-Clinical Quality Committee

3. Board
The Trust Board met on 10 occasions during 2022/23, including an extraordinary Trust Board meeting in June 2022 to approve the annual report and accounts. A record of attendance is kept for each Board meeting and is attached to each Board agenda.

The Board has also met jointly with NLAG as part of the Group Model and work continues in relation to the governance work streams and Board and Committees in Common.

4. Executive and Non-Executive Director Roles
Appendix B shows the Executive and Non-Executive roles in 2022/23.

5. Meeting Dates 2023/24
Due to the commencement of the Group Model and the new Board and Committees in Common, the dates for 2023/24 have not yet been finalised.

The dates will be approved by the Joint Board and then circulated for inclusion in diaries.

6. Recommendation
The Trust Board is requested to:
- review the contents of the report and request if any further information or assurance is required.

Rebecca Thompson
Head of Corporate Affairs
July 2023

AUDIT COMMITTEE

TERMS OF REFERENCE

1   **Constitution**

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

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

1.3   **Quoracy**
        A quorum shall be two members. A quorum must be maintained at all meetings.

1.4   **Attendance**
        (a)   The Chief Financial Officer, Director of Quality Governance, Head of Corporate Affairs, Head of Internal Audit, the Trust's nominated Local Counter Fraud Specialist and representatives of the External Auditors shall normally attend meetings advising the Committee on pertinent issues / areas.

        (b)   The Committee will meet in private with External and Internal Auditors without any Executive Directors or members of the Trust staff present at least once a year. Other private meetings will take place at the request of members or Auditors.

        (c)   The Head of Internal Audit, representatives of External Audit and the Local Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

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

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

        (f)   The Assistant Director of Finance – Compliance and Counter Fraud shall be Secretary to the Committee and shall provide appropriate support to the Chair of Committee and its members.

1

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

2   Authority

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

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

3   Role and Purpose of the Audit Committee
        The general duties of the Committee are to support the Board by:

        • Assessing the Trust's overarching framework of governance, risk and control

        • Obtaining assurances about the design and operation of internal controls

        • Seeking assurances about the underlying data (upon which assurances are based) to assess their reliability, security and accuracy

        • Challenging poor and/or unreliable sources of assurance

        • Challenging relevant managers when controls are not working, or data are unreliable

        The duties / responsibilities of the Committee are categorised as follows:

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

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

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

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

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

        (d)   The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications.

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(e)   The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (NHSCFA).

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

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

3.2   **Power to seek reports and assurances**
In carrying out this work the Committee will primarily utilise the work of Internal Audit, Counter fraud, External Audit and other assurance functions, but will not be limited to these sources. It may also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. The Committee will receive the minutes of the Board's Performance and Finance Committee, Quality Committee, Workforce, Education and Culture Committee and Charitable Funds Committee to inform its assurance work.

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

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

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

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

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

(d)   To review progress on implementing internal audit recommendations within agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the Committee can request the relevant operational manager to attend a meeting and give explanation.

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

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

3

3.4   **External Audit**

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:-

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

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

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

(d)   Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken alongside the annual audit plan together with the appropriateness of management responses.

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

(f)   Establishing a clear policy for the engagement of external auditors to supply non-audit services, and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

3.5   **Risk Management**

The Committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the Committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies

- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks

- Overseeing actions plans relating to regulatory requirements in terms of the NHS Oversight Framework and Use of Resources

- Providing the Board with assurance over developing partnership arrangements (e.g., integrated care systems) and mitigation of risks which may arise at the borders between such organisations. The Health and Care Act 2022 introduced new requirements for NHS bodies to work together to meet joint financial objectives and duties, and as such the Audit Committee will need to take a wider view when considering audit and assurance. Organisations need to agree together how best to recognise and manage risk across a system, including what assurances the Audit Committee will need and where these will come from

The Board will however retain the responsibility for routinely reviewing specific risks.

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3.6   **Financial Reporting**

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

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

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

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

(d)   Letter of Representation.

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

(f)   Significant adjustments resulting from the audit.

(g)   Explanations for significant variances.

3.7   **Other Assurance Functions**

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

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

3.7.3   The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud that meet the NHSCFA's standards and shall review the outcomes of counter fraud work. The Committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist and shall also receive regular progress reports on counter fraud activities.

3.7.4   The Committee will seek annual assurance that a current, clear and effective Whistleblowing or Protected Disclosures Policy is in place and that all Trust staff have access to this policy. One Non-Executive Director under the current policy (reference CP169) will be one of a number of internal contacts available to consult and be the "Whistleblowing Champion" of the Trust. The Trust's Freedom to Speak Up Guardian, or his or her nominated deputy, shall attend the Committee at least annually to provide assurance on the design and operation of the function.

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

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3.8 **Reporting**

3.8.1 The minutes of each Audit Committee meeting shall be submitted to the next meeting for formal approval as a true record of that meeting and submitted to the next meeting of the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

3.8.2 The Committee will report to the Board annually to describe how the Committee has fulfilled its terms of reference and its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and effectiveness of risk management in the organisation and the integration of governance arrangements.

3.8.3 The Committee will maintain an annual workplan capturing its main items of business at each scheduled meeting. This will be updated throughout the year as the Committee sees fit. Ad-hoc reports, in addition to those set out in its work plan, may also be requested by the Committee as necessary.

3.9 **Administration**

The Committee shall be supported administratively by the Assistant Director of Finance – Compliance and Counter Fraud. Their duties in this respect will include:

- Agreement of each agenda with the Committee Chair;
- Arranging secretarial support for the collation of papers and taking of the minutes;
- Keeping a record of matters arising and issues to be carried forward (action log);
- Advising the Committee on pertinent issues;
- Enabling the development and training of Committee members.

Agenda papers will be circulated to all members of the Committee no less than seven calendar days prior to each meeting. Late papers may only be circulated, or tabled at the meeting, with the prior approval of the Chair.

4 **Monitoring Compliance with these Terms of Reference**

4.1 In accordance with the requirements of good governance and in order to ensure its ongoing effectiveness, the Audit Committee will undertake an annual evaluation of its performance and attendance levels.

4.2 The Committee will carry out an annual self-assessment exercise that is based on the good practice guide found in the HFMA NHS Audit Committee Handbook (HMFA, 2018 and 2022 Supplement).

4.3 As part of the annual evaluation process, the Committee will formally review performance against core duties, completion of the actions outlined in the action log and effectiveness of the work programme.

4.4 Where gaps in compliance are identified arising from this evaluation, an action plan will be developed, and implementation will be monitored by the Committee.

4.5 The results from the annual evaluation exercise, including any agreed actions, will be reported to the Trust Board for information.

4.6 The Assistant Director of Finance – Compliance and Counter Fraud and the Chair of the Committee have a joint responsibility for ensuring compliance with these Terms of Reference. Any member or person in attendance who considers

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compliance with these Terms of Reference is at risk should bring their concerns to the attention of the Assistant Director of Finance – Compliance and Counter Fraud.

5   Review

The Committee will review its Terms of Reference annually, or as necessary in the intervening period, to ensure that they remain fit for purpose and best facilitate the discharge of its duties. It shall recommend any changes to the Trust Board for approval.

Next Scheduled Review date: April 2024

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HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

AUDIT COMMITTEE WORK PLAN

Item of Business	Apr 23	Jun 23 (Public Disclosure Statements)	Jul 23	Oct 23	Feb 24
Audit Committee - Annual Review of Terms of Reference					X
Audit Committee - Annual Review of Work Plan					X
Audit Committee - Annual Self-Assessment Exercise & Results					X
Audit Committee - Annual Report to Trust Board		X			
Audit Committee - Annual meeting dates/times/locations for coming year			X		
Audit Committee - Annual Review of External Auditor Performance				X	
Private Discussion with Auditors (internal and external)	as needed	as needed	as needed	X	as needed
Receive minutes from Board Sub-committees	X		X	X	X
Receive half yearly governance report from Quality and Remuneration Committees	X			X	
External Audit - Audit Strategy Memorandum (Audit plan / timetable / fee)	X				
External Audit - Routine Progress Reports and Sector Updates	X		X	X	X
External Audit - Letter of Representation		X			
External Audit – Audit Completion Report (and follow-up of any recommendations)		X			
External Audit – Auditors Annual Report				X	
External Audit - Changes to service provider	as needed		as needed	as needed	as needed
Internal Audit - Review and approve Annual Internal Audit Plan	X				
Internal Audit - Routine Progress Reports	X		X	X	X
Internal Audit - Head of Internal Audit Opinion	X (Draft)	X (Final)			
Internal Audit - Internal Audit Annual Report / review of effectiveness (KPI's)		X			
Internal Audit - Receive Status Report on Implementation of IA Recommendations	-	-	X	X	X
Internal Audit - Changes to service provider	as needed	-	as needed	as needed	as needed
Public Disclosure Statements: Review changes to Accounting Policies					X
Update on Financial Overview and Going Concern	X				X
Draft annual accounts	X				
Audited annual accounts		X			
Annual Governance Statement	X (Draft)	X (Final)			
Trust Annual Report	X (update only)	X			

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Item of Business	Apr 24	Jun 23 (Public Disclosure Statements)	Jul 23	Oct 23	Feb 24
LCFS - Annual Counter Fraud Operational Plan	X				
LCFS - Annual Counter Fraud Report			X		
LCFS - Written Progress Reports	X		X	X	X
LCFS - Annual review of Fraud and Corruption Policy			X		
LCFS - Results of Staff Fraud Awareness Survey - every 2 years			X		
LCFS - Review effectiveness of Counter Fraud service			X		
Clinical Audit - Receive Annual Report inc. Annual Plan and Effectiveness Review			X		
Review of Single Source Tender Waivers and Contract Renewals	X			X	
Review of Losses, Special Payments and Write Offs	X (Q3 & Q4)			X (Q1 & Q2)	
Review of Gifts, Hospitality and Declarations of Interest			X		X
Review of Credit Card Spending	X		X	X	X
Review of Debts >£50k and over 3 months old	X (Q3 & Q4)			X (Q1 & Q2)	
Review of Legal Fees					X
Review Draft Quality Accounts	X				
Update on Quality Account Delivery (QIP Delivery)	X				
Clinical Negligence Claims (Claims Annual Report)			X		
IG Committee Highlight Report inc. Data Security and Protection Toolkit Report	X		X	X	X
Annual Review of Declaring Gifts and External Interests Policy	X				
Annual Review of Risk Management Strategy	X				
Annual Review of Board Assurance Framework (BAF) Process			X		
Annual Review of Whistle Blowing procedures / FTSU Guardian	X				
Annual Review of SFI's and Standing Orders				X	
Annual Review of Policy for Engagement of External Auditors for Non-Audit Work					X
New HFMA NHS Audit Committee Handbook Items – July 2018					
Cyber security – Review the Trust's information governance and cyber security arrangements annually *(Private agenda item)*	as needed	as needed	X	as needed	as needed
Mergers and acquisitions – review new arrangements	as needed	as needed	as needed	as needed	as needed
Working with regulators - oversee action plans relating to regulatory requirements (e.g. NHS oversight framework; use of resources)	as needed	as needed	as needed	as needed	as needed
Working at Scale – oversee developing partnership arrangements (e.g. ICSs)	as needed	as needed	as needed	as needed	as needed

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Hull University Teaching Hospitals NHS Trust

Agenda Item		Meeting	Audit Committee		Meeting Date	16.02.23
Title		Self-Assessment Review of Committee Processes – HFMA NHS Audit Committee Handbook, 2018				
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 previously received at the Audit 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 Committee is asked to review the self-assessment and consider if the evidence provided is sufficient to approve the document.

Hull University Teaching Hospitals NHS Trust

Audit Committee
Self-Assessment Review of Committee Processes – HFMA NHS Audit Committee
Handbook, 2018

1. **Purpose of the Report**
   The purpose of the report is for the Audit Committee members to consider the HFMA Audit Committee self-assessment and decide whether the evidence provided is sufficient for approval.

2. **Background**
   The HFMA NHS Handbook 2018 helps NHS audit committees review and continually re-assess their systems of governance, risk management and control to ensure it remains effective and fit for purpose.

3. **Self-Assessment Checklist**
   The self-assessment checklist is attached at Appendix 1 for review by the Audit Committee. Evidence to support the responses has been added in the comments sections by the Head of Corporate Affairs.

   There are 3 areas that will require further discussion, these are:

   - Does the head of internal audit have a right of access to the committee and its chair at any time? The answer to this question is yes but it is not outlined in the Terms of Reference.
   - Do those working on counter fraud activity have a right of direct access to the committee and its chair? The answer to this question is yes but it is not outlined in the Terms of Reference.
   - Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors? Northern Lincolnshire and Goole NHS FT have this policy in place and it is the intension that the Trust adopts this policy for approval in April.

4. **Next Steps**
   If the Committee is happy with the self-assessment, this will be adopted annually and will be presented to the Board following endorsement at the Audit Committee.

5. **Recommendation**
   The Committee is asked to review the self-assessment and consider if the evidence provided is sufficient to approve the document.

   Rebecca Thompson
   Head of Corporate Affairs
   February 2023

Audit Committee

Self-Assessment Review of Committee Processes - HFMA NHS Audit Committee Handbook, 2018

16 February 2023

Area/ Question	Yes	No	Comments/Action
Composition, establishment and duties			
Does the audit committee have written terms of reference and have they been approved by the governing body?	√		Last approved by the Trust Board in July 2022.
Are the terms of reference reviewed annually?	√		Part of the Committee's annual work plan. Next review will be April 2023 for approval by the Board in July 2023.
Has the committee formally considered how it integrates with other committees that are reviewing risk?	√		The Committee's ToR specifically refers to how it integrates with other Trust Board Assurance sub-committees. It received all risk and control related disclosures through the Annual Governance Statement and receives a Risk Management update annually.
Are committee members independent of the management team?	√		The Committee's membership comprises 3 Non-Executive Directors.
Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?	√		Summary reports submitted to Trust Board.
Does the committee prepare an annual report on its work and performance for the governing body?	√		The Trust Annual report (which includes the Audit annual report) is submitted to the Trust Board.
Has the committee established a plan of matters to be dealt with across the year?	√		Formal work plan is agreed in April annually.
Are committee papers distributed in sufficient time for members to give them due consideration?	√		Generally 5 working days before each meeting.
Has the committee been quorate for each meeting this year?	√		Yes all meetings in 2022 were quorate.
Internal control and risk management			
Has the committee reviewed the effectiveness of the organisation's assurance framework?	√		Through internal audit annual review. The Committee receive the BAF governance review annually.

Area/ Question	Yes	No	Comments/Action
Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?	√		Through minutes from other sub-committees.
Has the committee reviewed the accuracy of the draft annual governance statement?	√		The Committee endorses the AGS before it is presented to the Board in June.
Has the committee reviewed key data against the data quality dimensions?	√		External audit review performance indicators as directed by NHSI as part of their year-end audit work, and report the results accordingly to the Committee. The Committee also receives reports from Internal Audit on the outcome of reviews of targeted KPI's as part of the IA annual plan.
Annual report and accounts and disclosure statements			
Does the committee receive and review a draft of the organisation's annual report and accounts?	√		Annual Report and Annual Accounts are endorsed by the Committee before being approved at the Trust Board annually.
Does the committee specifically review: • The going concern assessment • Changes in accounting policies • Changes in accounting practice due to changes in accounting standards • Changes in estimation techniques • Significant judgements made in preparing the accounts • Significant adjustments resulting from the audit • Explanations for any significant variances?	√		Facilitated as necessary through reports from Finance / External Auditor and discussion at Committee meetings.
Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?	√		Yes this is part of the Annual Accounts discussions prior to submission to NHSE/I.
Does the committee ensure it receives explanations for any unadjusted errors in the accounts found by the external auditors?	√		Robust discussions involving annual accounts. Letter of Representation includes explanations for areas of non-adjustment.

Area/ Question	Yes	No	Comments/Action
Internal audit			
Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?	√		Yes, this is included in the Committee's TOR
Does the committee review and approve the internal audit plan, and any changes to the plan?	√		Annual and strategic plans are approved prior to the beginning of each financial year.
Is the committee confident that the audit plan is derived from a clear risk assessment process?	√		Plan derived from Internal Audit's individual discussions with Trust Board members, followed by discussion of draft plan at an Executive Team meeting.
Does the committee receive periodic progress reports from the head of internal audit?	√		At each meeting.
Does the committee effectively monitor the implementation of management actions arising from internal audit reports?	√		At each meeting.
Does the head of internal audit have a right of access to the committee and its chair at any time?	√		Yes, although this is not outlined in the TOR
Is the committee confident that internal audit is free of any scope restrictions, or operational responsibilities?	√		Could be raised at the annual private meeting between the auditors and the Committee.
Has the committee evaluated whether internal audit complies with the *Public Sector Internal Audit Standards*?	√		The TOR states that the work carried out will meet NHS Internal Audit Standards which is monitored and assurance given by the Trust's Internal Auditors
Does the committee receive and review the head of internal audit's annual opinion?	√		Yes, this is evidenced in the minutes of the Audit Committee.
External audit			
Do the external auditors present their audit plan to the committee for agreement and approval?	√		Audit Committee minutes will show that this is received and approved.
Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?	√		The Audit Completion Report at the end of the financial statements covers the requirements of ISA 260
Does the committee review the external auditor's value for money conclusion?	√		Audit Committee minutes will evidence this.

Area/ Question	Yes	No	Comments/Action
Does the committee review the external auditor's opinion on the quality account when necessary? **[Note: this question is not relevant for CCGs]**	√		Audit Committee minutes will evidence this.
Does the committee hold periodic private discussions with the external auditors?	√		Once a year if deemed necessary
Does the committee assess the performance of external audit?	√		On-going assessment by exception.
Does the committee require assurance from external audit about its policies for ensuring independence?	√		Formal confirmation in audit strategy/fee documentation.
Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?		√	This policy to be added in April 2023.
Area/ Question	**Yes**	**No**	**Comments/Action**
Clinical audit [Note: this section is only relevant for providers]			
If the committee is NOT responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?	√		The clinical audit annual Report is received by the Audit Committee for assurance
If the committee is responsible for monitoring clinical audit has it: • Reviewed an annual clinical audit plan? • Received regular progress reports? • Monitored the implementation of management actions? • Received a report over the quality assurance processes covered by clinical audit activity?	N/A	N/A	
Counter fraud			
Does the committee review and approve the counter fraud work plans, and any changes to the plans?	√		Plan agreed with Chief Financial Officer and received by the Audit Committee for review.
Is the committee satisfied that the work plan is derived an appropriate risk assessment and that coverage is adequate?	√		Counter fraud work plan informed by register of fraud risks, internal audit, NHS Counter Fraud Authority (NHS CFA) intelligence reports, etc.
Does the audit committee receive periodic reports	√		Standing agenda item for written counter fraud progress reports from

Area/ Question	Yes	No	Comments/Action
about counter fraud activity?			the LCFS at each Audit Committee meeting.
Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?	√		Audit Committee minutes will evidence this where appropriate.
Do those working on counter fraud activity have a right of direct access to the committee and its chair?	√		Yes, although this is not outlined in the TOR.
Does the committee receive and review an annual report on counter fraud activity?	√		Yes, this is evidenced in the Audit Committee minutes.
Does the committee receive and discuss reports arising from quality inspections by NHSCFA?	√		Audit Committee minutes will evidence this where appropriate.

Hull University Teaching Hospitals NHS Trust

Quality Committee

Terms of Reference

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

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

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

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

3.   **Membership of the Committee**
     The committee shall comprise:
     Non Executive Director (Chair)
     Non Executive Director (Vice Chair)
     2 x Non-Executive Directors + Associate Non-Executive Director (if determined by the Trust Chairman)

Chief Nurse
Chief Medical Officer
Chief Pharmacist
Director of Quality Governance
Lead Allied Health Professional
Patient Council Representative
Head of Corporate Affairs

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

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

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

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

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

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

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

7. **Attendance at meetings**
Other senior employees may be invited to attend by the chair, particularly when the committee is discussing an issue that is the responsibility of that employee. The following staff will be expected to attend meetings at the invitation of the Chair:
- Chief Operating Officer
- Health Group Triumvirate Directors
- Assistant Director of Information
- R&D Manager

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

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

9.   Agenda and action points

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

10.   Reporting arrangements

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

11.   Duties and Responsibilities of the Committee

The committee is required to fulfil the following responsibilities:

11.1   Meet the annual objectives of the committee.

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

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

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

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

12.   Authority

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

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

13.   Relationships with other committees

The committee receives escalation reports from the:
- Patient Safety and Clinical Effectiveness Committee
- Patient Experience Committee
- Operational Risk and Compliance Committee
- Non-Clinical Quality Committee

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

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

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

14.   Administration

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

Date previous approved by Trust Board: July 2022
Date updates received by Trust Board:
Review date: July 2023

QUALITY COMMITTEE WORKPLAN 2023/24

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

		1	2	3	4	5	6	7	8	9	10	11	12
Mental Health Patients	JL/KR				x				x				
Falls Annual Report	JL/ RH			x			x						
Tissue Viability	JL/ DF		x	x						x			
Neonatal	AM					x			x				
VTE	MP				x					x			
Medication Errors	JG		x				x						
Sepsis / Early Assessment	MP							x					
Work Stream Updates													
Theatres Work Stream inc NatSSips2 and Medicine Management	MP					x		x					
Consent Work Stream	MP					x		x					
Digital Work Stream				x				x		x			
Nutrition	JL							x				x	
Health Group Governance	SR					x			x				
Policies and Procedures	SR							x					

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Quality Committee		**Meeting Date**	26 June 2023		
Title		Quality Committee Effectiveness Review						
Lead Director		Suzanne Rostron, Director of Quality Governance						
Author		Rebecca Thompson, Head of Corporate Affairs						
Report previously considered by (date)		The report is considered annually by the Committee 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 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 Quality Committee is asked to: • Review the information in this report • Agree the proposed actions in item 6 • Decide if any further information/assurance is required.

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Hull University Teaching Hospitals NHS Trust
Quality Committee Effectiveness/Assurance 2022/23
June 2023

1. **Purpose of the report**
   To highlight the reports received by the Quality Committee for assurance purposes during 2022/23. To highlight other areas of assurance received at the Trust Board, Board Development, the NED meeting and Performance and Finance Committee.

2. **Background**
   In July 2022 the effectiveness review of the Quality Committee was presented to the Trust Board. The results were positive with comments including the alignment of the Board Assurance Framework to the work of the Quality committee and alignment of the Quality and Trust Strategies.

   The Quality Committee reviews the workplan at every meeting and can request any changes/additions at any time. There is also an annual review of the Terms of Reference.

3. **Assurance that the Quality Committee received 2022/23**
   Table 1 highlights the assurance received in 2022/23 at the Quality Committee.

Table 1.

Date Received	Committee/source of assurance	CQC Assurance	Maternity Assurance	ED Assurance	Cardiology Assurance	Never Events Assurance	Other Assurance
April 2022	Quality Committee	Quality Report BAF – Quality Risks CQC Update Quality Accounts		BAF – Quality Risks			
May 2022	Quality Committee	Quality Report		Enhanced monitoring – Quality Delivery Group paper	Cardiology Update		Learning from deaths ORCsC highlight report Ophthalmology SI thematic review
June 2022	Quality Committee	Annual Falls report	CNST Maternity Scheme Report Atain Report			Patient Safety Quarterly Update	Cardiology Update Report Dementia and Delirium

2

Date Received	Committee/source of assurance	CQC Assurance	Maternity Assurance	ED Assurance	Cardiology Assurance	Never Events Assurance	Other Assurance
		BAF – Quality Risks Safeguarding Report Quality Report					
July 2022	Quality Committee	CQC Update Report Safeguarding Adults/Children annual reports Quality Report					CQI and Quality Strategy IPC Quality Report ORCsC highlight report NCQC highlight report
August 2022	Quality Committee	Safeguarding report Quality Report	CNST Report PMRT Report MCOC Report PQSAG Report				Anti-microbial Stewardship Mortality and learning from deaths PSCEsC highlight report
September 2022	Quality Committee	Patient Safety Update Fundamental Standards Update Safeguarding Report Quality Report				Patient Safety Quarterly Update	CQUIN
October 2022	Quality Committee	Quality Report National Inpatient Survey Report CQC Update BAF Quality Risks	Neonatal Quality Indicators/GIRFT Update ATAIN CNST PMRT East Kent review				IPC Update Research and Innovation Update ORCsC highlight report NCQC highlight report PSCEsc highlight report
November 2022	Quality Committee	CQC Concerns Action Plan Quality Report Quality Strategy Safety Oversight Group TOR	Maternity Services Thematic Review		Cardiology Update Report		Learning from Morbidity and Mortality Risk Management Strategy ORCsc highlight report

3

Date Received	Committee/source of assurance	CQC Assurance	Maternity Assurance	ED Assurance	Cardiology Assurance	Never Events Assurance	Other Assurance
December 2022	Quality Committee	Quality Report Patient Safety Quarterly Update Safeguarding Report Clinical Effectiveness Update Quality Strategy CQC Report/urgent CQC concerns action plan Safety Oversight Group Assurance Report	CNST PQSAG	ED Assurance Report		Patient Safety Quarterly Update	Medical certificate cause of death delays PSCE highlight report NCQC highlight report
January 2023	Quality Committee	Clinical Effectiveness CQC Update Quality Report Safety Oversight Group Assurance		CQC – ED Assurance report			MD, LD and Autism Strategy IPC Report Risk Management Strategy CQUIN Update PSCEsc highlight report Complaints recovery plan
February 2023	Quality Committee	Quality BAF risks CQC report Safety Oversight Group report Quality Assurance visits Quality Report	ATAIN CNST PMRT	CQC ED assurance report			VTE Report Tissue Viability presentation PSIRF transition Learning from deaths Patient Experience and Engagement report PSCEsc highlight report

4

Date Received	Committee/source of assurance	CQC Assurance	Maternity Assurance	ED Assurance	Cardiology Assurance	Never Events Assurance	Other Assurance
March 2023	Quality Committee	CQC Report Quality Accounts Fundamental standards report Quality report Safety Oversight Group	CQC Maternity Action Plan	CQC ED assurance report		Patient Safety Update Report	IPC BAF ORCsc highlight report

4. Further Assurance

Table 2 highlights further assurance received by the Board and NEDs in 2022/23.

Table 2

Committee/source of assurance	CQC Assurance	Maternity Assurance	ED Assurance	Cardiology Assurance	Other Assurance
NED Meetings	CEO Update every meeting	East Kent Report Review of Maternity	CEO Update every meeting ED Action Plan		Staff Morale Zero 30
Weekly NED Flash Report			ED Performance Ambulance Handovers		Other performance indicators
Trust Board	CQC Reports	Maternity Reports, CNST, PMRT, ATAIN Ockenden Update, Maternity Sis	Performance Report, every meeting	TAVI presentation and review	Finance Report, every meeting BAF Report quarterly
Board Development	CQC Well-Led CQC Inspection		Patients with No Criteria to reside		Board Assurance Framework Strategic Objectives National Staff Survey Elective Recovery Mortality Health Inequalities Dementia PSIRP Antimicrobial Resistance Mental Health, Learning Disabilities and Autism Organ Donation
Performance and Finance			Performance Report, every meeting ED Presentation		Finance Report, every meeting BAF Report quarterly

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The following table shows what we knew and discussed in 2022/23.

ED	Maternity	Surgery
Enhanced monitoring (NHSEI) for Quality in relation to Urgent and Emergency Care since May 21 with regular updates to Quality Committee. These meetings stopped whilst the ICB were building their structures. Risk of overcrowding in ED raised to 25 in October 2022 – the only risk on the risk register to have this rating. HUTH's version of the Bristol Model was the immediate response to this. A cluster of Sis in ED in October 2022 demonstrating harm caused by failure to monitor the deteriorating patient. Consistent non-achievement of A&E targets. 12 hour breaches following years of this never happening. Between 170-200 no criteria to reside patients continuously. Lowest staff survey results since 2015 (which then deteriorated further) Whistleblower to the CQC August 2022	NSHEI external review of Ockenden actions positive – however an action arising from this was the implementation of BSOTS via Badgernet. This has been delayed on a number of occasions. Quarterly reports (as required for CNST and Ockenden) detailing PMRT outputs. All maternity SIs to the Trust Board. East Kent presentation to QC and Board (Oct and Nov 22) – clearly showing similarities in some areas. Maternity Thematic Review presented to QC in November 2022 – again with the action to implement BSOTS. IVF footprint agreed to be used to separate ADU and triage – lengthy delays due to being a PFI building Medical staffing challenges regularly raised with a plan to address over a number of years – the ask was for 12 additional consultants which could not be met immediately. Board approval to pause continuity of carer due to patient safety and not enough midwives to run the service. Poor patient survey. Lowest staff survey results since 2015 (which then deteriorated further) High profile case striking a midwife off the register highlighting the cultural challenges in the department. Whistleblower to the CQC (October 2022) Cultural programme and leadership development in response to cultural concerns	Enhanced monitoring (NHSEI) for Quality in relation to elective recover since May 21 with regular updates to Quality Committee. These meetings stopped whilst the ICB were building their structures. 7 Never Events Thematic review of Never Events to QC. Negative internal assurance visit. Lowest staff survey results since 2015 (which then deteriorated further)

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5. 2022/23 Effectiveness Review Results

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

Each Committee member has been asked to complete a questionnaire regarding the effectiveness of the Quality Committee. Responses are anonymous to give confidence in providing narrative comments as well as scores. The scores for each statement are from 1 (poor or never) to 5 (excellent or always). The amalgamated and averaged scores are attached at appendix 1 for review and verbatim comments have been included for the Committee's information below. The amalgamated scores show that the Committee is effective due to scoring being 3 and above, with the majority of scores being 4.

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

There are some narrative comments to draw the Committee's attention to:
- Open channels of communication – NED reporting to the Board to provide assurance could be strengthened
- Meetings and administration – current challenges/meet often enough but agenda content often large/the meeting meets often but the agendas are busy and sometimes difficult to get through
- Committee Chair - Recent change and recognises that time is a factor and is trying to establish processes to move this forward
- Risk and control frameworks - This is developing with new ways of working with PSIRF
- Composition - Internal skill mix seems right
- Meetings and administration – Time is a challenge, even allowing that paper are pre-read it is hard for all matters to be covered
- Quality and quantity of information – Lots of data which isn't always explained or summarised
- Timeliness of information – Items often arrive too late to properly review
- Agenda items – As a presenter to the committee it has been unclear what information is expected from an annual report or deep dive e.g presentation or report and timeframe to deliver
- Annual reporting – question not clear
- Managing Committee meetings and discussions – This is better now with in the room discussions but was difficult on teams
- Risk Management – Board Assurance Framework is presented quarterly/ICB quality attendance could be strengthened. Lay rep perhaps have 2 people to ensure attendance

These comments, once discussed at the Quality Committee will be presented to the Board in July and any improvements agreed will be actioned by the Corporate Team for the coming year.

6. Actions following the review

We are proposing the following actions to improve effectiveness in 2023/24

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- Papers to be received at least 5 days before the meeting to give members time to read them
- Information packs to include the monthly Quality Report and any detail behind the deep dives (e.g. Quality Improvement Plan and any associated reports to other committees)
- CQC report to be presented as the presentation to the Quality Improvement Group. This will incorporate the deep dives related to the CQC for that month (again the full report and appendices will be provided but will be taken as read with the presentation highlighting key issues and committee members expected to ask questions)
- Expectation that all Committee members liaise with their Executive sponsor with responsibility for their area as to what their report/presentation should contain when asked to present information or prepare a deep dive

7. Recommendations

The Quality Committee is asked to:
- Review the information in this report
- Agree the proposed actions in item 6
- Decide if any further information/assurance is required.

Rebecca Thompson
Head of Corporate Affairs
June 2023

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Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Quality Committee – amalgamated average scores (7 responses)

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

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

Behaviours

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

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

Processes

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

Agenda Item	Meeting	Performance and Finance Committee	Meeting Date	22.05.23
Title	Performance and Finance Committee Terms of Reference			
Lead Director	Suzanne Rostron, Director of Quality Governance			
Author	Rebecca Thompson, Head of Corporate Affairs			
Report previously considered by (date)	The TOR are considered annually by the 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 Committee is asked to:
- Consider the changes made in the document
- Agree the Terms of Reference and recommend approval at the July 2023 Trust Board

Hull University Teaching Hospitals NHS Trust

Performance and Finance Committee

Terms of Reference

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.14   To receive assurance on the work being undertaken in relation to GIRFT

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

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

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

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

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

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

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

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

4.   Membership of the Committee
The Committee shall comprise:

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

Other officers will be invited to attend the Committee to speak to specific agenda items:
• Director of Estates, Facilities and Development
• Director of Strategy
• Programme Director for Scan4Safety
• Joint Chief Information Officer

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

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

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

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

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

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

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

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

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

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11. Reporting Arrangements

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

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

12. Duties and Responsibilities of the Committee

The Committee is required to fulfil the following responsibilities:

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

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

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

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

13. Scheme of Delegation

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

Capital Cost	Approving Board / Committee
£3m+	Trust Board
£3m – Less than £3m	Performance and Finance Committee
£0.5m – Less than £2m	Executive Management Board
£5k – Less than £0.5m	Capital Resource Allocation Committee

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

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

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

14. Authority

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

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

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15.   Relationship with Other Committees

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

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

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

16.   Administration

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

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

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PERFORMANCE & FINANCE WORKPLAN 2023/24

		FEB	MAR	APR	MAY	JUN	JUL	SEPT	OCT	NOV	DEC	FEB	MAR
PLANNING													
Financial Planning Process inc budgets	SE	x	x								x	x	x
Operational Planning	JR		x				x					x	
Winter Planning Process	JR							x					
Long Term Financial Planning	SE												
Procurement Strategy	EJ								x		x		
IM&T inc. digital exemplar	SM				x							x	
Capital Planning 2023/24	AD	x											x
CONTRACTING													
Demand, Capacity and Activity													
PERFORMANCE													
Performance Report / Elective Recovery	ER	x	x	x	x	x	x	x	x	x	x	x	x
Screening Programme Update	JM		x			x		x			x		x
Changes in Performance Standards	ER				x								
FINANCE REPORTS													
Finance Report	SE	x	x	x	x	x	x	x	x	x	x	x	x
Productivity and Efficiency	SE							x					
Costing	AD						x						x
Nursing Workforce Meeting	JL					x						x	
ASSURANCE AND GOVERNANCE													
Board Assurance Framework	RT			x		x			x		x		x
Business Cases													
Investment and Disinvestment													
Capital Resource Allocation Committee	AD	x	x	x	x	x	x	x	x	x	x	x	x
Scan4Safety	RE	x					x					x	
Getting it right first time (GIRFT)	MP	x						x					
Contract Approval		x	x	x	x	x	x	x	x	x	x	x	x
Terms of Reference	RT				x								
Review of Committee Effectiveness	RT				x								

Hull University Teaching Hospitals NHS Trust

Agenda Item		Meeting	Performance and Finance Committee	Meeting Date	26.06.23
Title		Committee Effectiveness Review			
Lead Director		Suzanne Rostron, Director of Quality Governance			
Author		Rachel Boulton, Quality Governance Officer			
Report previously considered by (date)		The effectiveness review is carried out annually.			

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

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

Hull University Teaching Hospitals NHS Trust

Performance and Finance Committee

Committee Effectiveness Review

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

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

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

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

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

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

Areas scoring less than a 4 or 5 were:
- Quantity of information (no comment attached)
- Consideration of impact on patients and stakeholders (no comment attached)
- There are no surprises (no comment attached)
- Composition (largely made up of the Trust Board members)
- Timeliness (information is usually out of date due to data submission timeframes which are nationally mandated but members contribute with latest, most up to date additional information)
- Stakeholders (not sure who the stakeholders are and/or whether the contact is appropriate/the relationship with new ICS stakeholders is not yet mature)

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

Rebecca Thompson
Head of Corporate Affairs
June 2023

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Performance and Finance Committee

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

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

Behaviours

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

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

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.						x	
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.						x	
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee.						x	

	Question	N/A	1	2	3	4	5	Comment
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.						x	
5.	**Quantity of information** The quantity of information received is appropriate and helps Committee members fulfil their role.						x	
6.	**Quality of information** The quality of information received is appropriate and helps Committee members fulfil their role.						x	
7.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.						x	
8.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.						x	
9.	**Annual reporting** The Committee makes best use of its annual reporting.						x	
	Question	**N/A**	**1**	**2**	**3**	**4**	**5**	**Comment**
10.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.					x		The relationship with new ICS stakeholders is not yet mature
11.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.						x	

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Performance and Finance Committee

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

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

Behaviours

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

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

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.					X		
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.						X	
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee.						X	

		N/A	1	2	3	4	5	Comment
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.						X	
5.	**Quantity of information** The quantity of information received is appropriate and helps Committee members fulfil their role.					X		
6.	**Quality of information** The quality of information received is appropriate and helps Committee members fulfil their role.					X		
7.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.					X		
8.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.					X		
9.	**Annual reporting** The Committee makes best use of its annual reporting.					X		
	Question	**N/A**	**1**	**2**	**3**	**4**	**5**	**Comment**
10.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.					X		
11.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.					X		

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Performance and Finance Committee

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

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

Behaviours

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

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

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.				X			Largely made up of Trust Board members
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.					X		
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee.					X		

	Question	N/A	1	2	3	4	5	Comment
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.					X		
5.	**Quantity of information** The quantity of information received is appropriate and helps Committee members fulfil their role.					X		
6.	**Quality of information** The quality of information received is appropriate and helps Committee members fulfil their role.					X		
7.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.				X			Information is usually out of date due to data submission timeframes which are nationally mandated but members contribute with latest, most up to date additional information.
8.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.					X		
9.	**Annual reporting** The Committee makes best use of its annual reporting.				X			
	Question	**N/A**	**1**	**2**	**3**	**4**	**5**	**Comment**
10.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.							Not sure who the stakeholders are and/or whether the contact is appropriate
11.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.					X		

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Performance and Finance Committee

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

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

Behaviours

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

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

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.					X		
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.						X	
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee.						X	

	Question	N/A	1	2	3	4	5	Comment
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.					X		
5.	**Quantity of information** The quantity of information received is appropriate and helps Committee members fulfil their role.				X			
6.	**Quality of information** The quality of information received is appropriate and helps Committee members fulfil their role.							
7.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.					X		
8.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.					X		
9.	**Annual reporting** The Committee makes best use of its annual reporting.					X		
	Question	**N/A**	**1**	**2**	**3**	**4**	**5**	**Comment**
10.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.					X		
11.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.					X		

Hull University Teaching Hospitals NHS Trust

Trust Board Workforce, Education and Culture Committee

Terms of Reference

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

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

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

3.   Responsibilities

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

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

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

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

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

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

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

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

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

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

4. **Membership of the Committee**
   The Committee shall comprise:
   - Non-Executive Director (Chair)
   - 2 Non-Executive Directors (one of whom will be designated as vice chair)
   - Director of Workforce & Organisational Development
   - Chief Medical Officer
   - Chief Nurse Officer
   - Staff Side Representative

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

   Other officers will be invited to attend the Committee to speak to specific agenda items, which can include, amongst others:
   - Director of Post Graduate Medical Education
   - Director of Undergraduate Medical Education
   - Guardian of Safe Working
   - Freedom to Speak up Guardian

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

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

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

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

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

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

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

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

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

11. Reporting Arrangements

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

12. Duties and Responsibilities of the Committee

The Committee is required to fulfil the following responsibilities:

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

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

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

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

13. Authority

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

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

14. Relationship with Other Committees

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

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

15. Administration

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

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

Workforce Education and Culture Committee Workplan 2023								
AGENDA ITEM	WHO	13-Feb	03-Apr	12-Jun	24-Jul	09-Oct	11-Dec	12-Feb
People Strategy Performance Report	SN	x	x	x	x	x	x	x
RECRUITMENT AND RETENTION OF STAFF								
Variable Pay Report	SN	x						x
Nursing and Midwifery Staffing Report	JL	x	x	x	x	x	x	x
LEADERSHIP, CAPABILITY & CAPACITY								
Leadership Programme Update	LV		x			x		
Talent Management	LV		x					x
INNOVATION, LEARNING AND CONTINOUS IMPROVEMENT								
Apprenticeship Programme	LV	x		x		x		x
Medical Undergraduate Progress Report	RD			x				x
Medical Education Progress Report	JK					x		x
Non-Medical Learning and Development Progress Report	LV	x		x		x		x
Organisational and Cultural Development (National Staff Survey)	SN		x					
EQUALITY, INCLUSION AND DIVERSITY								
Workforce Race Equality Standard (WRES)	HK				x			
Workforce Disability Equality Standard (WDES)	HK				x			
Modern Day Slavery Report	SN				x			
Gender Pay Report	SN	x						x
LGBTQ+ Network Objectives (Update Report)	HK/ TR						x	
Equality Delivery System 2022 (EDS 2022)	HK/MJ	x						
Trade Union Facility Time Publication Requirements	HK			x				
Equality, Diversity and Inclusion (Annual Report)	HK/MJ		x					
HEALTH AND WELLBEING								
Covid and Flu Vaccination Progress Report	SN	x	x				x	x
Health and Wellbeing Programme Report	LV/MH					x		
Occupational Health Annual Report	CH				x			
Staff Support Services Update	LV	x		x			x	x
Menopause Steering Group	SR					x		x
EMPLOYEE ENGAGEMENT, COMMUNCATION AND RECOGNITION								
Freedom to Speak Up Guardian Report	FM		x		x		x	
Guardian of Safe Working Report	ML	x	x			x	x	x
Employee Relations Progress Report	SN		x	x				
Responsible Officer Report	MP					x		
Quarterly Staff Survey	SN/MH	x	x			x	x	x
MODERNISING THE WAY WE WORK								
Non-Medical E-Rostering (Project Update)	HK						x	
Medical E-Rostering (Project Update)	HK	x				x		
Remarkable Bank (Medical Staff)	HK							x
Consultant Job Planning	MP					x		
Governance								

Hull University Teaching Hospitals NHS Trust

Agenda Item		Meeting	Workforce, Education and Culture Committee	Meeting Date	
Title		Committee Effectiveness Review			
Lead Director		Suzanne Rostron, Director of Quality Governance			
Author		Amy Slaughter, Personal Assistant			
Report previously considered by (date)		The effectiveness review is carried out annually.			

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

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

Hull University Teaching Hospitals NHS Trust

Workforce, Education and Culture Committee

Committee Effectiveness Review

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

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

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

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

There were 5 responses submitted out of a possible 14. Each response gave a score to each question.

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

The areas that scored 3 or below were:

- Managing Committee meetings and discussions
- Consideration of impact
- Risk and control frameworks
- Committee Chairman

The responses and verbatim comments are shown in Appendix 1.

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

Amy Slaughter
Personal Assistant
June 2023

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Workforce & Education Culture Committee

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

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

Behaviours

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

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

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.						X	
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.						X	
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee..						X	
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.						X	
5.	**Quality and Quantity of information** The quality and quantity of information received is appropriate and helps Committee members fulfil their role.	X						Cannot comment
6.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.	X						Cannot comment
7.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.						X	
8.	**Annual reporting** The Committee makes best use of its annual reporting.	X						Cannot comment
9.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.	X						Cannot comment
10.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.	X						Cannot comment

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Workforce, Education and Culture

Key

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

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

Behaviours

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

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

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.					✓		
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.					✓		
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee..						✓	
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.						✓	
5.	**Quality and Quantity of information** The quality and quantity of information received is appropriate and helps Committee members fulfil their role.					✓		
6.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.					✓		
7.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.					✓		
8.	**Annual reporting** The Committee makes best use of its annual reporting.					✓		
9.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.					✓		
10.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.					✓		

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO:

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

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

Behaviours

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

	Question	N/A	1	2	3	4	5	Comment
7.	**There are no surprises** Committee members are kept fully informed of relevant sensitive and difficult issues.					X		
8.	**Committee Chairman** The Committee Chairman's leadership style and tone promotes effective decision-making constructive debate and ensures that the Committee works as a team.				X			AGENDA FELT VERY RUSHED AT THE END AND SOME IMPORTANT ISSUES NOT GIVEN ENOUGH TIME.
9.	**Decisions** After a decision has been made, it is clear who is responsible for implementing it, and by when.				X			
10.	**Attendance and contribution to meetings** All Committee members attend and actively contribute at meetings.					X		
11.	**Open channel of communications** The Committee has open channels of communication with the Board and others and is properly briefed.					X		
12.	**Risk and control frameworks** The Committee's approach to reviewing risk in the organisation is open and questioning, and looks to learning points from events, rather than blame.				X			

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.				X			
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.				X			
3.	**Secretariat**							

	The secretariat functions acts as an appropriate conduit for the provision of information to the Committee..				X	
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.				X	
5.	**Quality and Quantity of information** The quality and quantity of information received is appropriate and helps Committee members fulfil their role.				X	
6.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.				X	
7.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.				X	
8.	**Annual reporting** The Committee makes best use of its annual reporting.				X	
9.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.			X		
10.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.			X		

(handwritten note next to item 4) AGENDA RUSHED AT THE END OF THE LAST MEETING

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: WECC

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

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

Behaviours

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

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

Processes

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

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO:

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

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

Behaviours

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

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

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.						x	
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.						x	
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee..						x	
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.						x	
5.	**Quality and Quantity of information** The quality and quantity of information received is appropriate and helps Committee members fulfil their role.						x	
6.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.						x	
7.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.						x	
8.	**Annual reporting** The Committee makes best use of its annual reporting.						x	
9.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.						xx	
10.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.							

Hull University Teaching Hospitals NHS Trust

Remuneration Committee
Terms of Reference

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

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

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

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

2.1 Remuneration

2.1.1   To approve the terms and conditions of the Chief Executive, Chief posts and Directors that report directly to the Chief Executive in accordance with Trust policies and following consultation with the Chief Executive, including;
- Salary, including any performance related pay or bonus
- Provision for other benefits, including pensions
- Allowances

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

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

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

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

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

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

1

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

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

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

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

2.2 Nomination

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

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

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

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

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

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

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

3.   Membership of the Committee
The Committee shall comprise:
- Trust Chairman
- All Non Executive Directors

2

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

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

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

4. Chairman of the committee
The Chairman of the Committee will be the Trust Chairman

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

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

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

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

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

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

10. Duties and Responsibilities of the Committee
The Committee is required to fulfil the following responsibilities:

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

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

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

3

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

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

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

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

Approved by the Board: July 2022

4

Hull University Teaching Hospitals NHS Trust

Remuneration and Terms of Service Committee

Committee Work Plan 2023/24

Item	18/05/23	26/05/23	24/08/23	23/11/23	22/02/24
Workplan 2023/24		x			
New Chief, VSM appointments (as and when they occur)	x				
NHS Providers' salary benchmark information (taken at first meeting when new data available)			x		
Top 20 earners and gross pay over £100,000			x		
Annual pay gap audit				x	
Chief Executive direct reports' appraisals			x		
Committee review of effectiveness		x			
Chief Executive Appraisal			x		
Structure of Executive portfolios – strategic overview				x	
Pensions				x	
Succession planning (strategic/pipeline annual discussion)					x
Retention					x
Cost of Living – proposal for Execs for previous year		x			
Potential Redundancies (as and when required)	x				
Succession planning (as posts come available)				x	
Trust Pay, Terms and Conditions Group (as and when required)		x	x	x	x

Requirement to meet 4 times as a minimum per financial year

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Audit Committee		**Meeting Date**	27.04.23
Title		Update from Quality and Remuneration Committees on governance and control issues discussed				
Lead Director		Suzanne Rostron, Director of Quality Governance				
Author		Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)		The report is received twice per year at the Audit 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 requirement to review every half year any governance or control issues from the Remuneration or Quality Committees has come from the Audit Committee review of effectiveness
- There are no significant control issues identified through these Committees to date

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

1

Hull University Teaching Hospitals NHS Trust

Audit Committee

Update from Quality and Remuneration Committees on governance and control issues discussed

1. **Purpose of the paper**
    The purpose of this paper is to provide a review of the agenda items considered by the Quality and Remuneration Committees from October 2022 to April 2023 and to highlight any gaps in control or governance that have been raised.

2. **Introduction**
    As part of its effectiveness review and to reflect best practice, the Audit Committee agreed that it should receive a six-monthly update on any governance and/or control issues raised at these Committees. This was last received by this Committee in October 2022.

3. **Summary of any issues**
    Attached to this paper at Appendix 1 are the workplans showing scheduled agenda items at both Committees. The Audit Committee is welcome to ask any questions about specific details on any agenda item that might contain any governance or control issues.

    3.1 Remuneration Committee
    The Remuneration Committee has considered some agenda items that have required the correct application of governance and control measures in the last 6 months. This paper confirms that this has been successfully done and there are no issues of concern to report to this Committee.

    The specific agenda items that this has concerned have included the appointment of a joint Director of Workforce (with NLAG), details of the VSM pay uplifts, the top 20 earners and the joint Chief Executive appointment process, remuneration package and communications plan. The Committee have also approved an interim Joint Director of Strategy.

    3.2 Quality Committee
    The Quality Committee continue to review the Quality Improvements and a thematic review was presented relating to Maternity Services. Other deep dives included; Tissue Viability, Patient Safety Incident Reporting Plan, Patient Experience and Pharmacy and Medicines Optimisation.

    Following the Ockenden Report the Quality Committee have focussed on maternity incidents and actions in place following the review. The Board is also sighted on maternity incidents at each meeting.

    Following the CQC inspection in October in which Emergency Medicine, Medicine and Surgery were audited, regular updates relating to the action plan and implementation of actions are received and scrutinised by the Quality Committee.

    The Quality Committee regularly reviews Serious Incidents, patient falls, pressure ulcers, learning from deaths, patient safety incidents and any other emerging quality issues.

    The Committee summary report is reported to each Board meeting.

2

The Trust has reported 7 Never Events this financial year. This does not represent a gap in reporting or governance, but were clinical incidents that required reporting and investigation.

Themes and trends from Serious Incident and Near Misses are routinely reviewed at the Serious Incident Committee.

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

Rebecca Thompson
Head of Corporate Affairs
April 2023

3

Hull University Teaching Hospitals NHS Trust

Charitable Funds Committee

Terms of Reference

1. **Formation of this committee**

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

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

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

2. **Role**

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

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

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

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

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

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

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

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

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

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

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

3. Membership of the Committee
The committee shall comprise:
    Chairman (Non Executive Director)
    Non-Executive Director
    Chief Financial Officer

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

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

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

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

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

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

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

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

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

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

10. Reporting arrangements

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

11.   Duties and Responsibilities of the Committee

The Committee is required to fulfil the following responsibilities:

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

12.   Authority

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

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

13.   Relationships with other committees

This Committee does not receive minutes of other committees.

14.   Administration

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

Date revised by Committee: 18 May 2023

Date approved by the Trust Board:

Review date: May 2024

Hull University Teaching Hospitals NHS Trust
Charitable Funds Committee

Workplan 2022/23

	Nov 2022	Feb 2023	May 2023	Aug 2023	Nov 2023
Bids for general funds	✓	✓	✓	✓	✓
Fundraising Register	✓		✓		✓
Project Director's Report	✓	✓	✓	✓	✓
WISHH Progress Report		✓		✓	
Financial Report	✓	✓	✓	✓	✓
Fund balances	✓	✓	✓	✓	✓
Review of procedures & policies		✓			✓
Spending plans and Fund Balances review		✓		✓	
Legacy update		✓		✓	
Running Costs Budget		✓			
COIF	✓		✓		✓
Year-end accounts and annual Governance report	✓				✓
Other current or technical Issues - as applicable	✓	✓	✓	✓	✓
Internal Audit Report (as applicable)	✓				✓
Committee Terms of Reference review			✓		

Requirement to meet a minimum of three times per year

1

Hull University Teaching Hospitals NHS Trust

Agenda Item		Meeting	Charitable Funds	Meeting Date	18.05.23
Title		Committee Effectiveness Review			
Lead Director		Suzanne Rostron, Director of Quality Governance			
Author		Rachel Boulton, Compliance Manager			
Report previously considered by (date)		The effectiveness review is carried out annually.			

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

Key Recommendations to be considered:

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

Hull University Teaching Hospitals NHS Trust

Charitable Funds Committee

Committee Effectiveness Review

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

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

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

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

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

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

The areas that scored 3 or below are:
- Stakeholders
- Risk and control frameworks
- Risk Management

The responses and verbatim comments are show at Appendix 1.

4. Recommendation
The Committee is asked to review the attached questionnaires and agree any relevant improvement actions that should be taken in response.

The Committee to agree the revision to the Terms of Reference in relation to the balance transfer to WISHH.

The Committee is also asked if there are any recommendations to make to the Trust Board.

Rachel Boulton
Compliance Manager

May 2023

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Charitable Funds

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

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

Behaviours

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

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

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.						√	
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.							In light of changes taking place terms of reference need to be revisited and future role of Committee redefined.
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee.						√	
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.						√	
5.	**Quality and Quantity of information** The quality and quantity of information received is appropriate and helps Committee members fulfil their role.					√		
6.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.						√	
7.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.						√	
8.	**Annual reporting** The Committee makes best use of its annual reporting.						√	
9.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.				√			I do not believe we have defined our stakeholders, as a committee
10.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.	X						Not a significant aspect in respect of this Committee's activities

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Charitable Funds

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

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

Behaviours

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

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

Processes

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

Assessment of the effectiveness of Board Committees

NAME OF COMMITTEE YOUR REVIEW RELATES TO: Charitable Funds

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

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

Behaviours

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

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

Processes

	Question	N/A	1	2	3	4	5	Comment
1.	**Composition** The Committee is the right size and has the best mix of skills to ensure its optimum effectiveness.						x	
2.	**Terms of reference** The terms of reference for the Committee are appropriate, with clearly defined roles and responsibilities, ensuring the right issues are being addressed.						x	Will probably need review when funds have been transferred to WISHH
3.	**Secretariat** The secretariat functions acts as an appropriate conduit for the provision of information to the Committee.						x	
4.	**Meetings and administration** The Committee meets sufficiently often, such that agenda items can be properly covered in the time allocated.						x	
5.	**Quality and Quantity of information** The quality and quantity of information received is appropriate and helps Committee members fulfil their role.						x	
6.	**Timeliness of information** Information is received in sufficient time to allow for proper consideration, with scope for additional briefing if necessary.						x	
7.	**Agenda items** The Committee cycle agenda covers all matters of importance to the Committee and to the Trust.						x	
8.	**Annual reporting** The Committee makes best use of its annual reporting.						x	
9.	**Stakeholders** The Committee has defined its stakeholders and ensures that the organisation has the right level of contact with them.						x	The recent meeting with WISHH trustees was very valuable
10.	**Risk management** The Committee uses an active and well-structured process to manage risk, taking account of the organisation's activities and the breadth of functions across the business.						x	

Hull University Teaching Hospitals NHS Trust

Non-Executive Directors' Terms of Office and Committee Membership 2023

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

AREA	ROLE	REFERENCE	LEAD
Overall Responsibility for the Trust	Accountable Officer	NHS Act 2006	Chris Long
Board Composition	Executive Nurse/Midwife	NHS Act 2006	Jo Ledger
	Executive Medical/Dental Officer	NHS Act 2006	Makani Purva
Emergency Preparedness	Accountable Officer for Emergency Preparedness	Emergency Preparedness Resilience and Response (EPRR), NHS England	Ellen Ryabov
	NED Lead for Emergency Preparedness	EPRR, NHS England	
Medicines Management	Accountable Officer for the Destruction of Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)	Jo Goode
	Accountable Officer for Controlled Drugs	Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI (2013/373)	Jo Goode
	Medicines Safety Officer	Patient Safety Alert NHS/PSA/D/2014/005	Simon Gaines
	Non-Medical Prescribing Lead	NMC Code of Conduct/Standards	Caroline Grantham
Finance	Accounting Officer	NHS Act 2006	Lee Bond
	Counter Fraud Board Lead (Executive)	Directions to NHS Bodies on Counter Fraud 2004	Lee Bond
	Counter Fraud Board Lead (Non-Executive)	Directions to NHS Bodies on Counter Fraud 2004	Tracey Zepherin
	Local Counter Fraud Specialist	Directions to NHS Bodies on Counter Fraud 2004	Sally Stevenson
	Security Management Director	Secretary of State Directions March 2005	Jug Johal
	Security Management Non-Executive Director	Secretary of State Directions March 2005	
	Local Security Management Specialist	Secretary of State Directions March 2005	
	Senior Compliance Officer	Bribery Act 2010	Jane Osman
	Procurement Non-Executive Director	NHS TDA	Mike Robson
	Hospital Pharmacy and Medicines Optimisation Executive Lead	NHSI, Carter Project	Makani Purva
Information Management/Governance	Caldicott Guardian	HSC1999/012	Alastair Pickering
	Senior Information Risk Officer (SIRO)	Information Governance Toolkit	Lee Bond
	Information Governance Lead	NHS Standard Contract	Alastair Pickering
	Chief Clinical Information Officer	NHS Information Strategy	Steve Jessop
	Data Protection Officer	Data Protection Act and General Data Protection Regulations	Taryn Milton
	Executive Board member for data and cyber security	Data Protection Act and General Data Protection Regulations	Shauna McMahon
	Lead Executive for Health & Safety	Health & Safety at Work Act 1974	Suzanne Rostron

	Trust Competent Person	Health & Safety at Work Act 1974	Christine Richards
Health & Safety	Fire Safety Lead	Firecode; Fire Safety in the NHS	Christine Richards
	Advisor for RIDDOR/COSHH	Health & Safety at Work Act 1974	Christine Richards
	Ionising Radiation (Medical Exposure) Lead (where organisations provide radiotherapy services)	Ionising Radiation (Medical Exposure) Regulations 2000	John Saunderson
	Radiation Protection Advisor	Ionising Radiation Regulations 1999	Jug Johal
Infection Control	Director of Infection Prevention & Control (DIPC)	Health & Social Care Act 2008 Code of Practice on Control of Infection	Greta Johnson
	Decontamination Lead	Health & Social Care Act 2008 Code of Practice on Control of Infection	Jug Johal
Safeguarding	Safeguarding Executive Lead	Safeguarding Accountability Assurance Framework NHS Standard Contract	Jo Ledger
	Lead Professional for Safeguarding	Safeguarding Accountability Assurance Framework	Kate Rudston
	Designated Doctor for Child Protection	Safeguarding Accountability Assurance Framework	Christopher Wood
	Designated Doctor for Safeguarding Adults	Safeguarding Accountability Assurance Framework	Christopher Wood
	Named Nurse for Safeguarding Adults	Safeguarding Accountability Assurance Framework	Christine Davidson Patricia Darley (Children)
	Designated Midwife for Safeguarding	Safeguarding Accountability Assurance Framework	Paula Peacock
	Deprivation of Liberty & Safeguarding (DoLS) Lead	Mental Capacity Act 2005	Rachel Hoggarth
	Mental Health Act Administrator	Mental Capacity Act 2005	Jayne Wilson
	Prevent Lead	Counter-Terrorism and Security Act 2015 NHS Standard Contract	Paula Longley
Freedom of Information Act	Freedom of Information Act Lead	Freedom of Information Act	Myles Howell
	Qualified Person for FOIA	Freedom of Information Act	
Freedom to Speak Up	Freedom to Speak Up Guardian	NHSE Requirement & requirement of NHS Standard Contract	Fran Moverley
	Executive Lead for FTSU	HSC 1999/198 Freedom to Speak Up Review/Francis Inquiry	Suzanne Rostron
	NED for Raising Concerns	HSC 1999/198 Freedom to Speak Up Review/Francis Inquiry	Tracey Zepherin
	Quality - Executive Lead	Francis Inquiry	Jo Ledger/Makani Purva/Suzanne Rostron
	Quality - Non-Executive Lead	Francis Inquiry	Stuart Hall

Quality/Patient Safety	Executive Lead for End of Life Care	More Care, Less Care Report 2013	Jo Ledger
	Non-Executive Lead for End of Life Care	More Care, Less Care Report 2013	Una Macleod
	Non-Executive Lead for Complaints	NHS Complaints Regulations	
	Responsible Person for Compliance with Complaints Regulations	NHS Complaints Regulations	Kate Rudston
	Complaints Manager	NHS Complaints Regulations	Leah Coneyworth
	Falls Lead (Non-Executive Director)	Falls and Fragility Audit Programme	Rosie Hoyle
	Hip Fracture Non-Executive Lead	Hip Fracture Review 2016	
	Guardian of Safe Working Hours	NHS Employers	Mamhoud Loubani
	Medicines Devices Safety Officer	Patient Safety Alert NHS/PSA/D/2014/006	Simon Gaines
	Central Alerting System (CAS) Liaison Officer	NHS England – Introduction to the National Patient Safety Alerting System	Christine Richards
	Responsible Officer for Revalidation	General Medical Council	Makani Purva
	NED responsible for Doctors Disciplinary	General Medical Council	Sean Lyons
	NED Lead for Mortality	Learning from Deaths Report 2017; NHS England	
	Quality Review Service Lead	NHS England	Suzanne Rostron
	Maternity Champion	Safer Maternity Care	Jo Ledger
	Patient Safety Specialist	NHS England Patient Safety Strategy https://www.england.nhs.uk/wp-content/uploads/2020/08/identifying-patient-safety-specialists-v2.pdf	Donna Pickering
	NED for Maternity Services	Ockenden review OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (ockendenmaternityreview.org.uk)	Stuart Hall
Human Tissue Authority	Designated Individual	Human Tissue Act	Ian Smith
Human Fertility & Embryology	Responsible Person	Human Fertility & Embryology Act	Keith Cunningham
Care Quality Commission	CQC Nominated Individual	Health & Social Care Act 2014	Suzanne Rostron
Sustainability	Trust Board Lead (Executive)	NHS Carbon Reduction Strategy 2009	Lee Bond
Equality & Diversity	Board Executive Lead	Equality Act 2010	Simon Nearney
	Executive Board Lead for Tackling Inequality	NHS England Phase 3 of the Covid response https://www.england.nhs.uk/wp-content/uploads/2020/08/implementing-phase-3-of-the-nhs-response-to-covid-19.pdf	Simon Nearney

REFERENCES

📄 6.4 - Register of Gifts and hospitality and interests paper July 2023.pdf

Agenda Item	Meeting	Trust Board	Meeting Date	12.07.23
Title	Gifts Hospitality and Sponsorship, Declarations of Interest			
Lead Director	Suzanne Rostron, Director of Quality Governance			
Author	Rebecca Thompson, Head of Corporate Affairs			
Report previously considered by (date)	The report is received by the Audit Committee annually			

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

Key Recommendations to be considered:
The Trust Board is requested to: • review the report and decide if there is assurance that the governance processes are in place to ensure compliance with the Trust policy

1

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

1. **Purpose of the paper**

   The purpose of the report is to present the Register of Gifts, Hospitality and Sponsorship 2022/23 to the Trust Board.

2. **Background**

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

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

3. **Declarations of Gifts, Hospitality and Sponsorship**

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

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

   The full register of declarations of gifts, hospitality and sponsorship for 2022/23 is available and is scrutinised by the Audit Committee.

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

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

4. **Declarations of Interests**

   Periodic reminders are also sent for declaration of interest forms to be reviewed and updated. All new starters are required to declare any relevant interests. The annual Fit and Proper Persons check on Board members took place in March and was reported at the May 2023 Trust Board meeting.

   The Trust publishes on its website the business interests (or nil returns) and receipt of gifts, hospitality and sponsorship of all Board members as well as the declared interests of Deputy Directors/significant decision makers. The policy has been recently amended so that all Bands from 8A above are requested to provide a declaration or a nil return.

2

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

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

5.   Recommendation
The Trust Board is requested to:
- review the report and decide if there is assurance that the governance processes are in place to ensure compliance with the Trust policy

Rebecca Thompson
Head of Corporate Affairs
July 2023

3

REFERENCES

📕 6.5 - Standing Orders - May 2023.pdf

Hull University Teaching Hospitals NHS Trust

Agenda Item		Meeting	Trust Board	Meeting Date	11.07.23
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 May 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 May 2023.

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2023/05	Hull University Teaching Hospitals NHS Trust and the Hull and East Yorkshire Medical Research Centre – Third variation agreement relating to a development agreement for lease and underlease in respect of the construction and letting of premises known as the new cyclotron and radio pharmacy facility at Castle Hill.	26/06/23	Chris Long – Chief Executive Officer Lee Bond – Chief Financial Officer

3   Recommendation

The Trust Board is requested to:
 • Authorise the use of the Trust's seal

Rebecca Thompson
Head of Corporate Affairs
July 2023

2

REFERENCES

6.6 - 2022 - 2023 Trust Safety Team Report.pdf

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Safety Team Annual Report 2022/23

Title:	Safety Team Annual Report 2022/23
Responsible Director:	Director of Governance
Author:	Ian Stanley, Deputy Safety Manager

Purpose	The purpose of this report is to provide information and assurance to the Trust Board and others, in relation to matters relating to the management of Safety within the Trust.	
BAF Risk	N/A	
Strategic Goals	Honest, caring and accountable culture	Y
	Valued, skilled and sufficient staff	Y
	High quality care	Y
	Great local services	Y
	Great specialist services	Y
	Partnership and integrated services	Y
	Financial sustainability	Y
Key Summary of Issues	Information is provided in the report on the following topics: • Safety Dept. KPI's • General RIDDOR Reportable Incidents • RIDDOR: Occupational Health • Annual incidents by Health Group • Reportable slip trip falls • Non-reportable slip trip falls • Timeliness of Reporting of incidents to the HSE • Site inspections • Staff incidents reported by severity • Quarterly safety inspections • EL / PL Claims • Manual Handling • Objectives for 2022/2023	

SUMMARY

Health Safety Executive:

- The Trust maintained its excellent record with the Health and Safety regulator during 2022/2023.
-

Face Fit Testing:

In October 2021, the management of the Face Fit Testing service was transferred from the Infection Control team to the Safety department.

Since taking charge of the service, it has been the subject of much focus which has seen the introduction of mandatory testing for all clinical staff a fully traceable booking system via HEY 24/7 and its progression to being the regionals best performing Trust for best part of the past nine months with approximately 3600 staff tested.

Because of additional demands and pressures on the Safety team, it has been decided that the management of the face fit testing would be transferred back to the Infection Control team as of February 2023.

Reportable Incidents:

- The Trust's Safety team reported (28) incidents to the HSE under the requirements of the RIDDOR Regulations 2013 in 2022/23. The most common causes were slip, trip and falls incidents with (13) - (4) Slips (4) Trips and (5) falls.

  This will result in an increased focus on the management of this hazard. Paradoxically, the incidence of less serious cases of slips, trips and falls (Non-RIDDOR reportable incidents) has increased in 2022/23:40 compared with 28 in 2021/22.

- In terms of timeliness of reporting to the HSE, (9) of the (28) incidents were reported after the 15 day target: and is an increase of (4) on the previous year by (5).

- The Trust's Occupational Health Team reported (11) incidents to HSE which is an increase of (3) with (9) Needle-stick injuries and (2) Exposure to blood borne viruses. There were no reported cases of work-related dermatitis for the seventh year running, overall this is an increase of (3) incidents when compared to the previous year (8).

Claims:

- 20 Employee Liability Claims were opened within the financial year 2022/2023. This is an increase of 9 from the previous financial year.

Moving Handling:

- In July 2022, it was agreed Manual Handling be moved from the Safety department to Corporate Nursing.

Safety Focus – 2023/24

- Key areas of safety management focus in 2023/24 include
- A focus on slips trips and falls prevention.
- Provide a course for managers to enable them to undertake risk assessments and inspection in their own areas and when to report accidents etc. along with training for new Safety Focal persons and updates.
- We have also recognised that due to COVID, organisational changes and the reduction of the Safety teams resources, there has been a drop in general risk assessments and the review of those assessments which will be a focus moving forward.

Safety Department Annual Report, 2022 / 2023

Contents:

1.   KPI's

Key Performance Indicators (KPI's) – Monitored quarterly - and covering the following topics:

- **Number (and rate – No. / 7932 employees x 100) of RIDDOR reportable incidents.** This is selected as a reactive KPI because of the reliability of the reporting: these incidents are less likely to go un-reported that more minor incidents and near-misses. The target for RIDDOR reportable incidents should always be as few as possible, though an organisation as large and complex as HUTH would certainly alert the regulator (HSE) if no such incidents were reported.

- **Total staff slips, trips and falls incident rate (not just RIDDOR).** The justification for this choice of KPI is that it is the single biggest cause of staff injury. The target improvement here would be a steady decrease, though with caution regarding incident reporting rates generally.

- **EL / PL Claims –** new employees' / public liability claims received (non-clinical).

- **Numbers of hazards identified by site quarterly inspections** by the Safety Team; a pro-active measure. We would want to see a reduction in the number of hazards identified in any given area upon subsequent inspections if the corrective actions have been taken.

- **Staff accidents reported by severity**. Numbers of those classed as either severe or catastrophic. A good reporting culture in the organisation would have staff recording high numbers of near misses, no harm or minor harm incidents. For this reason, an increase in overall staff incidents should not necessarily be seen as a negative outcome. However, we would want to see low numbers of those incidents classed as major or catastrophic, as such incidents are unlikely to go unreported.

2. Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 2013

General RIDDOR Reportable Incidents: totals and rates (per headcount x 100):

Table 1: Quarter 4

	FTE 7932		Rate	Total
Quarter 1	Apr	4	0.05	
	May	1	0.01	7
	Jun	2	0.02	
Quarter 2	Jul	4	0.05	
	Aug	4	0.05	11
	Sep	3	0.03	
Quarter 3	Oct	2	0.02	
	Nov	2	0.02	4
	Dec	-	-	
Quarter 4	Jan	2	0.02	
	Feb	3	0.03	6
	Mar	1	0.01	

Total			28

We have witnessed **(6)** incident which is an increase of **(2)** incident during quarter 4 when compared to quarter 3 **(6)**.

Table 2: Annual

RIDDOR Apr 2022 - Mar 2023	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	RIDDOR 2021 - 2022
	Quarter 1			Quarter 2			Quarter 3			Quarter 4				
Slip- trip fall	2	1	1	1	3	2	-	1	-	-	2	-	13	12
Manual handling	-	-	-	-	-	1	-	-	-	-	1	-	2	1
Struck by or against something	-	-	-	1	1	-	-	-	-	-	-	1	3	2
Contact with hot/cold, object/liquid, electric or machinery	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Contact with sharp material or object non medical	-	-	-	-	-	-	1	-	-	-	-	-	1	1
Other personal accident	2	-	1	1	-	-	1	1	-	2	-	-	8	3
Contact other medical sharps	-	-	-	1	-	-	-	-	-	-	-	-	1	1
Exposure to harmful agent e.g. radiation, substance, bio agent,	-	-	-	-	-	-	-	-	-	-	-	-	-	2
Total FTE 7932	4	1	2	4	4	3	2	2	0	2	3	1	28	22
	7			11			4			6				

Slip trip falls equates to (**13**) of the (**28**) reportable incidents for the year 2022 – 2023, however there remains a significant decrease of Moving Handling incidents with just (**2**) being reported.

Table 3: Three-Year Comparison

	2020 - 2021	2021 - 2022	2022 - 2023	Total
Quarter 1	5	6	7	18
Quarter 2	4	3	11	18
Quarter 3	7	6	4	17
Quarter 4	6	7	6	19
Total	22	22	28	72

When compared to the previous year 2021 – 2022 (**22**) we have witnessed a slight increase during 2022 – 2023 (**28**).

Graph 1: twelve-year comparison 2011 – 2023.

Yearly comparrison
2011 -2023

Year	Value
20212- 2023	27
2021 - 2022	22
2020 - 2021	22
2019 - 2020	10
2018 - 2019	27
2017 - 2018	18
2016 - 2017	32
2015 - 2016	33
2014 - 2015	40
2013 - 2014	35
2012 - 2013	42
2011 - 2012	54
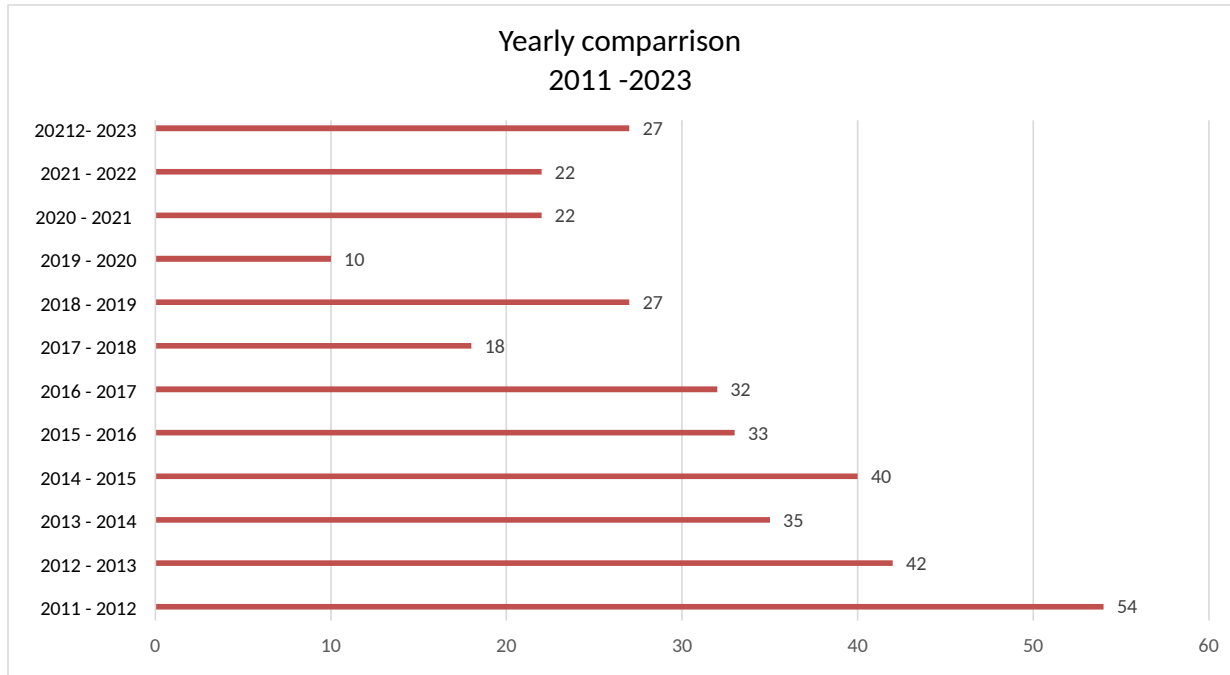
The above graph shows the total of reportable incidents over the past twelve years with a collective total being 362 reportable incidents.

In 2011 we reported (**54**) incidents, since then we have witnessed a steady decrease with 2019 being the exceptional with the lowest ever on record with the reporting of just (**10**) incidents.

The main factors for the increase for the past year is Slip trip fall's **(13).**

Graph 2: Year on year comparison for slip trip falls 2011 – 2023.

Slip trip falls 2011 - 2023

Year	Value
2022 - 2023	13
2021 - 2022	12
2020 - 2021	6
2019 - 2020	1
2018 - 2019	10
2017 - 2018	5
2016 - 2017	10
2015 - 2016	10
2014 - 2015	18
2013 - 2014	13
2012 - 2013	18
2011 - 2012	16
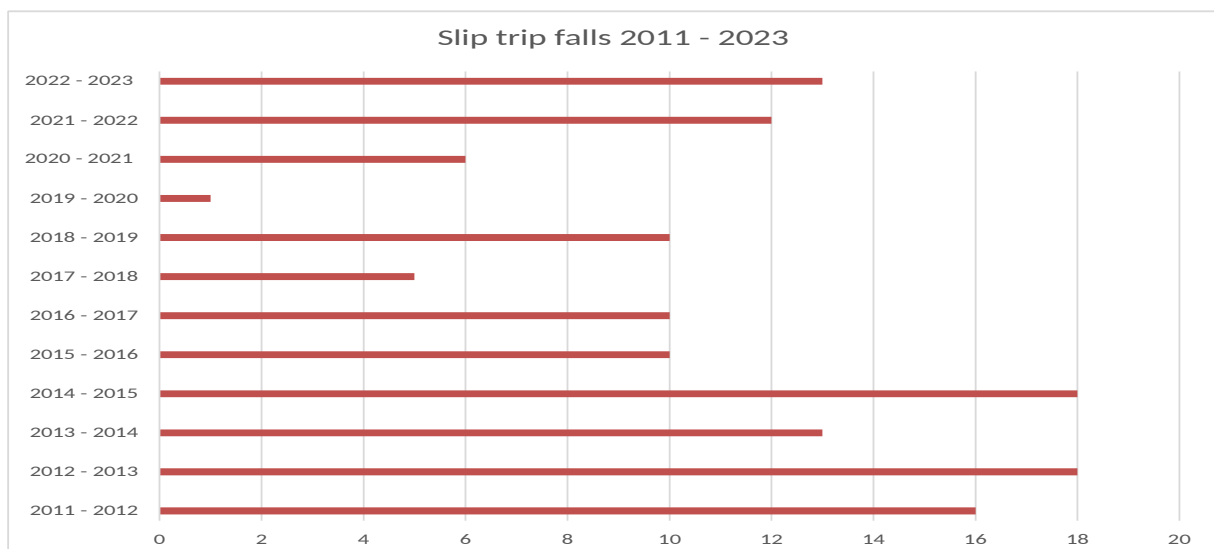
The above graph shows that we have witnessed a total of **(13) slip trip falls -** slip **(4)** trips **(4)** and falls **(5)** during 2022 – 2023.

3. Annual RIDDOR incidents by Health Group:

Page **6** of **18**

Table 4: Quarter 4

FTE 7932	CS	C	M	S	FWH	Total		Rate
Quarter 4 Jan	-	1	1	-	-	2		0.02
Quarter 4 Feb	1	-	-	-	-	1	5	0.01
Quarter 4 Mar	-	1	1	-	-	2		0.02

During quarter 4 we witnessed **(5)** incidents which was a slight increase of **(2)** when compared to quarter 3 **(3).**

Table 5: Annual

FTE 7932		CS	C	M	S	FWH	Total		Rate
Quarter 1	Apr	-	3	1	-	-	4		0.05
Quarter 1	May	-	-	1	1	-	2	7	0.02
Quarter 1	Jun	-	1	-	-	-	1		0.01
Quarter 2	Jul	-	1	1	1	1	4		0.05
Quarter 2	Aug	-	4	-	-	-	4	11	0.05
Quarter 2	Sep	-	1	-	2	-	3		0.03
Quarter 3	Oct	-	1	-	-	1	2		0.02
Quarter 3	Nov	-	-	1	-	-	1	3	0.01
Quarter 3	Dec	-	-	-	-	-	-		-
Quarter 4	Jan	-	1	1	-	-	2		0.02
Quarter 4	Feb	1	-	-	-	-	1	5	0.01
Quarter 4	Mar	-	1	1	0	-	2		0.02
Total		1	13	6	4	2	26		

Corporate **(13)** Medicine **(6)** Surgery **(4)** FWH **(2)** CS **(1)**

Table 6: Three-Year Comparison

	FTE	CS	C	M	S	FWH
2020 - 2021	7430	3	4	5	8	2
2021 - 2022	7932	4	7	7	4	-
2022 - 2023	7932	1	13	6	4	2
Total		8	24	18	16	4

When looking back over the past three years Corporate has had the most incidents with **(24)** and Medicine having the second most incidents with **(18)** and Surgery third with **(16)** incidents.

4. RIDDOR Reportable slip trip falls:

Table 7: Quarter 4

FTE 7932		Slip	Trip	Fall	Total	Rate
Quarter 4	Jan	-	-	-	-	-
	Feb	-	1	1	2	0.02
	Mar	-	-	-	-	-

There was a slight increase during quarter 4 with **(2)** incidents reported when compared to quarter 3 when **(1)** was reported.

Table 8: Annual

FTE 7932		Slip	Trip	Fall	Total	Rate
Quarter 1	Apr	1	-	1	2	0.02
	May	1	-	-	1	0.01
	Jun	-	-	1	1	0.01
Quarter 2	Jul	1	-	-	1	0.01
	Aug	1	2	-	3	0.03
	Sep	-	1	1	2	0.02
Quarter 3	Oct	-	-	-	-	-
	Nov	-	-	1	1	0.01
	Dec	-	-	-	-	-
Quarter 4	Jan	-	-	-	-	-
	Feb	-	1	1	2	0.02
	Mar	-	-	-	-	-
Total		4	4	5	13	

During 2022 – 2023 we have reported **(4)** slips and **(4)** trips and **(5)** falls.

Table 9: Three-Year Comparison

	Slip	Trip	Fall	Total	Rate
2020 - 2021	3	3	-	6	0.06
2021 - 2022	5	3	4	12	0.13
2022 - 2023	4	4	5	13	0.16
Total	12	10	9	31	

During 2022 – 2023, we have witnessed a slight increase of **(1)** when compared to 2021 – 2022.

Table 10: Overview of reportable slips 2022 – 2023

Slips	
1	Slip on loose gravel in car park – Plan in place to monitor and maintain carpark.
2	Slip on wet floor in sterile service area – staff made aware to clean any spills.
3	Slip on spill of water when jugs of water are taken from the fridge– Staff made aware of the accident and reminded to clean any spills.
4	Slip on spilled liquid, source unknown in main foyer of the Tower block.

Table 11: **Overview of reportable trips for** 2022 – 2023

Trips	
1	Trip on broken paving stone – Stone reported to the Estates department for repair.
2	Trip from catching foot in open floor duct – duct cover replaced.
3	Trip over the foot of the heras fence – Informed capital and contractor.
4	Tripped when stubbed foot on uneven flooring – Estates aware of flooring issue and is waiting for a suitable time to gain access to Ward 500.

Table 12: **Overview of reportable falls for** 2022 – 2023

Falls	
1	Fall from delivery vehicle – Port fell from vehicle while working.
2	Patient unwitnessed fall in side room.
3	Fall on footpath leading in to the main site- area monitored and is part of the quarterly inspections for identifying defects.
4	Patient fell from the last step of the main stair case – Stairs inspected no defects found external team also inspected stairs and was satisfied with current lay out.
5	Fall following stubbing foot on uneven floor covering on main corridor – Floor has since been repaired.

5. Non-RIDDOR reportable slip trip falls:
Table 13: Quarter 4

Quarter 4	Staff	Slip	Trip	Fall	Total	Rate
CS	1770	-	1	-	1	0.01
C	1876	1	3	-	4	0.04
M	1341	-	-	1	1	0.04
S	1852	1	-	-	1	0.01
FWH	1093	2	1	-	3	0.03

Total	7932	4	5	1	10

Quarter 4 showed no changed **(10)** when compared to the previous quarter **(10).**

Table 14: Annual

7932		Slip	Trip	Fall	Total	Rate
Quarter 1	Apr	-	2	-	2	0.02
	May	1	-	-	1	0.01
	Jun	2	4	-	6	0.06
Quarter 2	Jul	1	1	-	2	0.02
	Aug	1	2	-	3	0.03
	Sep	1	5	-	6	0.06
Quarter 3	Oct	1	4	-	5	0.05
	Nov	2	1	-	3	0.03
	Dec	1	1	-	2	0.02
Quarter 4	Jan	2	2	-	4	0.04
	Feb	-	-	1	1	0.01
	Mar	2	3	-	5	0.05

Total		14	25	1	40

There have been **(40)** non-reportable staff slips trip falls over the past twelve months; this is an increase of **(12)** on the previous year **(28).**

Table 15: Three-Year Comparison

	Slip	Trip	Fall	Total
2020 - 2021	28	12	2	42
2021 - 2022	10	12	6	28
2022 - 2023	14	25	1	40

Total	52	49	9	110

6. RIDDOR – reported by the Occupational Health Department:

Table 16: Quarter 4

FTE 7932		Needlestick	EBBV	Dermatitis		Total		Rate
Quarter 4	Jan	-	-	-		-		-
	Feb	1	-	-		1	2	0.01
	Mar	1	-	-		1		0.01

During quarter 4 we witnessed **(2)** incident which is a decrease of **(1)** against quarter 3 **(3)**.

Table 17: Annual

FTE 7932		Needlestick	EBBV	Dermatitis		Total		Rate
Quarter 1	Apr	-	-	-		-		-
	May	1	1	-		2	3	0.02
	Jun	1	-	-		1		0.01
Quarter 2	Jul	-	-	-		-		-
	Aug	1	-	-		1	3	0.01
	Sep	2	-	-		2		0.02
Quarter 3	Oct	1	-	-		1		0.01
	Nov	1	-	-		1	3	0.01
	Dec	-	1	-		1		0.01
Quarter 4	Jan	-	-	-		-		-
	Feb	1	-	-		1	2	0.01
	Mar	1	-	-		1		0.01

Total		Needlestick	EBBV	Dermatitis		Total	
Total		9	2	-		11	

During 2022 – 2023, we witnessed **(9)** needle stick injuries and **(2)** Exposure to Blood Born Viruses with no reported cases of dermatitis.

Table 18: Three-Year Comparison

	2020 - 2021	2021 - 2022	2022 - 2023
Needlestick	7	5	9
EBBV	4	3	2
Dermatitis	-	-	-
Total	**11**	**8**	**11**

We have witnessed **(11)** reportable incidents giving us an increase of **(3)** when compared to the previous 12 months it should also be noted that for the seventh consecutive year running (12/2015), there have been no reportable cases of Dermatitis.

7. Timeliness of Reporting of incidents to the HSE:

The reporting of incidents in accordance to regulation 4.2 of the RIDDOR Regulations 2013 - within 15 days

NB: The following information does _not_ include Occupational Health reportable incidents

Table 19: Quarter 4

	On time	Late		Total
Quarter 4	2	4		6

Quarter 4 shows there were **(4)** late reporting and **(2)** on time reported to the HSE, this was largely due to the incident being reported late to the Safety team.

Table 20: Annual

	On time	Late		Total
Quarter 1	4	3		7
Quarter 2	9	2		11
Quarter 3	4	-		4
Quarter 4	2	4		6
Total	19	9		28

The number of incidents reported from the previous year is (**22**) We have witnessed an increase over the past twelve months for the late reporting of incidents by (**6**) incidents meaning we have reported (**28**).

Table 21: Three-Year Comparison:

	On time	Late		Total
2020 - 2021	15	7		22
2021 - 2022	17	5		22
2022 - 2023	19	9		28
Total	**51**	**21**		**72**

We have witnessed an increase of incidents reported late during the past year with (**9**) against (**5**) for the previous year.

The main reasons for the late reporting is that the Safety team had not been notified of the incident within the specified period of 15 days.

8. Quarterly Site Inspections:

Hull Royal Infirmary:

Table 22: Type of defects found over the past year:

Type of defect	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Paving stones	-	-	-	-
Potholes	(orange)	(orange)	(orange)	(orange)
kerb edgings	(orange)	-	-	-
Bollards	-	-	-	-
Walls	-	-	-	-
Fencing	-	-		-
Service covers	(orange)	-	-	-
Vegitation	-	-	-	-

The above shows common defects found across two quarterly inspections, Potholes showing as the most common defect this is mainly evident in the Argyle street car park.

Table 23: Defects found.

Defects found						Total
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4		Total
High	-	-	-	-		-
Moderate	5	5	4	12		26
Low	-	-	2	2		4
Very low	-	1	-	-		1
Total	5	6	6	14		**31**

During the past 12 months, the majority of defects identified carried a risk rating of a moderate, with no risk identified as being high.

Castle Hill Hospital:

Table 24: Type of defects found over the past year:

Type of defect	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Paving stone	(orange)	(orange)	(orange)	-
Pot holes	(orange)	(orange)	(orange)	(orange)
kerb edgings	(orange)	-	-	-
Bollards	-	-	-	-
Walls	(orange)	-	-	-
Fencing	-	-	-	-
Service covers	-	-	(orange)	-
Vegitation	-	-	-	-

The above shows common defects found across all four quarterly inspections with potholes identified in each of the temporary car parks along with a number of broken paving stones on footpaths.

Table 25: Defects found:

Defects found						Total
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4		
High	-	-	-	-		-
Moderate	12	6	3	6		27
Low	4	-	5	2		11
Very low	-	-	-	-		-
Total	16	6	8	8		**38**

Table 26: Combined annual defects found and acted upon at HRI and CHH.

HRI - CHH Combined						Total
Risk rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4		
High	-	-	-	-		-
Moderate	43	11	7	18		79
Low	5	-	7	4		16
Very low	-	1	-	-		-
Total	48	12	14	8		**95**

As a combined total we identified (**95**) defects across HRI and CHH with (**26**) being acted upon leaving (**8**).

9. Staff incidents reported by severity:

Table 27: Quarterly incident by severity

Risk Rating	Quarter 1	Quarter 2	Quarter 3	Quarter 4		Total
No harm	18	26	29	35		108
Minor	50	40	40	94		224
Moderate	2	3	1	6		6
Major	-	-	-	1		1
Catastrophic	-	-	-	-		-
Total:	70	69	70	136		**339**

The above pattern is seen as encouraging: given that, high reporting combined with low severity rating is seen as a positive indicator of organisational safety culture, the fact that we have seen an increase in reported low severity ratings, combined with no major or catastrophic, is welcomed.

Table 28: Annual incident severity

Risk Rating	2022 - 2023
No harm	35
Minor	94
Moderate	6
Major	1
Catastrophic	-
Total:	136

Table 29: Three-year comparison incident by severity

Risk Rating	2020 - 2021	2021 - 2022	2022 - 2023	Total
No harm	131	90	35	256
Minor	283	207	94	584
Moderate	17	17	6	40
Major	1	-	1	2
Catastrophic	-	-	-	-
Total:	432	314	136	**882**

10. Quarterly Physical Inspections:

Table 30: Quarterly and three-year comparison of quarterly physical inspections: CHH

Castle Hill Hospital	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2020 - 2021	21	28	31	24	104
2021 - 2022	40	30	21	27	118
2022 - 2023	25	17	27	32	101
Total	86	75	79	83	**323**

Table 31: Three-year comparison of quarterly physical inspections: HRI

Hull Royal Infirmary	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2020 - 2021	29	29	29	25	112
2021 - 2022	41	38	21	19	119
2022 - 2023	27	19	45	51	142
Total	97	86	95	95	**373**

The above shows the number of physical inspections carried out by Wards and departments on a quarterly basis and shows the totals for the past three years.

However, due to COVID 19, we experienced a number of ward movements along with major disruption across the Trust, which has affected significantly on the number of inspections carried out and received.

However, the above shows a steady increase in numbers as services and staff resume back to some level of normality.

11. Safety Focal Person's:

Due to COVID there has been no further training of new Safety Focal Person's for the past year, however, there is a delegate waiting list and once the Trust reaches some

normality and staff are available for training and training can resume, then those who are on the waiting list will be contacted for training.

12 Employers Liability / Public Liability Claims

EL Claims 2022/2023:

20 Employee Liability Claims were opened within the financial year 2022/2023. **This is an increase of 9 from the previous financial year.**

The common theme over the past year has been incidents involving violence and injuries inflicted by patients. There have also been numerous claims involving slips, trips and falls.

Summaries Below

The staff member was attacked by a patient with a metal bar that he had pulled out from the bed. The patient had a history of aggressive behaviour.
Alleged, staff member assaulted whilst stopping patient climbing into bed with female patient. Level 5 security had been requested but not implemented.
Staff Nurse writing notes when a patient came out of his room wielding a drip stand and hit her across the back of her head with the base of the drip stand. The stand then broke and the patient continued to hit the staff member with the pole of the drip stand.
Alleged injury to pectoral muscle and suspected broken ribs from a fall due to excessive debris/mud on a pavement.
Member of staff was working in room 3 of the endoscopy unit preparing a patient for a procedure. As the Claimant approached the patient, she tripped over a power cable trailing from the equipment to the plug socket on the wall. As a consequence she fell forwards, striking her face on a metal clinical waste bin.
Alleged torn ligament on left foot resulting in pain and swelling because of an oxygen cylinder that fell on claimant's foot while trying to moving a patient.
The Claimant was working on the elderly dementia ward at HRI as a Hygienist. A patient had been admitted to the ward and was known to be verbally and physically violent towards others. The patient was attempting to leave the ward with another member of staff. The Claimant was concerned for her colleagues safety and so assisted them. In doing so, the patient attacked the Claimant.
Employee walking between Daisy DSU and the canteen entrance towards office 18/19 when a paving slab sunk, causing an uneven level. As a consequence she fell to the ground and sustained injury.

Alleged fracture to middle finger when attending to patient with high BMI.
Staff member walking from main tower block and tripped over the base of a railing.
Alleged breach of confidential information resulting in stress at work.
Employee walking through the main lift lobby of HRI tower block and slipped on liquid on the floor.
Claimant was walking from the car park to the rear of the cardiology building. She crossed a grassed area and slipped on the grass. As a consequence she fractured her ankle.
Member of staff sat working at a computer when a patient rolled up a towel and wrapped it around the Claimant's neck. In doing so the patient pulled the Claimant backwards and told her of his intention to kill her. She was dragged to the floor by the patient and as a consequence sustained injury and loss.
Staff member walking through ground floor waiting area (near pod G) and slipped on wet floor.   Water on floor was due to roof windows open and raining. Windows did not close in time.
Alleged puncture to finger by a used sharp instrument (clip) when clearing operating sets from the previous day that had been left out.
Claimant and a porter transferring a patient on a bed. The claimant alleges that the porter failed to slow down despite the request made by the Claimant. This resulted in a collision on a door by the bed. The bed bounced back hitting the Claimant's lower leg.
Employee attempting to sit down at computer chair when said chair rolled away. She fell backwards and hit her head and neck on the chair.
The Claimant slipped on an open duct on the helipad at HRI.
Employee stood up from nurses station when her foot became caught on trailing wires underneath the desk causing her to fall to the ground.

PL Claims 2019/2020

7 Public Liability Claims were opened in the financial year 2022/2023. This is an increase of 1 from the previous financial year.

Alleged trip up step outside of OCS office (near entrance 1B, CHH) when going to clock off from her shift. Employed by OCS.
Claimant was changing a clinical waste bag when a sharp was protruding the bag and pierced the Claimant's finger.
Alleged data breach regarding medical records from infectious diseases being sent to GP, despite patient's request to not send.
Alleged loss of 6 rings whilst admitted to ward 7, HRI.
Alleged data breach. Clinic letters sent to GP in error.
Alleged data breach following Claimant's instructions to not send ID clinic letters to GP.
Alleged data breach claim. Claimant's medical records were mixed up with another patient's medical records. The records were disclosed to Tri Star Medicals who sent the records to the other patient. The other patient has had sight of the Claimant's records.

Closed Claims

There were 19 EL claims closed in the financial year 2022/2023, 8 of which were settled, the remaining 11 were denied and/or withdrawn. 5 Public liability claims were closed within the same period, 2 were settled and 3 were denied and/or withdrawn.

CHARITABLE FUNDS SUMMARY

REFERENCES Only PDFs are attached

📄 6.7 - Charitable Funds Summary May23.pdf

Report to the Board in Public
Charitable Funds Committee May 2023

Item: Financial Report including Fund Balances	Level of assurance gained: Reasonable

The Committee agreed reasonable assurance.   The committee received a comprehensive update on the charities funds including the balance sheet.

It was noted that there had not been a lot of changes since the previous committee, the lack of activity on the balances supported the previous discussions to transfer remaining balances to the WISHH Charity to manage.

Item: General Purpose Funds	Level of assurance gained: Reasonable

The Committee agreed reasonable assurance.

The paper shared with the committee provided the background in relation to WISHH Charity and the proposed actions to be taken in transferring to the balances. The committee was in agreement that the transfer proposal would be submitted to the July board for approval.

Item: Project Director's Report	Level of assurance gained: Reasonable

The Committee agreed reasonable assurance.

The committee received a comprehensive overview of the funding proposals, investment management arrangements and the development of working arrangements to provide a better understand the charity's purpose and the needs of the Trust.

The Project Director of Fundraising also provided an update on existing benefactor funded developments, which are

- Allam Diabetes Centre – Hull Royal Infirmary
- Endoscopy/Digestive Diseases Development – Castle Hill Hospital
- Twin Robotic Theatre – Castle Hill Hospital
- Molecular Imaging Research Centre And Radiopharmacy
- PET/CT Scanning Capacity
- Hospital Arts Strategy

The committee also reviewed the terms of reference and discussed the effectiveness review.

REFERENCES

- 📕 7.1 - BAF Q1 July 2023 SR.pdf

- 📕 7.2 - CRR ORC May 2023 inc June updates.pdf

- 📕 7.3 - BAF 1 - Culture Risk.pdf

- 📕 7.4 - BAF 2 - Workforce Risk.pdf

- 📕 7.5 - BAF 3.1 - Quality.pdf

- 📕 7.6 - BAF 3.2 - Harm Free Care.pdf

- 📕 7.7 - BAF 4 - Performance Risk.pdf

- 📕 7.8 - BAF 5 - Partnership Risk.pdf

- 📕 7.9 - BAF 6 - Research an Innovation Risk.pdf

- 📕 7.9.1 - BAF 7.1 - Finance Risk.pdf

- 📕 7.9.2 - BAF 7.2 - Underlying Financial Position Risk.pdf

- 📕 7.9.3 - BAF 7.3 - Capital Risk.pdf

- 📕 7.9.4 - Assurance Rating.pdf

- 📕 7.9.5 - Risk Matrix.pdf

Agenda Item	Meeting	Quality Committee	Meeting Date	11.07.23
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 Committee is asked to: • Approve the Q1 risk ratings   • Approve the risk appetite scores in Table 1   • Decide if sufficient assurance has been provided

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1. **Purpose of the Report**
    The purpose of the report is to present the Q1 Board Assurance Framework to the Trust Board.

2. **Background**
    The Board agreed at its meeting in May 2023 that the 2022/23 Q4 risks would be carried over into the first 6 months of 2023/24 due to the Group Model development and potentially new strategic objectives. It was agreed that a Board Assurance Framework Development session would be held in Quarter 2.

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 and with meetings held between the Head of Corporate Affairs and the named Executive lead. The full Board Assurance Framework is appended to this report.

    Q1 Risk Ratings
    The table below shows all risks and risk ratings for Q1 2023/24. Section 5 in this report gives a brief overview of the risks.

Table 1

Risk	Inherent Risk (L x I)	Current Risk (L x I)			Target Risk	Risk Appetite
BAF 1 - The Trust does not make progress towards further improving a positive working culture this year	5 x 4 = 20	Q1 4 x 4 = 16			3 x 4 = 12	Low
BAF 2 - The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust	4 x 5 = 20	Q1 4 x 4 = 16			3 x 4 = 12	Low
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 a 'good' CQC rating.	4 x 4 = 16	Q1 4 x 4 = 16			3 x 4 = 12	Low
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 and Patients with No Criteria to Reside require partnership working to determine improvement plans.	5 x 5 = 25	Q1 5 x 5 = 25			4 x 4 = 16	Low
BAF 4 - There is a risk to access to Trust Services following the residual impact of Covid	5 x 5 = 25	Q1 4 x 5 = 20			4 x 4 = 16	Low
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	4 x 4 = 16	Q1 3 x 4 = 12			2 x 3 = 6	Moderate
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	4 x 4 = 16	Q1 3 x 4 = 12			2 x 4 = 8	Moderate

2

Risk		Q1				Target	Appetite
BAF 7.1 - There is a risk that the Trust does not achieve its financial plan for 2022/23	5 x 4 = 20	Q1 4 x 4 = 16				2 x 4 = 8	Moderate
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	4 x 5 = 20	Q1 4 x 5 = 20				4 x 5 = 20	Low
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	4 x 5 = 20	Q1 3 x 5 = 15				2 x 5 = 10	Moderate

Risk Appetite Matrix

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

4. Actions Update

A number of actions have been taken in Quarter 1 and these are shown in the Appendices.

5. Risk ratings

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

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. Work to address this risk has begun and will be monitored through the Workforce, Education and Culture Committee.

The recommendation is that the risk remains the same for Q1.

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 recommendation is that the risk remains the same for Q1.

BAF 3.1 – High Quality Care

The proposed risk rating has is due to a number of concerns raised by the CQC in relation to patient safety, both in ED and Maternity Services resulting in a section 31 letter. Action plans are in place and are being scrutinised by external support, the ICB and the CQC. The Quality Committee and the Board are receiving updates against the action plans at each meeting.

A Quality session has been established in the Private Board meeting to discuss the quality issues with the Health Group leadership teams.

The Quality Committee recommend that the Risk Rating remains the same for Q1 but the wording of the risk be changed to reflect the aim of a 'good' CQC rating rather than 'outstanding'. The Committee also recommend that the risk appetite be changed to low.

3

BAF 3.2 – Harm Free Care

The Quality Committee discussed the ED rating on the Corporate Risk Register (Appendix 2) and agreed that the risk rating on the BAF should be linked and increased to 25 as there are still major issues relating to over-crowding and access to services. The ED risk on the Corporate Risk Register is rated at 25. There was also ongoing operational pressures regarding the patients with no criteria to reside.

Therefore the Quality Committee are recommending that BAF risk 3.2 is uplifted to 5 x 5 = 25 and the target rating be uplifted to 4 x 4 = 16. This will be reviewed on a quarterly basis.

The Quality Committee also recommended removing Mental Health from the risk description due to the opening of the Mental Health Hub.

BAF 4 – Great Clinical Services

The Performance and Finance Committee discussed performance and the measures in place to mitigate this risk.

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 Committee discussed a number of initiatives that should begin to show improved performance which included: the Mental Health patient hub opening, the new sepsis pathway, the opening of Rosmore 2 and the new Day Surgery Unit opening at Castle Hill Hospital.

The Committee recommends the risk rating remains the same for Q1.

BAF 5 – Partnerships

The Trust is fully engaged with the ICS as well as the development of the Group Model with Northern Lincolnshire and Goole NHS Foundation Trust. Work is progressing through the Joint Boards and Group Development Committees in Common.

The Humber Acute Services review has changed to the Humber Clinical Collaborative Programme 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.

It is recommended that the Q1 risk rating remains the same.

BAF 6 – Research and Innovation

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.

It is recommended that the Q1 risk rating remains the same.

BAF 7.1 – Finance

The risk will be monitored at the Performance and Finance Committee against the 2023/24 financial plan.

The Performance and Finance Committee recommends a risk rating of 16 in Q1 with a view that this will improve each quarter if the financial plan is achieved.

BAF 7.2 – Underlying Financial Position

The underlying deficit will be monitored at the Performance and Finance Committee. The key

4

issues are linked to in-year pressures and un-identified CRES.

The Performance and Finance Committee recommends a risk rating of 20 due to the ongoing underlying issues.

BAF 7.3 – Capital and Infrastructure
The risk will be monitored at the Performance and Finance Committee against the 2023/24 capital plan.

The Performance and Finance Committee recommends a risk rating of 15 in Q1 with a view that this will improve each quarter if the capital plan is achieved.

6. Timetable
The Committees will continue to review the risk ratings in Q2 in the usual way and these will be presented to the September 2023 Board meeting. A Board Assurance Framework development session will be held in Q2.

7. Corporate Risk Register
Attached at Appendix 2 is the Corporate Risk Register for information and review. This is attached to ensure the Board and Committees can see the high level risks and how they are being managed and mitigated.

8. Recommendations
The Committee is asked to:
- Approve the Q1 risk ratings
- Approve the risk appetite scores in Table 1
- Decide if sufficient assurance has been provided

Rebecca Thompson
Head of Corporate Affairs
July 2023

5

BAF Risk movement throughout 2023/24

BAF 1 Culture

BAF 2 Staffing

BAF 3.1 Quality of Care

BAF 3.2 Patient Harm

BAF 4 Performance

6

BAF 5 Partnerships

	Inherent risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Target Risk
	16	12			6

BAF 6 Research and Innovation

	Inherent risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Target Risk
	16	12			8

7.1 Finance

	Inherent risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Target Risk
	20	20			8

7.2 Underlying Financial Position

	Inherent risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Target Risk
	20	20			20

7.3 Capital

	Inherent risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Target Risk
	20	15			10

7

Agenda Item		Meeting	Operational Risk and Compliance Sub-Committee	Meeting Date	10 May 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 for EMC oversight.
- 4031 current risk rating amended from 20 High to 12 Moderate. De-escalated onto the operational Risk Register

Hull University Teaching Hospitals NHS Trust

Corporate Risk Register Report
Operational Risk and Compliance Committee
May 2023 - (Updated June 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	Mar	Apr
Corporate Functions	4	3	2	0	0	0	0	0
Clinical Support - Health Group	2	2	2	2	1	1	1	1
Emergency Medicine - Health Group	2	2	2	2	2	2	2	2
Family and Women's Health - Health Group	3	2	2	2	2	2	2	2
Medicine - Health Group	1	0	0	0	0	0	0	0
Trustwide	5	5	5	5	6	3	6	6
Total	17	14	13	11	11	8	11	11

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	5	0	6
Total	1	9	1	11

2. Closed Risks

There have been no risks closed off the Corporate Risk Register since the last report.

3. De-escalated from Corporate Risk Register Back to the Operational Risk Register

There have been no risks de-escalated from the Corporate Risk Register back to the Operational Risk Register since the last report.

4. Changes to Risks and Risk Ratings

March
4031 - Patient transmitting hospital acquired infections due to inadequate bed spacing. Review with Senior IPC Matron Current RR amended from 20 High to 12 Moderate. Target RR amended from 10 to 6 Low.

5. Operational Risks Escalated for Inclusion on the Corporate Risk Register

There have been no risks escalated for inclusion onto the Corporate Risk Register since the last report.

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

7. Operational High Risks - for information only (Appendix 2)
There are currently 47 High risks on the Operational Risk Register that have not been escalated for inclusion onto the Corporate Risk.

8. Risk Management – Areas of Ongoing Improvement

1. Following a Risk Maturity Review in March, work and education around the quality of the risk title and descriptors has been a key focus.
2. Action plans are not always utilised to maximise focus and movement of the risks.
3. Although improvements are being seen, risks are not always reviewed within timescales.

Risk Management training has commenced covering fundamentals and the risk register. This has so far been well received and improvements have already been seen in the quality and management of some risks.

9. Recommendations

The Operational Risk and Compliance 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 for EMC oversight.
- 4031 current risk rating amended from 20 High to 12 Moderate. De-escalated back onto the operational Risk Register

Chris Richards
Risk Manager

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** February 2023 Reviewed at Speciality Governance. Awaiting submission and approval of business case. Risk remains the same. **Open Actions** Action 2 - Recruit to nursing, medical and technical staff.

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** March 2023 Current breast pathologist due to leave the Trust on 10.03.23. Escalate to Health Group that the trust has one consultant pathologist. Anything suspicious of cancer check for receptors. Any screening results

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.						cannot go to outsourcing. The service to check. **May 2023** Risk discussed at specialty. Currently down 1 consultant in Pathology. Require a plan from clinical support as to if they are appointing. A meeting with Angela Carling to be arranged. Reports not being finalised on Lorenzo. **Open Actions** None
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 4. Poor Patient experience 5. Staff Burnout 6. Difficulty in recruiting and	Rayner, Dr Ben	04/09/2019	25 5 X 5	**25** **5 x 5**	6 3 x 2	**Links** 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, **Updates** June 2023 ED monthly risk meeting Crowding and flow still in issue, increase in 12HR DTAs in May, no update currently

| retaining staff | | | | | | May 2023
ED monthly risk meeting
Despite a reduction of 12HR DTAs in April - crowding still an issue - evident in the 12hr DTAs logged already in May. This is an ongoing issue which is been managed on a shift to shift basis depending on demand and capacity.

Open Actions
None |

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

May 2023
Summary taken from March Performance and Activity Report:
In March the daily average of NCTR patients increased slightly from February to 207 per day. This is 19% of general and acute beds and 31% of HRI beds.
From April DCOO (Urgent and Emergency Care) has a daily meeting with HGs 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. |

						Open Actions None

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** June 2023 ED monthly risk meeting did not meet target - 49.3% for May 23 - despite this, department is feeling a bit better and work is still ongoing. mapping work being done on the pt journey to find where time is wasted in the timeline. this risk is directly effected by crowding issue. no update to rating May 2023 ED monthly risk meeting Improvements in meeting the 4 hour target are still being made but remain dependent on demand and space across the organisation as this links with the ED crowding risk. Targets were met in April 23 at 54% and a target of 56% was made for May 23. Improvements

			🟥	🟥	🟧	across the department are being managed within the task and finish groups held within the department. **Open Actions** None

3998 - Quality issues identified due to handover delays (Trustswide)

Risk: Quality issues identified due to handover delays causing unintentional harm to patients **Cause:** Number of ambulances waiting at A&E due to lack of Community Care, GPs and Urgent Care Treatment Centres. **Consequence:** Unintentional patient harm	Paul Walker	09/09/2021	25 5 x 5	**20** **5 x 4**	9 3 x 3	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services BAF Risk 3.2 - Quality issues identified due to handover delays **Updates** March 2023 Summary from March 2023 Performance and Activity Report; March position - increased numbers of delayed handovers from February due to lodged patients in ED but time reduced from 1:06hr to 53 minutes. The use of cohorting has increased and use of the Atrium continues (risk assessed). NCR continues to be single largest factor affecting performance with daily average of 207 patients with no medical need for acute services.

						Open Actions
						None

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 | 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

March 2023
Risk to be included in IPC reports for oversight.

March 2023
Advertised twice for assistants and initially managed to over recruit, all new staff need training and validation. The business case for day unit and aseptics has been approved and we can go out to advertise again. The air handling unit had an unplanned shutdown during the first week in March forcing us to do a full cleaning and to cancel over 40 chemotherapy treatments for the day. It's a symptom of the lack of regular maintenance and planned shutdowns during the year due to pressures but that will need to be addressed |

patients -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			█████	█████	█████	April 2023 Reviewed Pharmacy Governance. 3 new band 3 and 1 band 2, however 1 band 3 has handed in notice. They are in the process of being trained. The number of bought in products has been reviewed and a list of drugs available from every provider compiled. Once the Aseptic unit shut down has been completed, this piece of work will be taken forwards. Fluorouracil pumps and paclitaxel pumps, have been sourced for purchase, so will no longer need to be made in the Aseptic Unit. **<u>Open Actions</u>** Action 1 – Appoint an Assistant Action 2 – increase bought in drugs Action 3 – update isolators replacement programme

preplanning near to impossible) or the reduction of number of items we can prepare.						

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

Open Actions
None |

4179 - Delivering on the Operational Plan requirement to reduce the backlog of long-waiting patients (Trust wide)

Condition: 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.	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 **Update** New risk to replace 3995 - Significant waiting list issues including access to screening and follow-up programmes **Open Actions** None

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. **Open Actions** None

Appendix 2 – For Information Only - Operational High Risks not escalated for inclusion onto the Corporate Risk Register

ID	Specialty	Title	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)
3646	Clinical Haematology (Ward)	Haematology Medical Staffing locally and regionally	25	High	20	High	8	Moderate
2982	Paediatric Surgery	Lack of Anaesthetic cover for Under 2's out of hours	20	High	20	High	10	Moderate
4163	A and E	Patient safety measures vs. flow in the Emergency Department	20	High	20	High	8	Moderate
4032	Radiotherapy	Potential non compliance with the IR(ME)R legislation for incident investigation and mandatory reporting	25	High	20	High	5	Low
4068	Orthopaedics (Elective)	Risk to patient safety due to reduction in ability to treat elective Orthopaedic & Neurosurgery (Spinal) patients @ CHH	20	High	20	High	10	Moderate
4122	Theatres	Risk to patient safety due to the urgent replacement of Air/Oxygen gas blenders for the heart lung machines.	20	High	20	High	4	Low
4071	Occupational Therapy	There is a risk that patients assessment and therapy requirements within OT are not identified due to capacity and demand issues	25	High	20	High	6	Low
3983	Radiotherapy	There is a risk to patient safety, accreditation, and quality of the Rt Physics service due to insufficient staff establishment	25	High	20	High	8	Moderate
4148	Diabetes and Endocrinology	Capcity Shortfalls in DEXA scanning	20	High	16	High	8	Moderate
4207	A and E	Crowding in the Paediatric ED	20	High	16	High	8	Moderate
4002	Gynaecology Oncology	Delayed gynaecology cancer pathways *(inherent RR being checked)*	12	Moderate	16	High	4	Low
3919		E-Radiology Results System: Results not being Actioned Appropriately	16	High	16	High	4	Low
4120	Systems and Applications	Inability for HUTH to meet the NHSx mandate of one EPR for the ICS by March 2025	16	High	16	High	1	Very Low
3918	Acute Medicine	Lack of Adequate Substantive Consultant Workforce in Acute Medicine	16	High	16	High	4	Low
4037	Cardiology	Lack of Suitably Trained Staff to Perform Cardiac Stress Testing	16	High	16	High	1	Very Low

3988	Radiotherapy	Lack of Therapeutic Radiographer Staffing	20	High	16	High	3	Very Low
3125		Multiple junior doctor vacancies - risk to patient safety and care	20	High	16	High	8	Moderate
4141	Systems and Applications	Network shares (passwords in clear text, sensitive patient data, backups, logs, world writable shares, etc)	16	High	16	High	4	Low
4208	A and E	Patient safety is being compromised due to long stays in the ED causing pressure sores on trolleys that are unfit for prolonged	16	High	16	High	8	Moderate
4056	A and E	Reduced medical staffing numbers (doctors, ACP's etc) leading to increased waiting time for patients and workload on existing cl	20	High	16	High	12	Moderate
4170	Major Trauma	Risk of increased morbidity and mortality for elderly MTC patients due to inadequate DME support for Major Trauma Centre	25	High	16	High	10	Moderate
4169	Cardiology	Risk to Continuity of TAVI service due to staffing shortfalls	16	High	16	High	4	Low
4041	Orthopaedics (Trauma)	Risk to patient outcomes from delays due to bed capacity for Priority 1b trauma patients	16	High	16	High	4	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	16	High	8	Moderate
3945	Infection Control	There is a risk that patients develop a preventable Healthcare Associated Infection during an inpatient/outpatient episode	20	High	16	High	6	Low
3946	Nuclear Medicine	There is a risk to patient safety due to the inability to meet the current demand for mps imaging	20	High	16	High	2	Very Low
4030	Nuclear Medicine	There is a risk to service continuity within Nuclear Medicine due to a lack of technical staffing	20	High	16	High	1	Very Low
4134	Systems and Applications	Weak passwords (Domain Users)	16	High	16	High	4	Low
4160	Cardiology	Absence of 8A Matron support within Cardiology at HUTH	15	High	15	High	6	Low
4137	Business	Accuracy of Data of Business Decision Making	15	High	15	High	5	Low

	Intelligence and Information				High		High	Low
4138	Systems and Applications	Annual Penetration Testing Delayed	15	High	15	High	5	Low
3962	Radiology	Cardiac CT demand outstripping capacity	15	High	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	20	High	15	High	6	Low
4012	Ophthalmology	Clinical risk to patients referred as new patients into the new wet macular degeneration pathway	20	High	15	High	6	Low
4011	Ophthalmology	Clinical risk to patients requiring sub-specialist Medical Retina outpatient follow-up due to lack of capacity	20	High	15	High	6	Low
3475	Gynaecology	Concerns surrounding RCOG Trainee Curriculum - Obstetrics and Gynaecology	20	High	15	High	5	Low
4132	Systems and Applications	Cyber Security vulnerabilities	15	High	15	High	5	Low
4115	Ear Nose and Throat (use this one)	ENT Laser replacement	15	High	15	High	3	Very Low
3291	Radiotherapy	Failure to update the Dosimetry Check Patient Transit Dose System	15	High	15	High	2	Very Low
4203	Neurosurgery	Inability to consistently provide complex neurosurgery due to microscope instability.	15	High	15	High	4	Low
4200	Community Paediatrics	Increased risk of harm to patients and families due to inadequate co-located psychology support to children and young people.	20	High	15	High	5	Low
4173	Chest Medicine	Nintedanib Change in guidance impacting on clinical capacity to deliver increasing numbers of patients	15	High	15	High	6	Low
3979	Radiology	Patient care is being compromised within General Radiology because of staff shortages	15	High	15	High	3	Very Low
3252	Ophthalmology	Patients with Diabetic Eye Disease are experiencing delays in assessment and treatment resulting in potential loss of sight	15	High	15	High	6	Low

4033	Radiotherapy	Potential inability to deliver Colorectal Contact Radiotherapy due to equipment related issues	25	High	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	25	High	15	High	10	Moderate
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	15	High	3	Very Low

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 Theme: Culture **Appetite: Low** **Risk: 1**	**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	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	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	Review and relaunch of the staff charter. This is well underway and will be ratified at Workforce Transformation Committee Relaunching the PACT training. This will be mandatory for all staff. All staff will receive a 90 minute session on civility, the relaunched staff charter and expectations of managers. The session contains a new section on how to raise concerns and challenge behaviours. We are identifying staff to deliver the training including clinical and medical leaders. Briefing all 700 B6/B7+ managers at the trust in a series of sessions throughout July and August on the staff charter and PACT training. This will set out, clearly, expectations of managers in challenging and dealing with poor behaviours. Launching a reporting tool (piloted in maternity and cardiology). This will be rolled out across the Trust and has input and support from HR, FTSUG, and OD.Staff can report anonymously or 'on the record' and receive support for tackling issues. Marketing campaign – BAD BEHAVIOUR DOESN'T WORK – to go out in the next couple of months, promoting the charter, the reporting tool and highlighting poor behaviours and their impact.	

	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:** Staff Survey 2022 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 30.06.23 (Q1)**			**Planned target risk position by 31/03/2024**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
5	4	20	4	4	16	3	4	12

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 Theme: Workforce **Appetite: Low** **Risk: 2**	**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 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 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.	
				Metrics: Staff Survey People Performance Report **Independent / semi-independent:** CQC NHS England/Improvement Internal Audits	**Outcomes:** Q1 Trust adjusted vacancy rate = 2.1% Turnover 11.9% against a target of 9.3% Less than 1 year leavers = 21.3% Consultant job plans = 77.8% Sickness = 4.5% Appraisals Medical =		

						92.9% Appraisals AFC staff = 68.4%		
Inherent Risk			**Risk position as at 30.06.23 (Q1)**			**Planned target risk position by 31/03/2024**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	5	20	4	4	16	3	4	12

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

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

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 CQC Action Plans in place	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	CQC Report – Requires Improvement rating ED, Medicine and Surgery inspections result 'inadequate' for safe CQC Maternity Inspection – Section 31 imposing conditions on the Trust's registration	Transition to PSIRF from April 2023. Targeted work with HGs regarding complaints is ongoing. Implementation of new PHSO complaints framework underway 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 CQC ED1.2: Sepsis training and competencies. Implementation commenced as planned in November 2022. However, sufficient training has not yet been provided. 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. 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. An update report was presented	

to the February 2023 Quality Committee. If Board members would find a copy of this useful, it can be found in the upload from February 23 in the shared area.

The following actions have been undertaken since the implementation of the digital task and finish group:
All ED Digital Nursing Records reviewed and revised, now in live with integrated clinical notes populating clinical record:
- ED Safeguarding
- Mental Health Triage
- ED Nursing Assessment
- ED Infection
- ED Moving & Handling
- Purpose -T [pressure ulcer prevention
- SPACES – Intentional rounding
- Acuity
- Sepsis

Introduction of Clinical Dashboards
- ED Overview
- ED Safety Huddle
- ED Sepsis

Clinical Escalations is planned to be rolled out in ED by the end of April 2023 [automated escalations of NEWS2 score to ED Safety Dr and ED Safety Nurse]

Manchester Triage – currently in test with plan to review mid-April.

All of the above work has been supported by appropriate training and support for staff.

The following action has been completed as planned; however, there is a further update to add and is reported below.

ED5.5: This relates to the cohorting of patients waiting with an ambulance crew. This action was completed as planned; however, a further update to this and following the ICB assurance review in ED was for the glass in the Atrium to be frosted, this has now been completed.

CQC Trustwide actions
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)).

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

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)).

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)). |

Risks from Risk Register:
3460 - Availability of Radiology Support for Paediatric & Neonatal Services.

3282 - Failure in the Trust systems to ensure requested test results, pathology and radiology, are reviewed & actioned by the requester

3450 - There is a risk of increased pressure damage to patients due to failing or lack of pressure relieving mattresses

Metrics:
National Audit Benchmarking Harm Free Care

Patient Experience Survey

Independent / semi-independent:
CQC inspections
Internal audits
External reviews (e.g. NHSEI)

Outcomes:
Q1 PSIRF now in place – the weekly patient safety summit continue to meet to review patient safety incidents.

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
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 and Patients with No Criteria to Reside 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	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 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. 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 opened July 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 impact (2x specialities – referrals have increased) Clinical Admin Service continue to proactively contact patients with TCIs/appointments to	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 Continue with the plans to introduce the 90 day plan of the ground floor model designated mental health assessment area adjacent to ED now open	

| | | | | | check they are attending/if treatment is still required – small number of removals

Progressing mutual aid support from providers within and without of H&NY and continuing to in-source capacity where possible to support pressured specialities | | |
| | **Risks 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 | **Outcomes:**
Q1
4 hour performance = 66.6%

Waiting list = 69,263

104 week wait = 0

380 over 60 minute ambulance handovers

167 breaches - 12 hour trolley waits

patients per day with no criteria to reside = 209

78 week breaches = 77

The number of patients waiting to start treatment on 62 pathway has reduced to 1,325

1 of 9 cancer standards were met in April 2023 | | |

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/24		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	5	5	25	4	4	16

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/HCCP 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 Cancer performance 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 Bi-monthly Board Report Health Group Performance and Accountability meetings monitor recovery plans in place	Trust Recovery Plans Paragon Suite rehabilitation facility Waiting list	Continued focus at speciality level of patients dated and/or risks now focussed to achieve and maintain zero 104-week waits. 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	
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			**Metrics:** Health Group recovery plan trajectories **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit	**Outcomes:** Q1 Waiting list 69,263 Ambulance handover position 64.9% in less than 30 minutes 104 week wait = 0 78 week wait = 77 Patients with no criteria to reside = 209 per day 1 out of 9 cancer waiting times national standards achieved		

Strategic Theme: Performance
Appetite: Low
Risk: 4

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

Inherent Risk			Risk position as at 30.06.23 (Q4)			Planned target risk position by 31/03/2024		
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

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 Clinical Collaborative 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 Out of hospital programme at various stages of development	Bi-monthly reports detailing progress to the Committees in Common Group Development Committees in Common Joint Board meeting 28 June 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	**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	
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:** Humber Acute Services Review has changed to Humber Clinical Collaborative Programme		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/24		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	3	6

Strategic Theme: Strategy
Strategic Appetite: Moderate
Risk: 5

	Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic objective: Research and Innovation **Assurance Committee:** Quality Committee **Executive Lead:** CMO **CQC Domain:** Safe **Enabling Strategies/Plans:** Research and Innovation Strategy							
Strategic Theme: Research and Innovation **Appetite:** Moderate **Risk: 6**	**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. 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. 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	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 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.	Q1 Joint RDI working between HUTH and NLAG Joint strategy to be agreed	

| | | | associated skills in the workforce and from our dedicated H-Digital Teams. | | | | | |
| Risks from Risk Register:
No risks highlighted | | | | Metrics:
Recovery Activity R&I

Capacity

Independent / semi-independent:
NHS E/I
HASR
CQC
ICS | Outcomes: | | | |

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	4	16	3	4	12	2	4	8

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 Theme: Financial Appetite: Moderate Risk: 7.1	**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 2022/23 Financial Performance Review meetings in place with Health Groups Monthly scrutiny of the Balance Sheet by the Performance and Finance Committee Realistic and achievable plan in place developed with staff input and sustainability funds identified	Ongoing development of accountability of Health Groups – further improvements required Gap in identified CRES schemes and required level	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 Locums in Clinical Support (Oncology and Haematology) Lung Health check	The Trust has a planned deficit of £7.2m for 2023/24	
	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:** Deficit of £1.7m reported at month 1, £1.4m worse than plan		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	4	4	16	2	4	8

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 Theme: Finance **Appetite:** Low **Risk:** 7.2	**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	Regular update reports to the Performance and Finance Committee	Lost income due to Junior Doctors strike	Ongoing development of accountability of Health Groups	
	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:** reported deficit of £1.7m at month 1, £1.4m worse than plan		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	4	5	20

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

Strategic Theme: Financial
Appetite: Moderate
Risk: 7.3

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. **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	Monthly updates to the Performance and Finance Committee Regular updates to the Board	Building works impacting on patients and staff	Capital Plan Phase 1 of Day Surgery Scheme	
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:**		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	3	5	15	2	5	10

Actions taken, planned and draft assurance rating (AR)

BAF Risk 1		Culture The Trust does not make progress towards further improving a positive working culture this year.						
		Inherent Risk Rating		**Current Risk Rating**			**Target Risk Rating**	
		5 x 4 = 20		4 x 4 = 16			3 x 4 = 12	
Q1 Actions	AR	Q2 Actions	AR	Q3 Actions	AR	Q4 Actions	AR	Year End Position
Review and relaunch of the staff charter. This is well underway and will be ratified at Workforce Transformation Committee

Relaunching the PACT training. This will be mandatory for all staff. All staff will receive a 90 minute session on civility, the relaunched staff charter and expectations of managers. The session contains a new section on how to raise concerns and challenge behaviours. We are identifying staff to deliver the training including clinical and medical leaders.

Briefing all 700 B6/B7+ managers at the trust in a series of sessions throughout July and August on the staff charter and PACT training. This will set out, clearly, expectations of managers in challenging and dealing with poor behaviours.

Launching a reporting tool (piloted in maternity and cardiology). This will be rolled out across the Trust and has input and support from HR, FTSUG, and OD.Staff can report anonymously or 'on the record' and receive support for tackling issues.

Marketing campaign – BAD BEHAVIOUR DOESN'T WORK – to go out in the next couple of months, promoting the charter, the reporting tool and highlighting poor behaviours and their impact. | | | | | | | | |

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

BAF Risk 2		Workforce							
		The Trust does not effectively manage its risks around staffing levels in both quality and quantity of staff across Trust							
		Inherent Risk Rating			**Current Risk Rating**			**Target Risk Rating**	
		4 x 5 = 20			4 x 4 = 16			3 x 4 = 12	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**		**AR**	**Q4 Actions**	**AR**	**Year End Position**
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.									

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 a 'good' rating					
		Inherent Risk Rating		Current Risk Rating		Target Risk Rating	
		4 x 4 = 16		4 x 4 = 16		3 x 4 = 12	
Q1 Actions	AR	Q2 Actions	AR	Q3 Actions	AR	Q4 Actions	AR	Year End Position

Q1 Actions	AR	Q2 Actions	AR	Q3 Actions	AR	Q4 Actions	AR	Year End Position
CQC ED1.2: Sepsis training and competencies. Implementation commenced as planned in November 2022. However, sufficient training has not yet been provided. 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. 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. The following actions have been undertaken since the implementation of the digital task and finish group: All ED Digital Nursing Records reviewed and revised, now in live with integrated clinical notes populating clinical record: • ED Safeguarding • Mental Health Triage • ED Nursing Assessment • ED Infection • ED Moving & Handling • Purpose -T [pressure ulcer prevention • SPACES – Intentional rounding • Acuity • Sepsis Introduction of Clinical Dashboards • ED Overview • ED Safety Huddle • ED Sepsis Clinical Escalations is planned to be rolled out in ED by the end of April 2023 [automated escalations of NEWS2 score to ED Safety Dr and ED Safety Nurse] Manchester Triage – currently in test with plan to review mid-April. All of the above work has been supported by appropriate training and support for staff. The following action has been completed as planned; however, there is a further								

update to add and is reported below. ED5.5: This relates to the cohorting of patients waiting with an ambulance crew. This action was completed as planned; however, a further update to this and following the ICB assurance review in ED was for the glass in the Atrium to be frosted, this has now been completed. CQC Trustwide actions TW1: The trust must ensure care and treatment of service users must only be provided with the consent of the relevant person. TW2: The trust must ensure that mandatory training compliance, including training, meets the trust target. 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. 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.						

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			5 x 5 = 25			4 x 4 = 16	
Q1 Actions	AR	Q2 Actions	AR	Q3 Actions	AR	Q4 Actions	AR	Year End Position	
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 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									

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			**Current Risk Rating**		**Target Risk Rating**	
		5 x 5 = 25			4 x 5 = 20		4 x 4 = 16	
Q1 Actions	**A R**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**
CDU for Nurse Led pathways to be implemented from 22nd May 2023. These pathways historically breach in ECA as awaiting timed treatment/results. 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. From 10th April 2023 day-time cohorting was provided by HUTH From 10th April 2023, a 2nd Nurse was 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. This has been delayed YAS have a number of improvement programmes to be prioritised. 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%. we delivered 64.9% 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. Targeted HG & speciality meetings continue to reduce waiting Internal milestones set to reduce maximum waits								

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 and continuing in April, into May 2023. This will be required into Q2. 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.						

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 HCCP due to recovery constraints					
		Inherent Risk Rating		Current Risk Rating		Target Risk Rating	
		4 x 4 = 16		3 x 4 = 12		2 x 3 = 6	
Q1 Actions	AR	Q2 Actions	AR	Q3 Actions	AR	Q4 Actions	AR	Year End Position
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 Pause and review of Humber Clinical Collaborative Programme								

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			**Current Risk Rating**			**Target Risk Rating**	
		4 x 4 = 16			**3 x 4 = 12**			**2 x 4 = 8**	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
Joint RDI working between HUTH and NLAG Joint strategy to be agreed									

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 7.1		**Financial** Expenditure incurred exceeds income by greater than agreed control total						
		Inherent Risk Rating			**Current Risk Rating**		**Target Risk Rating**	
		5 x 4 = 20			**4 x 4 = 16**		**2 x 4 = 8**	
Q1 Actions	**A R**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**
The Trust has a planned deficit of £7.2m for 2023/24								

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			4 x 5 = 20	
Q1 Actions	**A R**	**Q2 Actions**	**AR**	**Q3 Actions**	**A R**	**Q4 Actions**	**AR**	**Year End Position**
Ongoing development of accountability of Health Groups 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.								

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 7.3		**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**	
Capital Plan The initial programme for 2023/24 is an assessment based on a "do minimum" basis and makes provision for base allocations for Medical Equipment (£2.5m); IM&T (£2.5m) and Backlog Maintenance (£2.5m).									

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.

	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

(Left axis label: Likelihood Score)

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

QUALITY REPORT

REFERENCES

📕 Quality Report - Quality Committee - June 2023.pdf

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		Meeting	Quality Committee	Meeting Date	June 2023
Title	Quality Report				
Lead Director	Suzanne Rostron, Director of Quality Governance, Jo Ledger, Chief Nurse and Prof Makani Purva, Chief Medical Officer				
Author	Michela Littlewood - Associate Director of Quality Donna Pickering – Head of Patient Safety and Improvement, Leah Coneyworth – Head of Quality Compliance and Patient Experience Kelly Northcott-Orr Head of Continuous Quality Improvement				
Report previously considered by (date)	This report has not previously been considered				

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 Quality Committee is recommended to review the executive summary of the key indicators and decide if sufficient assurance has been received with the actions taken to address the concern areas. In addition to confirm if any further action is required.

Quality Report

May 2023 Performance Data

Produced for the June 2023 Quality Committee

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 April 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	First thematic review undertaken using PSIRF Transition to PSIRF 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 has set a new trajectory to clear the open SIs declared in line with the Serious Incident Framework (2015) by August 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. All incidents are discussed at the Weekly Patient Safety Summit (WPSS). From 1st April the format has changed in line with PSIRF and the focus is on different investigation and learning responses. Approaches used are AAR, Safety Huddles, and Thematic Reviews to identify if there are other improvement opportunities. PSIIs are declared if they meet the learning responses set in the PSIRP. The Patient Safety Team support the Health Groups with learning responses during the transition period.

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
Effectiveness Domain	HSMR	The rolling HSMR is 116.07 and the monthly (January 2023) HSMR is 108.56 which has decreased compared to the previous month. The rolling HSMR is showing a steady rate and displays no sudden elevations	The Trust continues to demonstrate a HSMR with "higher than expected" deaths and is therefore an outlier in HSMR.	The Sepsis and Pneumonia steering groups continue to provide insight data, with detailed action plans being delivered in order to further improve outcomes for these patient cohorts.
	SHMI	Trust SHMI has continued on a downwards trend since the end of 2021 and in November 2022 has dropped further to 1.08. Pneumonia SHMI continues to remain "as expected" and has remained at 1.03 since August 2022 Sepsis SHMI continues to demonstrate 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.	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 is marginally higher than the National Level of 1.0 at 1.07; Stroke SHMI is continually reducing and is very close to the "as expected" range.	HUTH is one of the middle performing Trusts when compared to its peers against stroke.	Regular updates in relation to Stroke mortality given to the Trust Mortality and Morbidity Committee.
	Structured Judgement	25% of deaths have had a Structure Judgement Review,	Development of feedback mechanisms, identified by RSM Auditors, minor action for	Action identified by a recent audit of the Learning from Deaths framework,

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
	Reviews	which has continued to improve following increased engagement from clinicians since late 2022	improvement following the Mortality and Learning from Death internal audit.	undertaken by RMS, a quality control to check the quality of the SJR against the expectations set out by Trust policy, as well as the National Quality Board. From April 2023 quarterly audit undertaken on a sample of SJR's
	Indicator	**Successes**	**Risks / Challenges**	**Actions / Future Plans**
Responsive Domain	PALS and Complaints	Eliminated the complaints to be logged backlog, with no complaints overdue for logging by the end of May 2023

The Model Complaints Standards Steering Group had its second meeting. Approved changes to the Early Resolution and Consent processes

Continue to implement the early resolution process with the aim of addressing concerns in a quicker timeframe with a reduction in the number of concerns that are escalated to a formal complaint.

Leadership from Nurse Directors in the Health Groups to increase the number of complaints closed within 40 days whilst also reducing the number of complaints overdue

Increase in the number of complaints now also closed within 0-29 and 30-40 days

Reduction in the backlog of overdue complaints within Medicine. In December 2022, Medicine had 41 overdue complaints with the longest one open at 434 days. In May 2022, | Maintaining 3 working day timeframe for acknowledging and logging complaints

Maintain improvements against the planned outcomes

Main theme continues to be cancellations, delays and waiting times – no changes to the main themes | Implement a reflective practice group with NED engagement

Undertake a deep dive into the complaint re-opened and the reasons why to identify areas for improvement in the responses provided to complainants and the quality

Continue to deliver the NHS Model Complaint Standards via the Steering Group

Improve triangulation of data to inform more focussed learning from patient experience

Agree the process for 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

Use complainant feedback on the complaints process to continually improve practice |

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
		Medicine had 6 overdue complaints with the longest one open at 85 days Reduction in the backlog of overdue complaints within Surgery. In December 2022, Surgery had 57 overdue complaints with the longest one open at 450 days. In May 2022, Surgery had 16 overdue complaints with the longest one open at 261 days		
Well-led Domain	Continuous Quality Improvement	Cohort 5 QSIR Practitioner is being 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 Just culture work has been undertaken to include staff feedback.	Continued development of the CQI website.	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. Progress is being made with a number of QI projects. Think Tank Initiatives are being rolled out. Just culture work will be presented in a future quality report Progress is being made with Getting It Right First Time (GIRFT) with face to face Deep Dive visit on 24 April 2023 for Acute and General Medicine. On 10 May 2023, a Trust level Gateway Review (Deep Dive) took place virtually for Gynaecology services. .

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 April 2023.
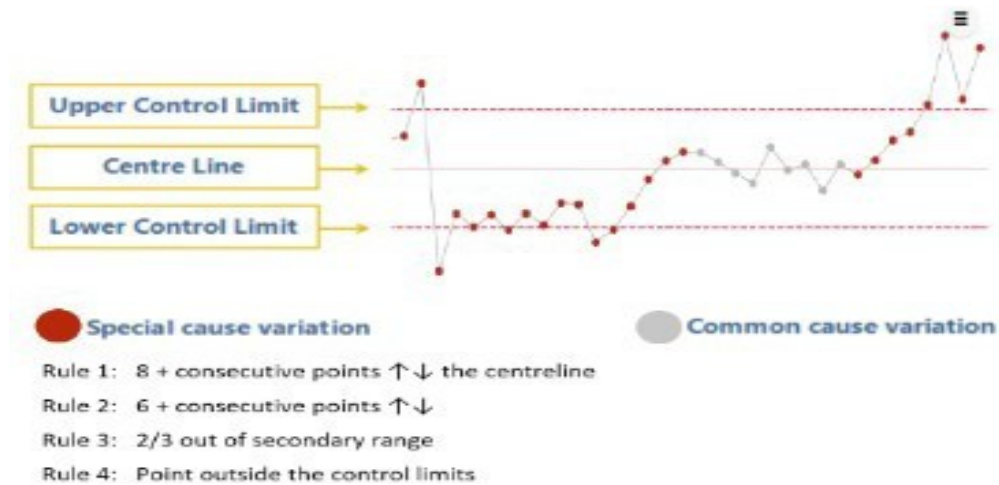
Statistical Process Control (SPC) is an established analytical technique that plots data over a period of time to help us understand variation and assurance and as a result directing us to the correct area of improvement for the appropriate action to be taken to make a difference. The charts also allow 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

Target

Upper Control Limit

Mean Control Limit

Lower Control Limit

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

x-Chart   Patient Incidents Reported

x-Chart   Patient Incidents p1000bd
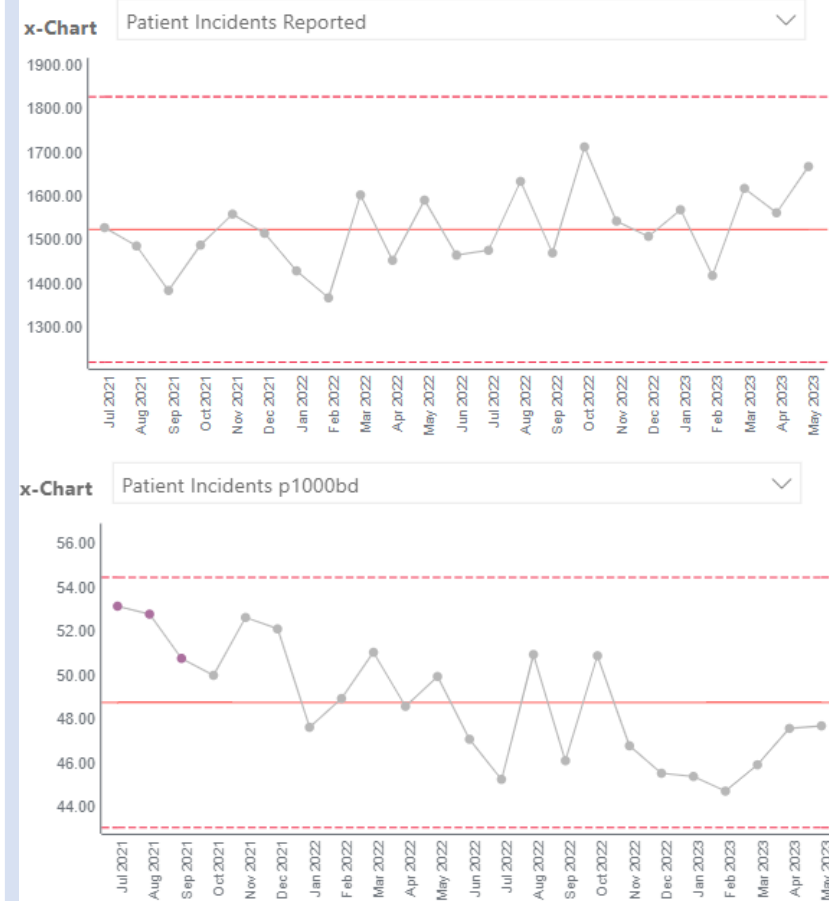
What is the charts are telling us:
- There were 48 patient safety incidents per 1000 bed days recorded in May 2023 (n=1669); 3.2 (per 1000 bed days) incidents resulted in moderate, severe or catastrophic harm to the patient.
- The number of incidents being reported against all severities per 1000 bed days has seen a reduction over the last 6 months to below the mean
- The number of incidents causing harm to patients (per 1000 bed days) is showing an upward trend overall with the number reported in May outside of the upper control limits.

Successes:
- The Trust has a positive patient safety reporting culture (high volume, low harm).
- The Trust continues to sustain incident-reporting levels above the national average of 45 with a mean of ~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 are discussed positively.
- The Patient Safety Team continued to facilitate a AARs in May.

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 were fewer incidents of other incident types reported, with the next highest group being treatment and care incidents with 15 reported.
- There were 6 incidents causing harm reported for moisture associated skin damage incidents.
- MHG had the highest number of incidents overall, and SHG the most that resulted in harm.
- There were 5 patient deaths reported in May, 3 in MHG, and 2 in FWHG.
- Proportion harm may appear higher as the number of incident being reported is lower, further incident reporting work will take place to address this.
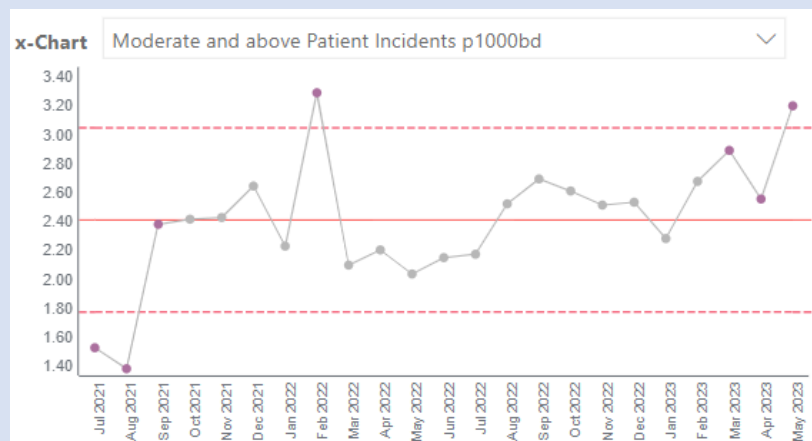
| **Patient Safety Incidents reported per 1000 bed days Patient Safety Incidents causing harm per 1000 bed days**	**Aim:** To promote a safe learning culture by reporting patient safety incidents
	Target: To see a reduction in the number of incidents resulting in harm

- A review has been undertaken of the maternity incident risk rating and further review is planned to look at minor and no harm incidents.
- Maternity have established a daily incident review process to ensure the correct grading.

Actions / Future Plans for Improvement:

- Quality Improvement Project underway to increase the number of patient safety events being reported and this 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 contributory factor are discussed at Weekly Patient Safety Summit (WPSS) for investigating as PSIIs focussing on system errors.

2.2 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSIIs) DECLARED

Number of Serious Incidents and PSIIs reported
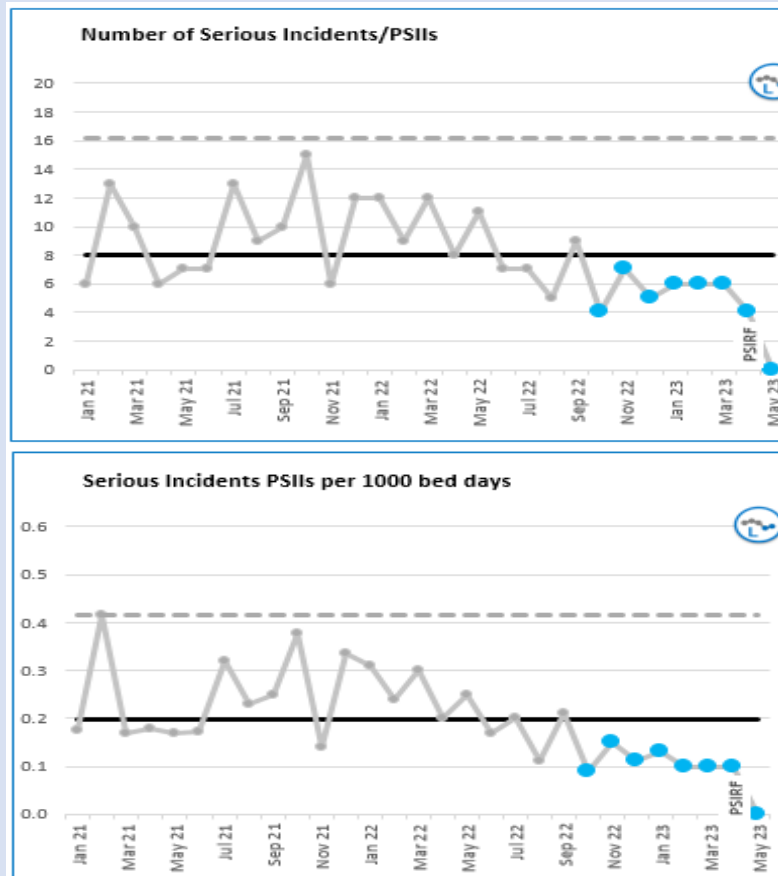
Serious Incidents/PSIIs per 1000 bed days

Aim: To investigate PSIIs with the aim of learning how to reduce risk and associated harm and ensure supportive systems and process are in place through continuous improvement

What is the chart telling us:

- The Trust did not declare any serious incidents or PSIIs in May 2023.
- There was a maternity still birth, an After Action Review was undertaken and referred to HSIB for investigation.
- The graphs show a shift change in the number of SIs reported over the last 8 months.

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 began transition from the SI Framework (2015) to PSIRF from 1st April 2023.
- PSIRF information and investigations toolkit is available on Pattie.

Key Risks and Challenges:

- Although there were no serious incidents declared in May there is still the possibility that there are incidents where harm has not yet been recognised with the potential to still declare SIs retrospectively in line with the SIF, 2015.
- 2 patient deaths were included in a thematic review being undertaken for deaths of patients on the TAVI waiting list.
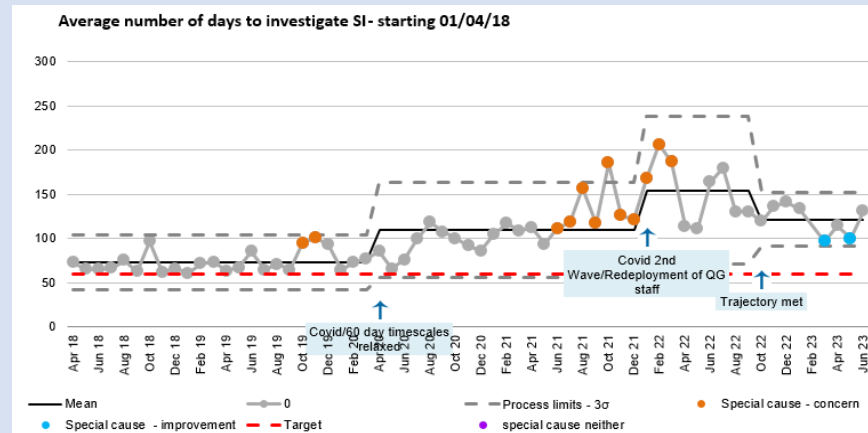
Actions / Future Plans for Improvement:

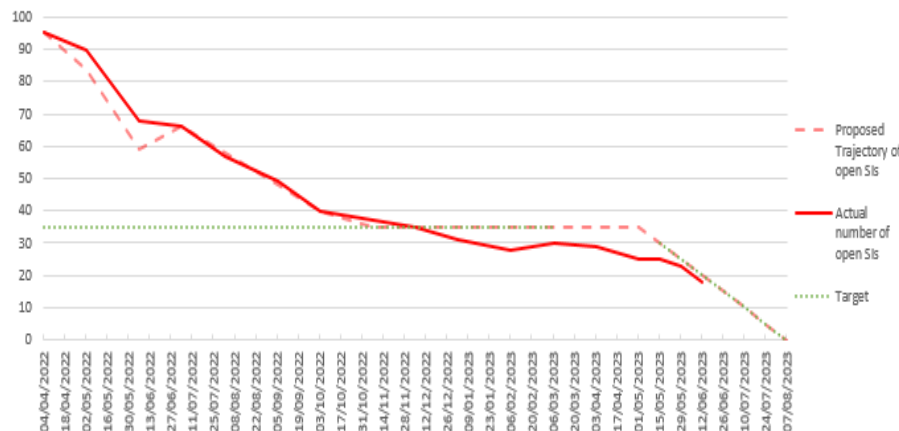- To engage with patients, families and staff affected by the incident to contribute

Number of Serious Incidents and PSIIs reported Serious Incidents/PSIIs per 1000 bed days	Aim: To investigate PSIIs with the aim of learning how to reduce risk and associated harm and ensure supportive systems and process are in place through continuous improvement
	• to learning responses and continuous improvement. • To apply a range of systems-based approaches to learning from patient safety incidents, strengthening awareness of SIEPS and other systems-based methodology. • To learn from thematic reviews in no harm and near miss incidents (Safety II). • To grow the Patient Safety Champion network and number of Learning Response Leads for strengthened ward to board learning.

Average number of days to investigate serious incidents Trajectory for closing all open serious incidents

Future plan that these charts will not be included and only a narrative will be provided until the end of August 2023

Aim: For no serious incident investigation to be open for more than 100 days

Target: For all serious incidents declared prior to transition to the PSIRF to be investigated by August 2023

Average number of days to investigate SI- starting 01/04/18

Trajectory of reducing open SIs declared pre PSIRF

What is the chart telling us:

- The number of open investigations at the end of May was 23 and within the agreed tolerance levels with ~25 open.
- The number of Serious Incidents that have been open over 100 days remained at 10.
- The average number of days taken to investigate SIs in the month was 100. 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 23 open at the end of May 2023 and the number continues to decrease.

Key Risks and Challenges:

- The number of SIs that still remain open means that it will be at least a couple of months before the Trust can fully transition to the new way of investigating PSIIs and moving towards a Safety II culture.

Actions / Future Plans for Improvement:

- A new trajectory has been set for all serious incidents declared prior to the transition to PSIRF to be investigated by August 2023; those declared during the transition period will be investigated within 60 day timescales.
- Work continues focus on the investigations open over 100 days and to ensure families are kept updated.
- 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.

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

x-Chart — Hospital Acquired Pressures Ulcers reported

x-Chart — Deep Tissue Injury Hospital Acquired Pressures Ulcers reported
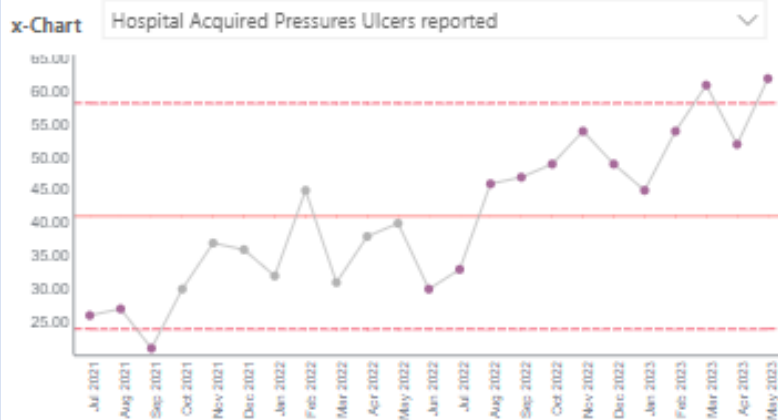
What is the chart telling us:

- There were 1.70 pressure ulcers per 1,000 bed days resulting in moderate and above harm in April (n=62).
- Category 2 pressure ulcers now at 37; this is on the upper control limit.
- DTIs have increased in April to 18; these remain within the control limits.
- Unstageable pressure ulcers have decreased to 6 incidents, this is within control limits.
- Whilst the chart appears to show an overall increase in Hospital Acquired Pressure Ulcers which is above the upper control limit for the second time in three months, there are anomalies in the data and once validated by the TVN team the overall trend is downwards (54 in May, 48 in April and 55 in March).
- The charts include incidents which are still under investigation and have yet to be validated which may account for some of the anomalies

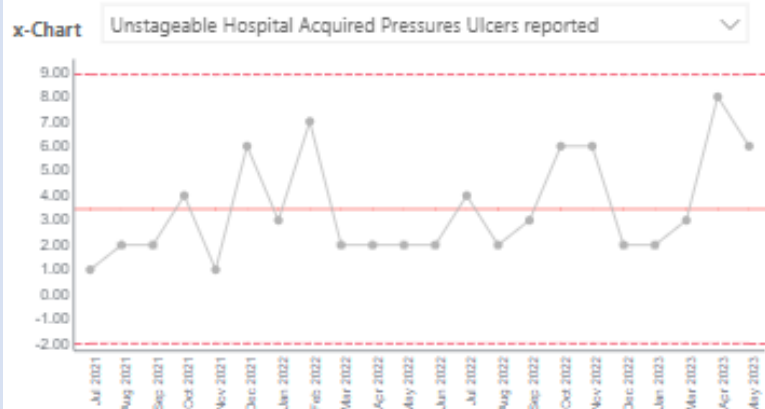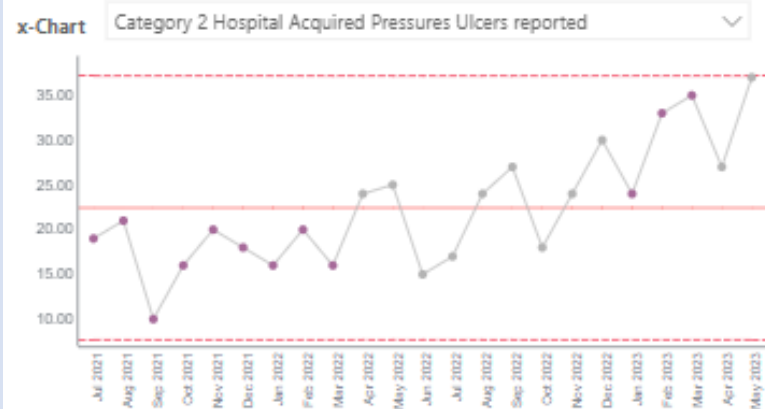**NB the SPC charts do not include device related pressure damage**
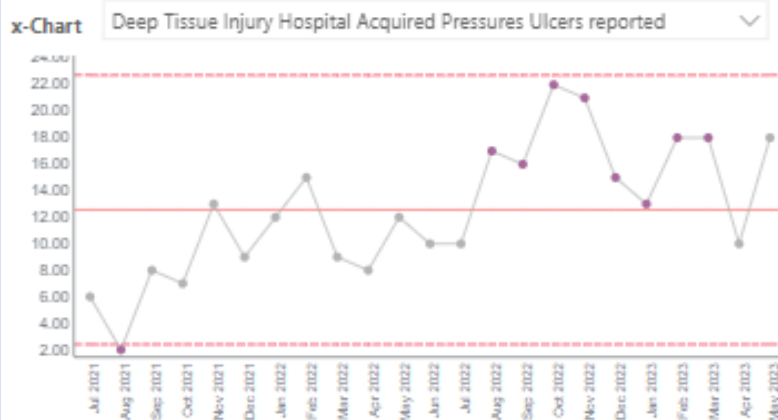
Successes:

- Fundamental Standards Audit has seen an improvement in the red scores (13 in February to 6 in June). Amber is still the predominant score.
- Tissue Viability Improvement video has been launched with actions to be implemented from July.
- Assurance will gained through HG reports submitted via Safer Skin Committee.
- Skin Champions study days successful (19 attendances) with more planned for the year.
- Link Nurse study days are a success with more booked going into the next year.
- Housekeeper study day with IPC, Falls and Meds Management very successful with more planned throughout the year – places highly sought after.
- Bi-monthly mattress audit compliance has increased.
- Increase in digital photography of wounds across the organisation leading to timely treatment of wounds and evidence in safeguarding cases.

Hospital acquired pressure ulcers	**Aim:** To have a zero tolerance approach to hospital acquired pressure ulcers
Deep Tissue Injury pressure ulcers	**Target:** To reduce the number of hospital acquired pressure ulcers to below the mean
Category 2 pressure ulcers	

x-Chart — Category 2 Hospital Acquired Pressures Ulcers reported

x-Chart — Unstageable Hospital Acquired Pressures Ulcers reported

- Maternity specific study day planned for July.
- More dates for nursing assistant face to face training planned.
- The Tissue Viability Strategy has been aligned with PSIRF processes.

Key Risks and Challenges:

- There were 37 Category 2 pressure ulcers reported (plus 6 device related); 0 Category 3 pressure ulcers, 18 Deep Tissue Injuries (DTI) (plus 3 device related) and 6 unstageable pressure injuries (plus 1 device related).
- CQUINN number 12 potentially will not be achieved as individualised care plans do not have patient preference question so not evidenced.

Actions / Future Plans for Improvement:

- Task and finish group has finished.
- QR codes for beds and profiling have been applied to Medstrom Solo beds and the rest are due to be completed in July.
- Paediatric specific study day to be confirmed.
- Video for bi-monthly mattress audit procedure to be uploaded to Pattie.
- All registered nurses to complete a full skin inspection for every patient at least once a shift.
- Nurse in charge to check all high risk patients and review documentation to ensure the correct plan of care is in place.
- The CQUIN Steering group will work with TV Matron to try and achieve CQUIN 12.
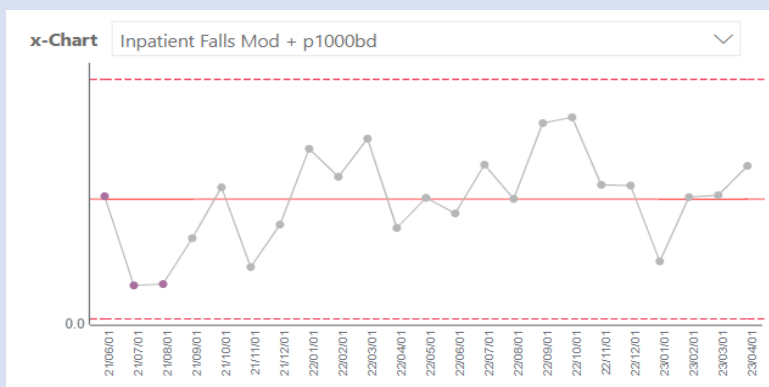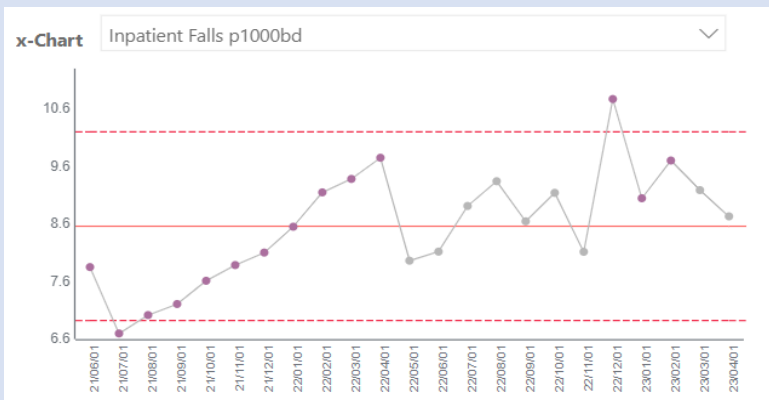
2.5 INPATIENT FALLS CAUSING HARM

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 6.8 inpatient falls per 1000 bed days in April 2023 (n= 300)
- 0.23 (per1000 bed days) inpatient falls that 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, with 44.4% noted to have some degree of cognitive impairment on admission.
- The number of inpatient falls per 1000 bed days has continued to increase during April 2023.

Successes:

- 130 staff received face to face training in April.
- Falls training overall has increased from 56.1% to 59.5%.
- 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	446	858	1304
Preventing Falls in Hospital: Carefall	44	23	67
Preventing Falls in Hospital: Fallsafe	2071	861	2932
Grand Total	**2561**	**1742**	**4303**

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. This proved to be well received and appreciated by all staff in attendance.
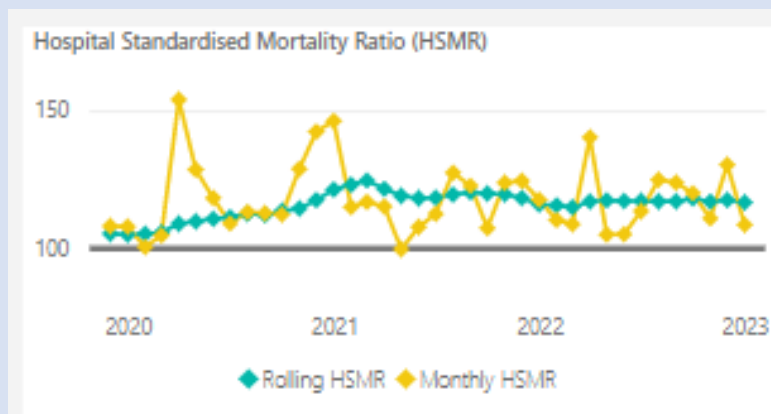
Inpatient falls per 1000 bed days Inpatient falls resulting in harm per 1000 bed days	Aim: To reduce the number of inpatient falls resulting in harm Target: To reduce the number of inpatient falls to below the mean
	Key Risks and Challenges: • No additional falls information has been provided for April, this will be discussed with the falls team. • Training rooms still to be 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.

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
This is the previous data set for information, this was in the previous report	Target: Below 100

Hospital Standardised Mortality Ratio (HSMR)

Deaths and Crude Mortality

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)

This is the previous data set for information, this was in the previous report
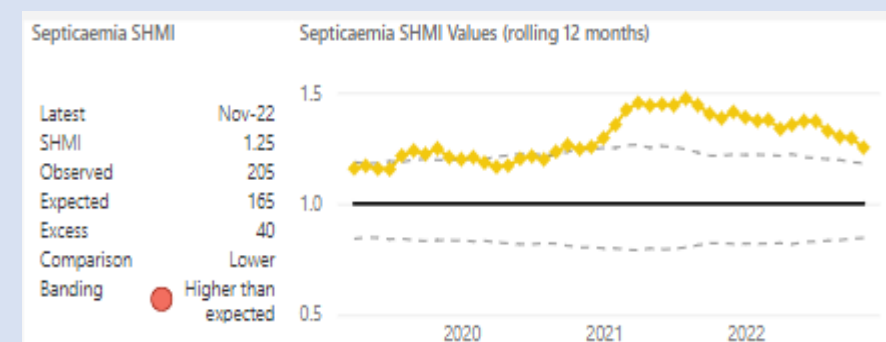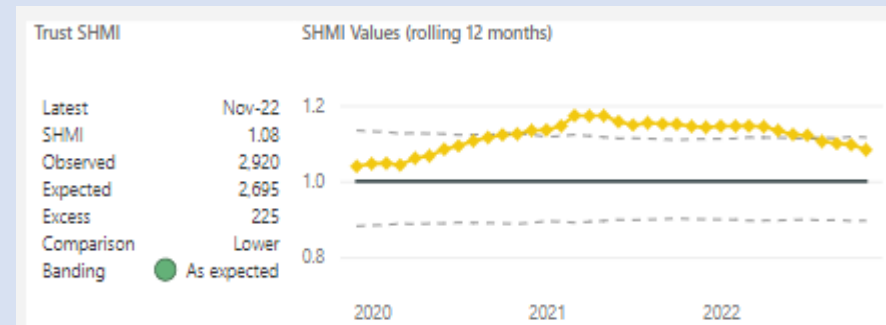
Aim: To reduce the SHMI to below the national average of 1.0 and improve patient outcomes

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.

Pneumonia SHMI

Latest	Nov-22
SHMI	1.03
Observed	315
Expected	305
Excess	10
Comparison	Lower
Banding	As expected

Pneumonia SHMI Values (rolling 12 months)

Stroke SHMI

Latest	Nov-22
SHMI	1.07
Observed	155
Expected	145
Excess	10
Comparison	No Change
Banding	

Stroke SHMI Values (rolling 12 months)
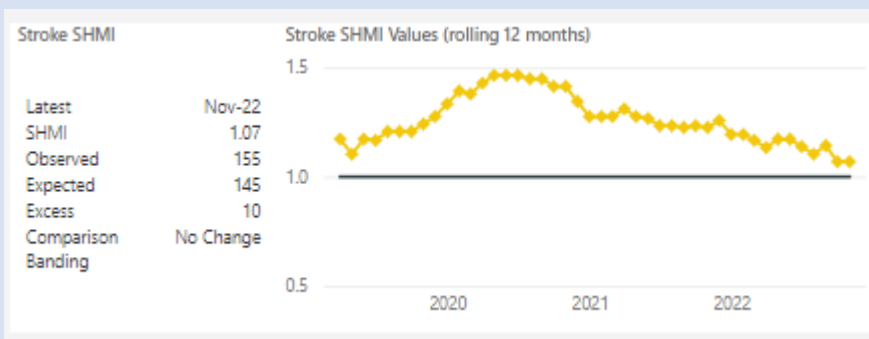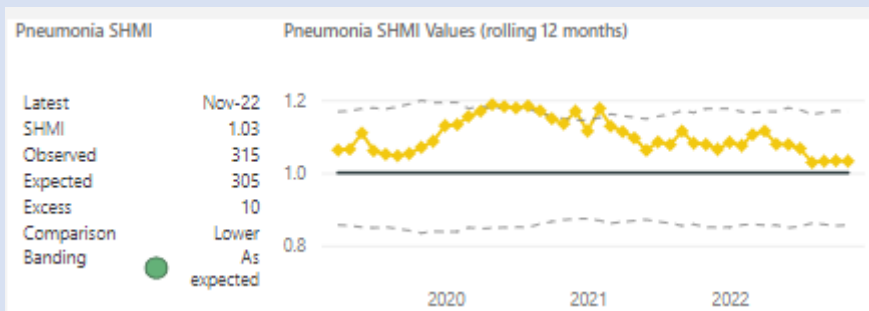
- Continual delivery of the Stroke improvement plan, improving service and outcomes for stroke patients.
- Continual review of stroke deaths, including discussions at Stroke M&M meetings.
- Regular updates in relation to Stroke mortality given to the Trust Mortality and Morbidity Committee.
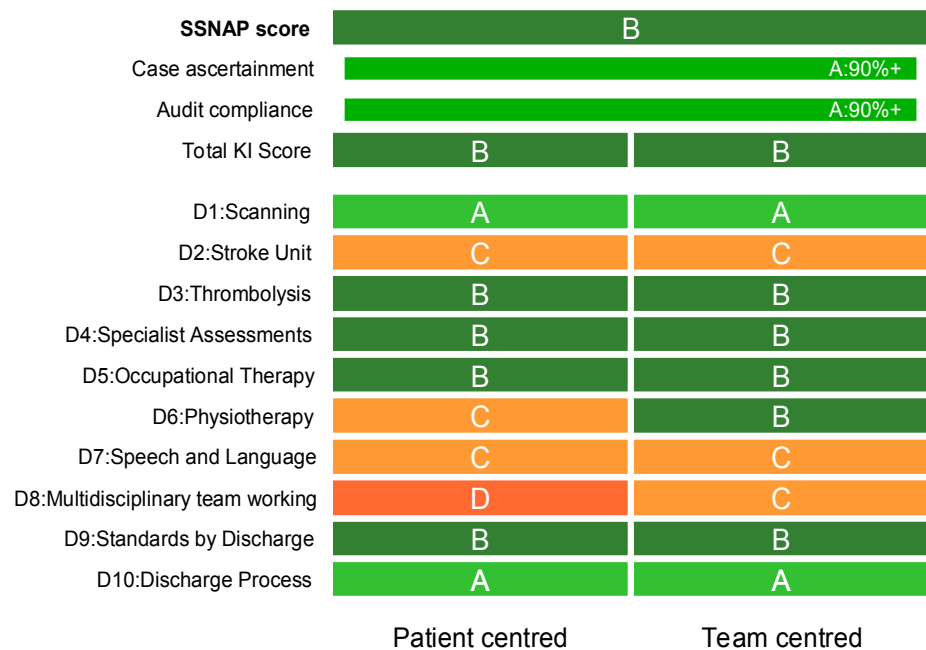
January to March 2023

The below chart represents HUTH's SSNAP score between January 2023 and March 2023 and provides a more current picture.

	Patient centred	Team centred
SSNAP score	B	
Case ascertainment	A:90%+	
Audit compliance	A:90%+	
Total KI Score	B	B
D1:Scanning	A	A
D2:Stroke Unit	C	C
D3:Thrombolysis	B	B
D4:Specialist Assessments	B	B
D5:Occupational Therapy	B	B
D6:Physiotherapy	C	B
D7:Speech and Language	C	C
D8:Multidisciplinary team working	D	C
D9:Standards by Discharge	B	B
D10:Discharge Process	A	A

Source: SSNAP Jan to Mar 2023
Team level results

Team 173

A- Indicates highest score to E- lowest

2021-2022

There are no new figures for patients who have had a stroke, further updates are expected towards the latter part of 2023.

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
This is the previous data set for information, this was in the previous report	**Target:** Below 100
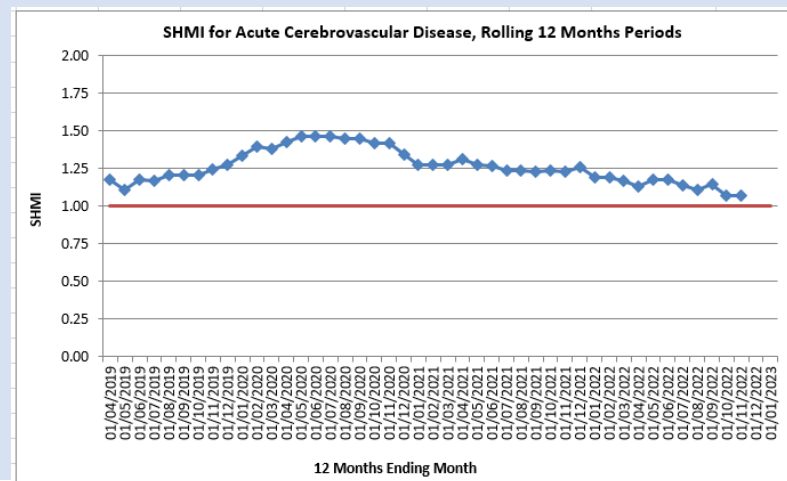
What is the chart telling us:

- 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.
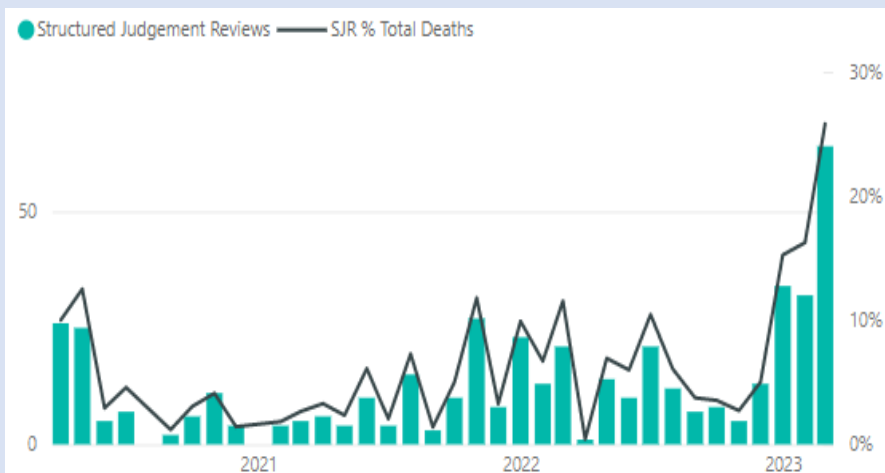
Successes:
- Stroke SHMI is the lowest it has been in 4 years.
- The Stroke service continues to deliver structured judgement reviews on all of its deceased patients.

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 undertaken 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

Complaints Received	**Aim:** To improve the management of the complaints to ensure the effective and responsive management of complaints received **Target:** Improve the management of complaints

Trust (exc EMHG) - Complaints received in month

Emergency Medicine HG - Complaints received in month

What is the chart telling us:

- There was 42 complaints were received in May 2023, 8 of which were seconds

Successes:

- Eliminated the complaints to be logged backlog, with no complaints overdue for logging by the end of May 2023
- The Model Complaints Standards Steering Group had its second meeting. Approved changes to the Early Resolution and Consent processes
- Continue to implement the early resolution process with the aim of addressing concerns in a quicker timeframe with a reduction in the number of concerns that are escalated to a formal complaint.

Key Risks and Challenges:

- Maintaining 3 working day timeframe for acknowledging and logging complaints

Actions / Future Plans for Improvement:

- Implement a reflective practice group with NED engagement
- Undertake a deep dive into the complaint re-opened and the reasons why to identify areas for improvement in the responses provided to complainants and the quality
- Continue to deliver the NHS Model Complaint Standards via the Steering Group
- Improve triangulation of data to inform more focussed learning from patient experience

Complaints Received	**Aim:** To improve the management of the complaints to ensure the effective and responsive management of complaints received
	Target: Improve the management of complaints

Trust (exc EMHG) - Complaints received per 1000 FCEs

Re-opened and Closed Complaints 2022-23

- Total re-opened
- Total Closed

Complaints Received	Aim: To improve the management of the complaints to ensure the effective and responsive management of complaints received Target: Improve the management of complaints

4.2 COMPLAINTS CLOSED

% of complaints closed within 40 days

% of complaints closed within 40 days

% HG Complaints Closed within 40 days

- SHG % complaints closed within 40 days
- MHG % of complaints closed within 40 days
- FWHG % of complaints closed within 40 days
- CSHG % of complaints closed within 40 days
- EAMHG % of complaints closed within 40 days

Aim: Increase % of complaints closed within 40 day target

Target: 80%

What is the chart telling us:

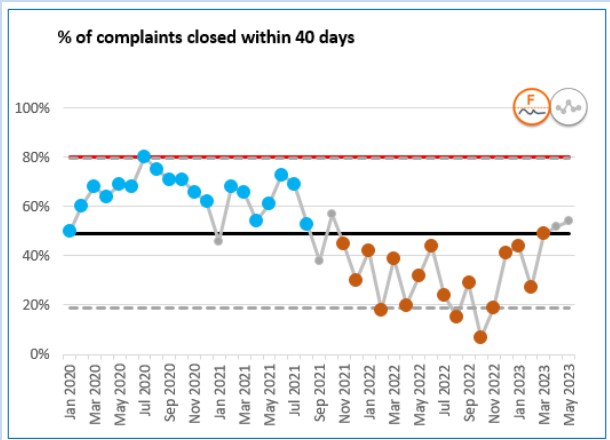- The charts demonstrates continued improvements against the closing of complaints within 40 days. Although the target of 80% has not yet been achieved 54% of complaints were closed within 40 days in May 2023.

- Surgery and Medicine increasing the number of complaints closed within 40 days

- Number of complaints closed between 0 – 40 days increased from December 2022 with 152 closed – broken down between 0 – 29 days and 30 – 40 days

- Increase in complaints closed that were over 41 days to over 100 days

- Reduction in the backlog of overdue complaints within Medicine and Surgery

Successes:
- Leadership from Nurse Directors in the Health Groups to increase the number of complaints closed within 40 days whilst also reducing the number of complaints overdue
- Increase in the number of complaints now also closed within 0-29 and 30-40 days
- Reduction in the backlog of overdue complaints within Medicine. In December 2022, Medicine had 41 overdue complaints with the longest one open at 434 days. In May 2022, Medicine had 6 overdue complaints with the longest one open at 85 days
- Reduction in the backlog of overdue complaints within Surgery. In December 2022, Surgery had 57 overdue complaints with the longest one open at 450 days. In May 2022, Surgery had 16 overdue complaints with the longest one open at 261 days

Key Risks and Challenges:

- Maintain improvements against the planned outcomes
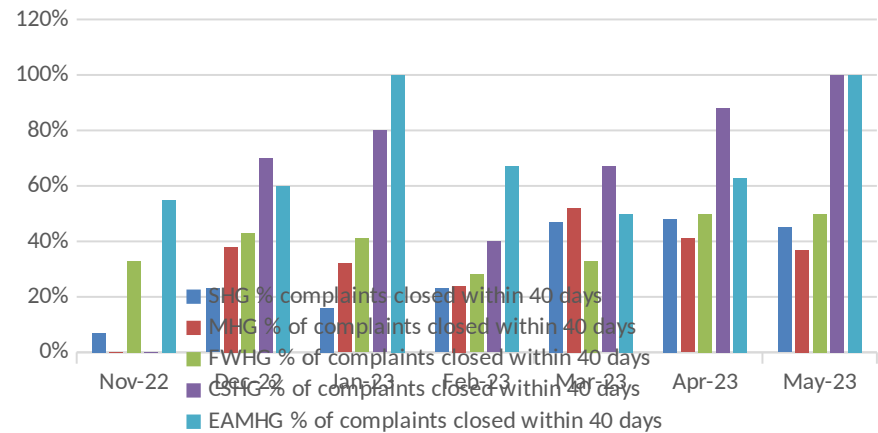
Complaints closed by days lapsed
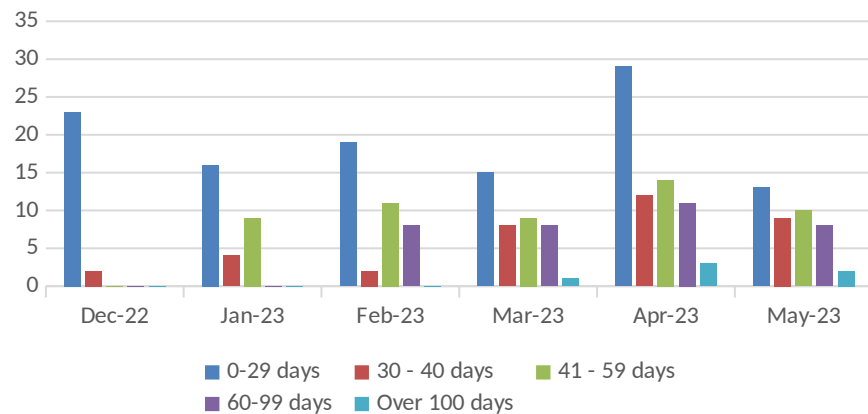
Surgery Health Group Backlog Reduction
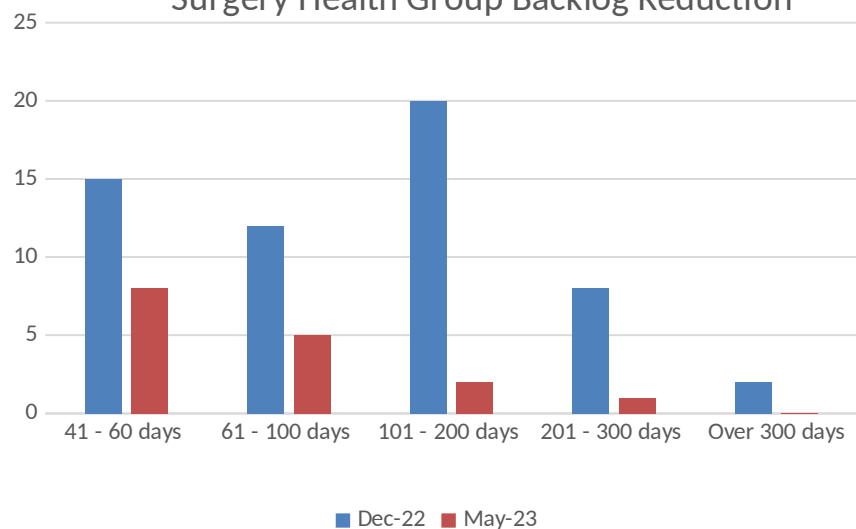
Actions / Future Plans for Improvement:
- Continue weekly challenge meetings with Medicine, Surgery and Family and Women's.
- Agree the process for the Patient Experience Team to co-ordinate cross-Health Group complaints to ensure a joined up approach is undertaken and all questions are answered in a timely manner
- Use complainant feedback on the complaints process to continually improve practice

Medicine Health Group Backlog Reduction

PALS Received

Trust (exc EMHG) - PALs received per 1000 FCEs

Emergency Medicine HG - PALs received in month
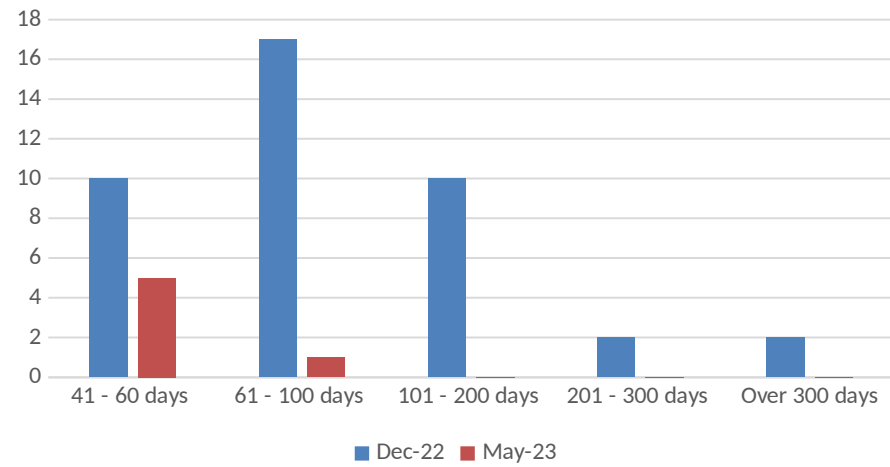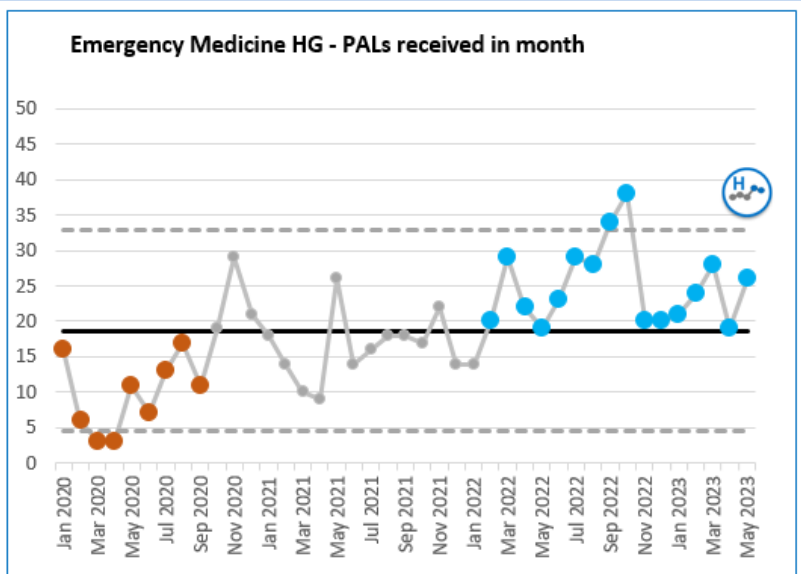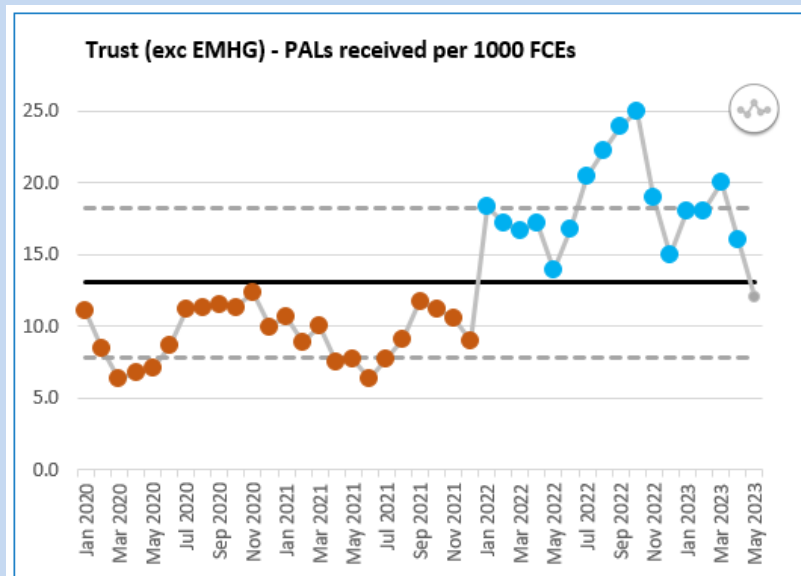
Aim: To reduce the number of PALS escalating to a complaint

Target: To monitor

What is the chart telling us:
- Received 213 PALS Trust-wide and 26 for Emergency Medicine Health Group. Therefore, a total of 239 PALS received in April 2023
-

Successes:
- Early resolutions introduced

Key Risks and Challenges:
- Main theme continues to be cancellations, delays and waiting times – no changes to the main themes

Compliments Received
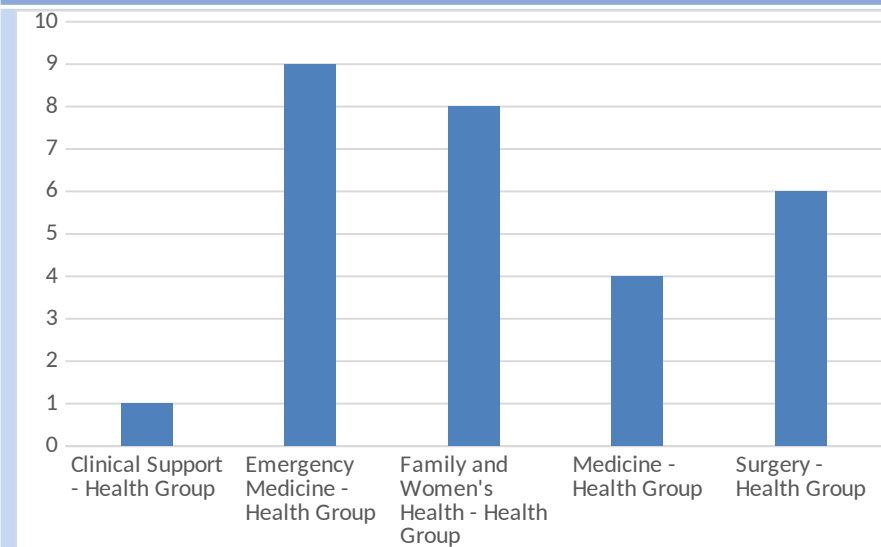
Aim: To record and share the compliments received via the PALS team

What is the chart telling us:
- 28 compliments received via the PALS team in May 2023

Successes:
- The main theme detailed within the compliments is the care and comfort (including privacy and dignity) provided to our patients by staff. This shines through in all Health Groups.

Key Risks and Challenges:
- None

Actions / Future Plans for Improvement:
- Continue to share all compliments received to the relevant areas for good practice to be acknowledged and staff/teams thanked as required.

5. WELL-LED DOMAIN

CONTINUOUS QUALITY IMPROVEMENT

5.1 TRAINING

Delivery of 2023/24 Quality, Service Improvement and Redesign (QSIR) programmes continues to progress well. Cohort 5 of the QSIR Practitioner course is due to finish on 21 June 2023 resulting in a further 15 members of staff completing the course.

The first collaborative QSIR Virtual session with the North West and North East System Improvement Team and other QSIR Faculties across the region took place on 8 June 2023 and over 100 members of staff across the region attended. The final session will take place on 29 June 2023 and evaluation of the success of the training will be reviewed, this will inform whether a collaborative approach will continue moving forward.

Development for the 2024/25 QSIR training programme is currently underway. The development of the training programme will include how we can build and strengthen our training capability across the Trust to make sure staff are supported to undertake and lead on improvement whilst taking into consideration, what steps are needed to assess and support a return on investment following training. The final training programme will be shared with the Quality Committee by September 2023.

5.2 QUALITY IMPROVEMENT

78 QIPS have been shared with the CQI team with a majority received from Junior Doctors who are required to undertake improvement projects a part of their career progression.

Following the QI Kick Start Improvement workshop for the Emergency Department in April 2023, there has been fantastic progress with the development of a High Acuity Bay to support the deteriorating patient. The bay is on track to commence from the end of June 2023.

Members of staff from the Trust attended the International Forum on Quality and Safety in Healthcare. The forum was held in Copenhagen in May 2023 and CMO, Prof. Makani Purva, Deputy CMO, Mr Peter Sedman, Medical QI Leads, Miss Noemi Kelemen and Dr Sanjay Gupta, Leadership Fellow Dr Jessica Haslam and Chief Registrar, Dr Natasha Abbas were all in attendance.

The team showcased a number of improvement and safety initiatives which focused on adapting to a changing world whilst creating equity, sustainability and wellbeing in healthcare.

Five QI projects were presented at the Forum by the HUTH team:

1. Improving efficiency of care-development of Breast Surgery Antimicrobial prophylaxis guidance
2. Reducing antimicrobial resistance in plastic surgery and hand trauma
3. Sustainable quality improvement led by front line staff
4. Simulation, a change management tool in patient safety instigations
5. Druggles, a QI initiative on medication safety

The conference had renowned and experienced 'leaders in improvement that were of international calibre. Those in attendance had an enriching and stimulating experience participating in site visits, interactive workshops and keynote lectures. The importance of being versatile in improvement initiatives and building broad rather than narrow bridges, was clearly demonstrated in some of the large scale improvement projects.

One session introduced the concept of 'Trojan Mice', which are small, well focused changes, introduced on an ongoing basis in an inconspicuous way – '*collectively, a few Trojan mice will change more than one Trojan horse ever could*.' The workshop on "double loop thinking" (contrasted with "single-loop thinking"), challenged the participants to think about why teams and organisations keep repeating similar attempts at the problem(s), with no variation of method and without ever questioning or redefining the goal.

Those attending the forum have been invigorated with lots of new ideas and will be sharing these with the wider CQI and Patient Safety teams.

5.3   THINKTANK

There were **2** further submissions received within the last month and all parties have been contacted to help support and move their ideas forward.

The last Think Tank Group meeting took place on 12 June 2023. Actions have been put in place to support with progression and updates for a number of outstanding submissions. This will support with a full data cleanse along with an in-depth review into the outcomes from submissions received, the next steps will be to showcase as share as many outcomes as possible as well as any learning.

5.4   90 DAY CHALLENGES

As part of the Great Leaders programme, the 90 Day Challenge programme combines research based Solutions Focused Thinking Framework with proven improvement and redesign techniques and approaches from QSIR to support individuals to undertake a change project. The following is a recent example of the improvement challenges undertaken and subsequent successes of the project:

- Clare Kirk, a Team Leaders in Cardiology Hub 7, set out to reduce the total number of patients sitting un-validated on her Tracking Access Plan (TAP) list by 20%. Claire was able to reduce the TAP by 91% as part of the 90-Day Challenge. Validation releases capacity. It provides quality assurance and improves access by taking 'noise' out of the system. Claire was able to apply the same principle to tackle the 'overdue' patients on the Surveillance Tracking Access Plan list within 4 weeks.

- Liz Leadley in Radiology set about improving patient access by reducing the plain film wait time for MSK x-Rays from 15 weeks to 6 weeks. She met that goal and now serves the Trust as a Rapid Diagnostic Tracker.

- Rachel Summers a Rapid Diagnostic Tracker wanted to reduce waste, by looking at reducing the duplicate referrals which are sent alongside a Rapid Diagnostic Referral. She worked across the system, engaging closely with a GP practice in order to improve patient experience and increase staff capacity, thereby making the Rapid diagnostic pathway more streamlined. An unintended but positive consequence of the project, was a stronger relationship with the practice and deeper understanding across the system.

REFERENCES

📄 CQC Update Report - Trust Board July 2023.pdf

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		Meeting	Trust Board	Meeting Date	11 July 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 June Quality Committee; 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 risk with action MAT3.8 in relation to delays with the roll out of the BadgerNet system as the delays will impact on the implementation of BSOTs. This will also impact on that element of the S31 action plan • Receive the updates in this report and decide if any further information and/ or assurance is required

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HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
CARE QUALITY COMMISSION (CQC) UPDATE REPORT
Prepared for the Trust Board to be held in July 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 and April 2023 (Maternity).

2. **CQC UNANNOUNCED INSPECTION**
   2.1 Emergency Department
   The ED regulatory action plan includes 27 actions against the 15 'Must do' and 10 actions against the 3 'Should do' actions. The ED action plan is monitored at the ED Safety Champions with oversight and escalation to the Safety Oversight Group. It was last updated at the meeting held 14 June 2023. A brief breakdown against the progress of the actions so far is provided in the table below.

ED urgent action plan – 43 actions	
Actions completed with evidence of completion provided	41
Actions implemented with ongoing monitoring	0
Actions not yet due but on track	0
Actions overdue	2
Must actions – 27 actions	
Actions completed with evidence of completion provided	13
Actions implemented with ongoing monitoring	6
Actions not yet due but on track	7
Actions overdue	1
Should do actions – 10 actions	
Actions completed with evidence of completion provided	8
Actions implemented with ongoing monitoring	2
Actions not yet due but on track	0
Actions overdue	0

An update against overdue actions is as follows:
• Must Do Action ED6.2, this action was to agree a trajectory for all Trust employed Security Staff to receive risk reduction training. This has been agreed with the provider, a trajectory for completion is now required.
• Urgent Action 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.
• Urgent 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 presented the Committee with a full update at the May 2023 meeting.

The ED Safety Champions which includes a non-executive director is now reviewing whether the urgent actions have remained in place and whether the impact is as planned. Where measures of success are not yet being achieved reviews are being taken as to whether the initial actions need amending or new actions in place. Where this is the case they will be escalated to Quality Committee and the ED Safety Champions meeting. This in turn will be escalated to the HUTH QIG for system support in any changes to current action plans.

2.2 Surgery

The Surgery regulatory action plan includes 87 actions against the 25 'Must do' actions and 9 actions against the 13 'Should do' actions (some of the 'should do' actions link to a must do action). It is now reviewed at the fortnightly Safety Oversight Group. A brief breakdown against the progress of the actions so far is provided in the table below.

Must do actions – 87 actions	
Actions completed with evidence of completion provided	11
Actions implemented with ongoing monitoring	34
Actions not yet due but on track	42
Actions overdue	0
Should do actions – 9 actions	
Actions completed with evidence of completion provided	0
Actions implemented with ongoing monitoring	3
Actions not yet due but on track	5
Actions overdue	0

There is nothing to escalate at this stage regarding the Surgery action plan; however, it must be noted that the update above will not change until the available evidence is reviewed at the next Surgery Check and Challenge meeting.

2.3 Medicine

The Medicine regulatory action plan includes 39 actions against the 7 'Must do' actions. It is now monitored the monthly Medicine Check and Challenge Meeting with oversight and escalation to the Safety Oversight Group. It was last updated at the meeting held 12 June 2023. A brief breakdown against the progress of the actions so far is provided in the table below.

Must do actions – 39 actions	
Actions completed with evidence of completion provided	4
Actions implemented with ongoing monitoring	15
Actions not yet due but on track	19
Actions overdue	1

An update against the overdue actions is as follows:
• Action MED1.5 – Implementation of a monthly mental capacity audit to be undertaken by the Junior Doctors in each specialty. This is to be addressed as a priority.

2.4 Trust-wide

The Trust-wide regulatory action plan includes 10 actions against the 4 'Must do' actions. It is now monitored at the Safety Oversight Group and will be updated at the meeting held 12 June 2023. A brief breakdown against the progress of the actions so far is provided in the table below.

Must do actions – 10 actions	
Actions completed with evidence of completion provided	3
Actions implemented with ongoing monitoring	5
Actions not yet due but on track	2
Actions overdue	0

There is a risk with action TW4.2 in relation to opening the intermediate discharge unit in the way the Trust envisaged when the action was submitted. Since this time a decision has been made that CHCP will manage this unit. The Trust is actively engaged in the weekly meetings

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to progress this but no longer has ultimate control of this action. This has also been escalated as a risk to the June 2023 HUTH QIG.

3. **MATERNITY INSPECTION**
   3.1 Urgent Actions
   The Maternity urgent action plan includes 41 actions. It is monitored by the weekly Maternity Check and Challenge Meeting with reporting and escalation to the Monthly Maternity Safety Champions which includes a non-executive director and oversight and escalation at the Safety Oversight Group. It was last updated at the meeting held 07 July 2023. A brief breakdown against the progress of the actions so far is provided in the table below.

Maternity urgent action plan – 41 actions	
Actions completed with evidence of completion provided	35
Actions implemented with ongoing monitoring	5
Actions not yet due but on track	1
Actions overdue	0

There is a risk with action MAT3.8 in relation to the delays with the roll out of the BadgerNet system. This has been escalated via a number of routes and the Chair of the Quality Committee agreed that this would also be reported in this paper to the Trust Board. The Executive Team are in agreement that the Trust and the Maternity Service should undertake all the necessary steps that can be taken to prevent or minimise the delay. Whilst there is a possibility that we may be able to reduce the delay from February 2024 to November 2023 this isn't secured and may not be a viable option due to the loss of training dates in June 2023 and July 2023 and the increasing risk of staff shortages due to maternity leave. All possible options continued to be explored; however, it is important for the Trust Board to be aware that the February 2024 may have to be the date that the service work towards, which impacts on compliance with that particular element of the S31 action plan and pushing it back by 4-5 months. This has also been escalated to the CQC, NHSEI and ICB as part of our Quality Improvement Group in July 2023.

The Trust Board is also to note one deviation to plan, as follows:
• Action MAT3.5 on the urgent action plan set out for all Midwives on ADU, Maple and Labour to undertake the additional competencies; however, after a discussion at recent assurance visit and the Maternity Check and Challenge meeting it was agreed to prioritise the areas with ADU first to be completed between now and the end of July 2023.

3.2 Section 31 Actions
The Maternity Section 31 action plan includes 31 actions. It is monitored by the weekly Maternity Check and Challenge Meeting with reporting and escalation to the Monthly Maternity Safety Champions and oversight and escalation at the Safety Oversight Group. It was last updated at the meeting held 07 July 2023. A brief breakdown against the progress of the actions so far is provided in the table below.

Maternity Section 31 action plan – 31 actions	
Actions completed with evidence of completion provided	17
Actions implemented with ongoing monitoring	8
Actions not yet due but on track	6
Actions overdue	1

An update against overdue actions is as follows:
• MAT3.6 – this action was to review the current Maternity TNA and update to reflect all training for Midwives and Medical Staff. There has been a delay to this as a result of the

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publication of the CNST Year 5 standards and the timings allocated to the training needs as part of that. They need to be reflected in the TNA.

The Trust Board is also to note one deviation to plan, as follows:
• MAT7.1 and MAT8.1 – these actions were regarding the governance and PMRT review. The governance / PMRT review plan has been developed and the governance review has begun; however, this is now a variation to plan as this plan has also been shared with Mike Wright (external support to Maternity) for comment and to add any additional areas of focus

The support that was approved in terms of maternity governance systems and processes commenced on the 19 June. The Board received an update on this from the external consultant providing the support on the 13 June and were satisfied with the approach described and ways we can learn from Shrewsbury and Telford's improvement journey. One of the learning points from this was a system called 'Monday.com'. The Chief Information Officer shared that we have this system in HUTH so using it should be a quick win for us. This would significantly reduce the amount of work currently undertaken relying on spreadsheets and emailing evidence to be stored in files as this could all be done by those with the actions directly uploading their evidence. This can be shared with interested parties, such as the ICB, and reduce the reporting burden for the Trust. Discussions are ongoing regarding the arrangements and potential fees required to increase the use of Monday.com across the Trust.

As part of the conditions placed on the Trust under the Section 31, there is a requirement for the Trust to submit a monthly report. This provided the first submission on 28 June 2023, a few days ahead of the 30 June 2023 deadline. The next submission is due by 28 July 2023.

4. OUTCOME MEASURES
The ED Safety Champions now receive and scrutinise the performance against the outcome measures highlighted on the ED action plan, overall performance data is starting to show improvements but further improvement is required. An ED deep dive and update against the outcomes will be presented to the July 2023 HUTH QIG.

5. ASSURANCE REVIEWS
5.1 Emergency Department
The ED assurance visits continue to be undertaken on a monthly basis with a multidisciplinary team and an external panel member (where possible) to focus on key areas and still provide oversight that the actions have been sustained.

5.2 Maternity Services
The Maternity assurance visits continue to be undertaken on a monthly basis to focus on the priority areas for improvement and to seek assurance the changes are happening as required and are achieving the required impact. There remain some inconsistencies in the use of the triage form and the rag rating of women. This is being actioned via the weekly Maternity Check and Challenge Meeting.

6. SAFETY OVERSIGHT GROUP
The Safety Oversight Group has been established since the 14 November 2022 and has been previously chaired by the Director of Quality Governance. SOG continues to meet monthly; however, it was agreed it would be chaired by the Chief Executive to provide challenge and seek assurance as required. The Chief Executive has chaired one meeting so far.

The group continues to be 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.

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The Quality Committee receives a monthly assurance report from the Safety Oversight Group.

7. **ASSURANCE PROGRAMME**
The increased assurance visits programme has commenced with seven specialities been visited to date. The assurance teams are multidisciplinary and includes non-executives and executives. Healthwatch have also agreed to be part of the assurance visits when available. Initial feedback being shared with the health groups which is followed up with a letter to enable service to review the areas for improvement and identify any further actions to address them using a quality improvement approach.

8. **QUALITY IMPROVEMENT GROUP**
The latest HUTH QIG Meeting was held on 07 July 2023.

A discussion was held about the Quality Transition Criteria for the HUTH QIG. This set out the process which will be followed and the measures which will be reviewed as part of the current 'intensive' quality support along with some initial timescales for the programme. The transition criteria to allow the Trust to exit the intensive surveillance included. The following criteria was mapped out against timescales, measures and offers of support to the Trust:

• Significant progress to be made against the CQC must do actions. The actions must be addressed and improvements sustained over a period of time (e.g. 6-12 months) with evidence that they have been embedded
• Trust to have a RI or above rating in Safe and for ED
• Demonstration of sustainable improvements in Maternity with no enforcement conditions
• Completion of the independent governance review with the recommendations agreed, actioned and implemented
• The Trust has also committed to a future well-led assessment (post-appointment pf the Group CEO)

The Trust provided an update against the actions and improvement work undertaken in relation to the Digital solutions and IPC since the inspection in November 2022 for Trust wide, ED, Medicine and Surgery. There were no new risks to escalate and the offers of support remained the same with minor updates on discussions that have occurred since the June 2023 QIG meeting.

The Trust also provided an update against the Maternity Section 31 action plan. The key risks for escalation and requests for support remained the same, this included the risk of delays to BadgerNet. An update was requested by the Trust on progress against the decision on whether the Trust will be accepted on the national Maternity Safety Support Programme. NHSE confirmed that a meeting is scheduled for 19 July 2023 where it is hoped a decision will be made. The Trust also requested for additional support regarding the external representation on PMRT. The ICB agreed to take this action forward.

The presentations were well received and the improvement work undertaken so far were acknowledged positively.

9. **RECOMMENDATIONS**
The Trust Board is recommended to:
• Acknowledge the risk with action MAT3.8 in relation to delays with the roll out of the BadgerNet system as the delays will impact on the implementation of BSOTs. This will also impact on that element of the S31 action plan
• Receive the updates in this report and decide if any further information and/ or assurance is required

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Head of Quality Compliance and Patient Experience
July 2023

REFERENCES   Only PDFs are attached

📕 8.3 - Board and Committee Front Sheet - DIPC Annual Report for Trust Board.pdf

📕 8.3.1 - DIPC Annual Report 2022 2023.pdf

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item		Meeting	Trust Board	Meeting Date	11th July 2023
Title		Director of Infection Prevention & Control (DIPC) Annual Report 2022/23			
Lead Director		Jo Ledger, Acting Chief Nurse			
Author		Greta Johnson, Director of Infection Prevention & Control			
Report previously considered by (date)		Considered by members of the Strategic Infection Reduction Committee			

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

Key Recommendations to be considered:

This annual report provides an overview of the work done in accordance with the Infection Prevention and Control Board Assurance Framework (IPC BAF) during the financial year 2022-23. It is a record of the Trust's activity and achievements in preventing healthcare associated infection, and in managing infectious diseases, inclusive of the ongoing COVID-19 pandemic more generally. It also describes areas where improvement is needed.

Key points of consideration:

- *During 2022-23, the Trust continued to monitor healthcare associated infection case numbers and trends. The Trust performed at or better than the benchmark in all cases with the exception of hospital onset MSSA BSIs and GNBSIs which will be a priority for 2023-24.*

- *The Trust via an antimicrobial stewardship programme continues to collaborate with clinical teams to develop antimicrobial prescribing guidance in line with national guidance and continues to monitor compliance with regards antimicrobial prescribing and escalate to improve patient outcomes.*

- *The Trust is the highest placer of vascular lines in the region and with it the increased risk of suboptimal management and ensuing line related infections – this too is a priority for 2023-24.*

- *The identification of sepsis on admission and during inpatient care along with the*

impact on morbidity and mortality is a much needed area for quality improvement and priority for 2023-24

- *The findings from the CQC inspection associated with suboptimal IPC practice are a driver for improvement not only in the areas inspected but Trust-wide*

- *Utilisation of the national IPC BAF during 2023-24 as a means to provide assurance*

- *The identification and management of resistant infections with the propensity to cause outbreaks are and will be a priority for the IPCT and Trust*

- *Ownership of patient outcomes associated with surgical site infections will be multi-disciplinary and not confined to the IPCT*

- *During 2022-23 patients medically fit but unable to be discharged continued to increase alongside the Trust ensuring elective recovery was prioritised. This continued to create other issues such as caring for patients on wards across the Trust with finite staffing resource. Patients with no criteria to reside remain in hospital longer and with it the potential to develop healthcare associated infections during protracted hospital stays.*

- *The lack of robust digital systems to support an effective IPCT is a significant risk both from a governance and quality perspective and relies heavily on the IPCT managing with the outdated systems, which with time will affect the quality of data collected, the functionality of the team and potentially impact on patient safety. This will be mitigated by the introduction of funded ICNET during 2023-24 but to date is delayed due to the LIMS project*

- *Working alongside Northern Lincolnshire & Goole Hospitals NHS Foundation Trust, York and Scarborough Teaching Hospitals NHS Foundation Trust, Integrated Care Boards, System Partners, NHS England and UKHSA will continue during 2023-24*

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST (HUTHT)

DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC)

ANNUAL REPORT 2022-23

1   PURPOSE OF THE REPORT

Effective infection prevention & control is fundamental to the delivery of high quality, safe and effective patient care. This remains a significant priority for the Trust with an objective for engagement and ownership of infection prevention & control throughout the organisation at all levels from ward to board.

This annual report provides an overview of the work done in accordance with the Infection Prevention and Control Board Assurance Framework (IPC BAF) during the financial year 2022-23.

2   BACKGROUND

This report is required by the Code of Practice for the Prevention and Control of Healthcare Associated Infection contained in the Health and Social Care Act 2008.

3   INFECTION PREVENTION & CONTROL ARRANGEMENTS

Greta Johnson is the Trust **Director of Infection Prevention and Control (DIPC)** and was responsible for leading and managing the Trust's Infection Prevention and Control (IPC) plan during 2022-23. Jo Ledger, Acting Chief Nursing Officer, had executive responsibility for infection prevention and control during 2022-23. During 2022-23 the role of **Infection Control Doctor (ICD)** was facilitated by Dr Debbie Wearmouth, Consultant Microbiologist. During 2022-23, ongoing recruitment for Infectious Diseases Consultants and a Consultant Microbiologist continued.

Infection prevention & control meetings are held to ensure the Trust remain compliant with the Health & Social Care Act (2008): code of practice on the prevention and control of infections. During 2022-23, **Strategic Infection Reduction Committee (SIRC)** continued to meet, although the focus and purpose changed to include a Developmental SIRC meeting, providing the opportunity to discuss key areas for improvement such as compliance with NHS Cleaning Standards and antimicrobial stewardship. SIRC and Developmental SIRC meet every other month. SIRC is a performance management and assurance committee, responsible for holding the Health Groups and Directorates to account for their performance in preventing and managing healthcare associated infections/ infectious diseases, and providing information and assurance to the Trust Board that all issues relating to infection prevention and control governance are being managed safely and effectively. Attendance by the senior HG representatives has been good, and most meetings were quorate.

The **Operational Infection Reduction Committee** (OIRC), continued to meet monthly. During 2022-23 this committee was chaired by the Infection Control Doctor. The Committee is a forum for the Health Groups to demonstrate their compliance with Trust and national policies and procedures, and to share good practice. Attendance by the senior HG representatives has been good, and most meetings are quorate. The OIRC is an expert advisory body, with the core role of providing advice to the Trust Board and Health Groups

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on issues pertaining to infection management (including the structure and governance of the infection prevention and control team). The Committee has representation from each Health Group, from the IPC team, the Department of Infection, Occupational Health, the Estates & Facilities Directorate, and Pharmacy. It reports to the SIRC. The OIRC has responsibility for guiding infection prevention and control activity within the Trust, interpreting external guidance and instruction, and providing the Chief Executive with relevant information and advice. It also advises the Trust on its statutory requirements in relation to infection prevention and control and the decontamination of medical and surgical equipment.

4   OTHER RELEVANT COMMITTEES

The Trust has specific committees responsible for decontamination and for water safety. These committees have representation on the Operational Infection Reduction Committee (OIRC), and report to SIRC. There have been previous concerns about frequency of meetings and attendance but these were mitigated during 2022-23 by Health Groups nominating representatives to attend. The chair of the Water Safety Committee, which is a mandatory institution, saw an improvement in attendance by Health Groups and Fresenius Renal Unit. The Water Safety Committee benefitted from the continuation of input from an Authorising Engineer for water safety. A Trust wide Water Safety Plan is in place and monitored accordingly. Water safety issues are also reviewed regularly by both the SIRC and OIRC.

The Trust's designated Board level Decontamination Lead (as required by the Health and Social Care Act) is the Director of Estates, Facilities & Development supported by the Surgical Health Group Medical & Nursing Directors. The Trust Decontamination Committee reconvened in May 2022 and met quarterly during 2022-23 and items for escalation were facilitated via OIRC and SIRC.

During 2022-23, a Trust Ventilation Safety Group was convened following specific guidance released by the Department of Health in 2021 (Health Technical Memorandum 03-01, HTM 03-01). The management of ventilation systems of a healthcare provider should be overseen by the Ventilation Safety Group (VSG). The Ventilation Safety Group benefits from the input from an Authorising Engineer for ventilation safety. Ventilation safety issues are escalated via OIRC and SIRC. During 2023-24, a Trust wide Ventilation Safety Plan will be drafted and monitored through the relevant committees.

The formation of a Command Structure to support the COVID19 pandemic and the ongoing Trust challenges with associated meetings such as Gold Command has further supported the IPC with both the DIPC and ICD in attendance, to inform and advise.

5   THE WIDER INFECTON PREVENTION & CONTROL TEAM

The clinical IPC team is composed of an Infection Prevention and Control Doctor, a Senior Matron, an Operational Matron and specialist Infection Prevention and Control nurses, and supporting secretarial and administrative staff. During 2022-23, members of the IPCT have been aligned to Health Groups to ensure in reach, education and support are provided to assist clinical teams with day to day management of patient care and maintaining a safe clinical environment.

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Continuing to deliver an effective IPC proactive and reactive service has developed further during 2022-23 with support from the Consultant Microbiologist/ Infection Control Doctor, Infectious Diseases Consultants, Corporate Nursing team and site team. There is currently no system analyst, data manager, or epidemiological/ SSI surveillance support for the team.

The clinical IPC team work in unison with the wider **Department of Infection clinical team** inclusive of Consultant Infectious Disease physicians, Consultant Microbiologist, Virology Consultant Clinical Scientist and Clinical Scientists in Medical Microbiology. The nursing team consists of Specialist Nurses in HIV, viral hepatitis, sepsis and Outpatient Antibiotic Therapy (OPAT), as well as a team of ward-based nurses managing the infectious disease ward at Castle Hill Hospital (CHH), these individuals currently are managed by a Matron within the Support Services Division, Clinical Support Health Group.

In addition to the core clinical IPC team an increasing number of other clinicians are being recruited to support the Trust's efforts including the Quality Team and clinicians with a special interest in the quality of care patients receive and delivering prudent infection prevention & control practice.

The Infection Prevention and Control Link Practitioners act as a resource for good infection prevention practice within their clinical areas. Study days are facilitated by the Infection Prevention and Control Team (IPCT) and Link Practitioners continued to be supported by the IPCT to be proactive in implementing guidance and maintaining IPC standards in their workplace.

Access to infection prevention and control information can also be obtained from the Trust Pattie page and via the Trust's global email address Ask Infection, facilitated by the Infectious Diseases consultants in the first instance, with support available from the IPC team as required. In addition, a global IPC team email address remained available for staff to access and email the team with queries, concerns and/or requests for advice or assistance.

6   SURVEILLANCE OF HEALTHCARE ASSOCIATED INFECTION

Fingertips data (Office for Health Improvement & Disparities)

The Office for Health Improvement & Disparities produce regularly-updated information on a variety of IPC parameters, benchmarking NHS Trusts against other organisations in England (https://fingertips.phe.org.uk/profile/amr-local-indicators/data). The huge amount of information available can be grouped in various ways: the appendices contain spine plots of the performance of the Trust against all other acute NHS trusts in England in overall performance on all HAI targets (Appendix 1), in antimicrobial prescribing data (Appendix 2), in antimicrobial resistance data (Appendix 3) and in other IPC measured initiatives/metrics (Appendix 4). This information represents 2021-22 data (depending on availability of information) against the NHS initiative targets, HUTHT has performed at or better than the benchmark in all cases. For the wider range of HAI targets the Trust generally falls between the 25th and 75th centile, but was a negative outlier for hospital onset Meticillin Sensitive Staphylococcus Aureus (MSSA) and Pseudomonas aeruginosa blood stream infections (BSI) during 2022-23. Performance remained good for the antimicrobial prescribing targets: the Trust was better than the benchmark value in all criteria, and remained a significant (positive) outlier in some areas.

Further HCAI trend analysis is provided in Appendix 5&6

Meticillin resistant *Staphylococcus aureus* (MRSA) bloodstream infection (BSI)

The Trust had achieved a year on year reduction in cases of MRSA BSI since reporting 102 cases in 2005-6 when mandatory surveillance was introduced. Up until 2013 NHS trusts were set progressively decreasing maximum thresholds for MRSA BSI by the Department of Health & Social Care.

From 2013-14 the Department of Health & Social Care moved away from a fixed numerical target in favour of a policy of 'zero tolerance of avoidable infection'. It was accepted, that there would continue to be small numbers of infections seen, and that the national aim was to reach an 'irreducible minimum'. National figures support this contention (Figure 1). The numbers of total and hospital onset MRSA BSI diagnosed in the Trust for the last 3 years are shown in Figure 2.
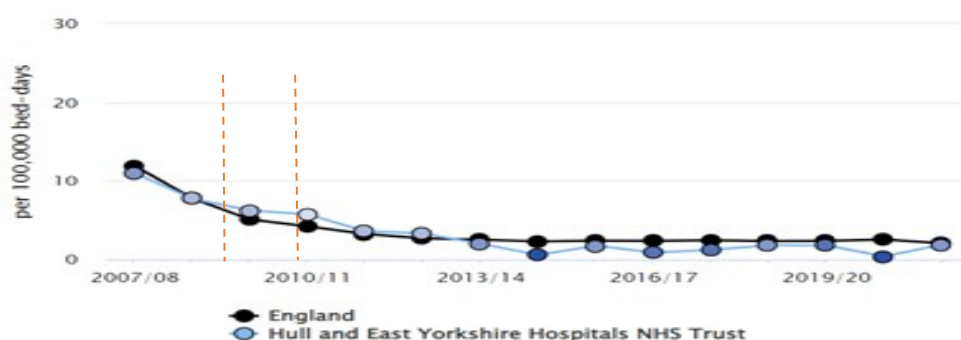

Figure 1. MRSA bacteraemia all rates by reporting acute trust and financial year in England 2007-2021 in comparison with Hull University Teaching Hospitals NHS Trust (red lines indicate introduction of universal screening)
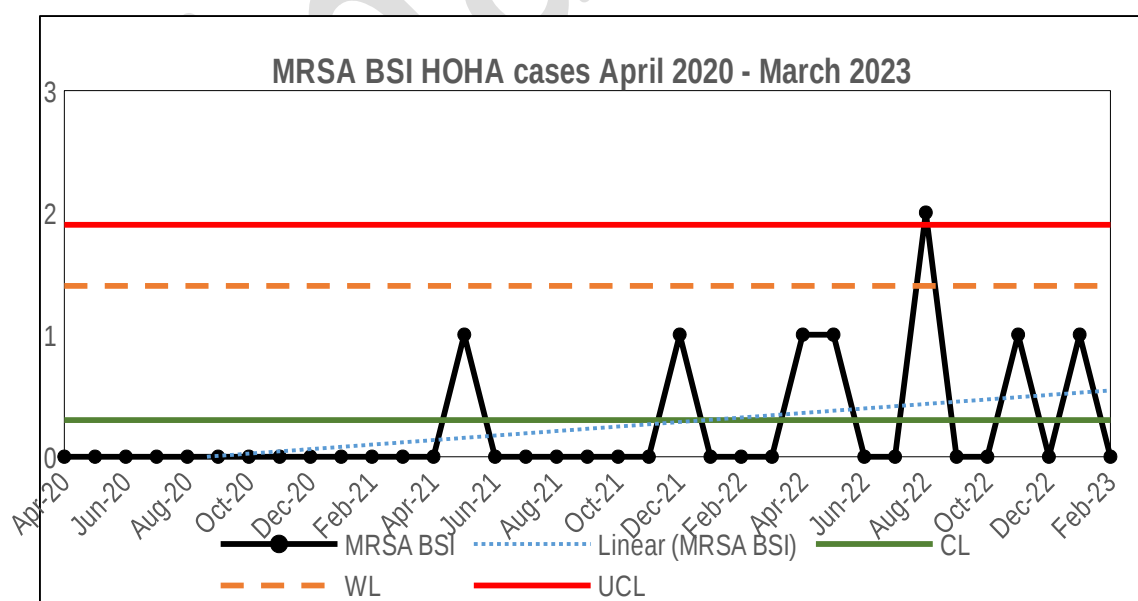
Figure 2. MRSA bloodstream infection diagnosed in HUTHT 2020-23

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During 2022-23, six hospital onset healthcare associated (HOHA) cases were reported, one in April 2022, one in May 2022, a further two in August 2022, one in November 2022 and the last case reported in January 2023. This was a marked increase in reported cases. All six cases were investigated via Post Infection Reviews (PIR) by both the Trust and System Partners. Two further community onset community associated (COCA) cases were reported in September 2022 and March 2023. The majority of HOHA cases, 50% were reported in the Medicine Health Group, 33% in Surgery Health Group and latterly 17% in Clinical Support Health Group with no reported cases in Families & Women's Health Group. There were no reported outbreaks of MRSA BSI.

Of the six reported HOHA MRSA bacteraemia cases all represent patients with complex past medical histories and multiple comorbidities, six cases investigated via PIR and five tabled to date at the Hull & East Riding HCAI Review Group – all five cases agreed as unavoidable with no lapses in care identified with the sixth case scheduled to be tabled in June 2023.

From a national perspective, the incidence rate of hospital-onset MRSA bacteraemia peaked at 1.4 cases per 100,000 bed-days in January and March 2021, due in part to a rise in the percentage of hospital-onset bacteraemia cases positive for COVID-19 on screening. Comparing October to December 2022 with the same period in 2019 (October to December 2019), which was a more typical year before the COVID-19 pandemic, a 13.3% decrease was seen in all reported counts of cases from 233 to 202 cases, with a corresponding decrease in rate of 13.5% from 1.64 to 1.42 per 100,000 population. However, the count of hospital-onset MRSA bacteraemia cases increased by one from 71 to 72, with a 1.7% increase in incidence rate from 0.80 to 0.81 per 100,000 bed-days. Trends suggest a return to pre COVID-19 levels in hospital-onset counts and rates.

The hospital-onset rate at Hull University Teaching Hospitals NHS Trust is 0.6 per 100,000 bed-days compared to the England hospital-onset rate of 0.7 per 100,000 bed-days (2021-22 available data).

Among other measures to try to reduce the number of MRSA BSI, the Department of Health in 2010 mandated that all patients admitted to hospital in England must be screened for MRSA skin colonisation. This has proved difficult to implement in practice, and the efficacy of such universal screening (as opposed to testing patients at higher risk) has always been debated. In 2014 the DH Expert Advisory Group on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) reviewed the available evidence, and recommended that all Trusts move from a policy of universal screening to one of selective screening of high risk patients. In October 2021, the Hospital Infection Society (HIS) and Infection Prevention Society (IPS) published national guidelines for the prevention and control of meticillin-resistant Staphylococcus aureus (MRSA). The guideline supports screening for MRSA carriage either as a targeted approach but using universal screening as appropriate depending on local facilities. The Trust developed a risk assessment to assist clinical areas with identifying which patients, which areas and when HCAI screening is required inclusive of MRSA and at the time of writing this report this IPC risk assessment will be included in NerveCentre assessment during 2023-2024. This will be vital not only for the identification and reporting of MRSA but other resistant organisms such as Carbapenemase producing Enterobacteriaceae (CPE) and Vancomycin Resistant Enterococci (VRE).

Clostridioides difficile Associated Diarrhoea (CDAD)

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The Trust has participated in the mandatory surveillance of Clostridioides difficile since 2004 and was previously a significant outlier with regards hospital acquired C difficile infection during 2011-12, reported hospital onset cases fell following a number of interventions during 2012-13 and the Trust has maintained a steady improvement in performance since then (Figure 3). In 2019, the Department of Health and PHE introduced updated CDAD objectives which included the addition of a prior healthcare exposure element for community onset cases, reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission has continued during 2022-23.

•	hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission (HOHA)

•	community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (COHA)

•	community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks (COIA)

•	community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks (COCA)

Acute provider objectives via NHS Standard Contract 2022/23 were published for 2022-23 on the 27th April 2022 and data was collected utilising these two categories:

•	hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission

•	community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

Clostridioides difficile 2022/2023 Threshold	Year-end Reported Cases
58 reported cases (HOHA & COHA combined)	59 reported cases (33 HOHA & 26 COHA combined

This demonstrates a continued reduction in HOHA reported cases but an increase in COHA cases. The hospital-onset rate at Hull University Teaching Hospitals NHS Trust is 10.8 per 100,000 bed-days compared to the England hospital-onset rate of 16.2 per 100,000 bed-days (2021-22 available data). The majority of reportable cases, 55% were reported in the Medicine Health Group, 24% in Clinical Support, 16% in Surgery Health Group and latterly 5% in Families & Women's Health Group.

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Figure 3. C. difficile all rates by reporting acute trust and financial year in England 2007-2022 in comparison with Hull University Teaching Hospitals NHS Trust per 100,000 bed-days (UKHSA Fingertips)
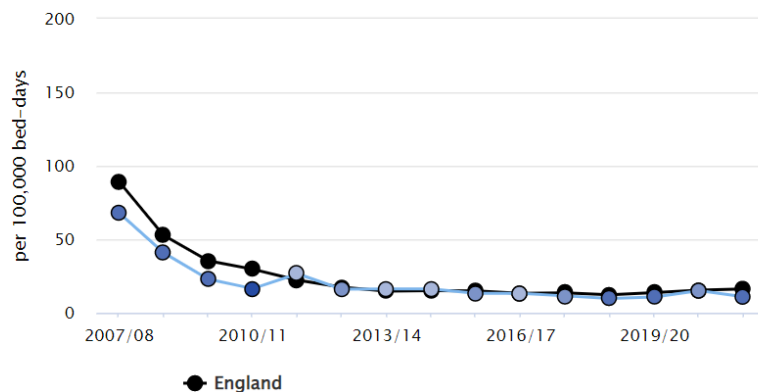
Figure 4. C. difficile hospital-onset rates by reporting acute trust and financial year in England 2007-2022 in comparison with Hull University Teaching Hospitals NHS Trust per 100,000 bed-days (UKHSA Fingertips)

From a national perspective, there has been a sustained increase in (primarily) hospital-onset Clostridiodes difficile infection (CDI) cases reported in England compared with 2019. Historical increases in CDI incidence have been linked to newly emergent strains and/or antibiotic prescribing, however, neither cause appears to explain the ongoing increase. A comparison of data from quarter one (January to March) 2022 to the same period in 2019, which is more generalisable than CDI data recorded during the COVID-19 pandemic, shows there was a 25.5% increase in the number of all reported CDI cases. The rise in incidence has been driven primarily by hospital-onset cases, which have increased by 42.5%, from 950 in quarter one in 2019 to 1,354 cases in quarter one 2022. The reason for this national increase is currently unknown but under investigation. As a consequence, NHS England and UKHSA during Quarter 4 (2022-23) invited Trusts across England to a national CDI collaborative event whose CDI hospital onset rates breached their respective thresholds to scope how to tackle this increase in CDI cases. Regionally, a working group has been tasked with identifying three key action areas for CDI reduction, with a focus on the behaviour changes needed to drive sustained improvements – the Trust as a positive outlier responded to a CDI survey request which will inform regional CDI strategy centred on a systematic approach to improvement.

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Since December 2021, the Hull & East Yorkshire HCAI Review Group with Trust IPCT and System Partners representatives met monthly to review community and hospital onset cases of Clostridioides difficile providing the ability to confirm and challenge RCA outcomes along with scope to discuss other complex infections, such as MRSA bacteraemia. During 2022-23 to date, thirty two CDI cases (HOHA & COHA) have been tabled and five (16%) lapses in practice identified of cases associated with suboptimal antimicrobial prescribing.
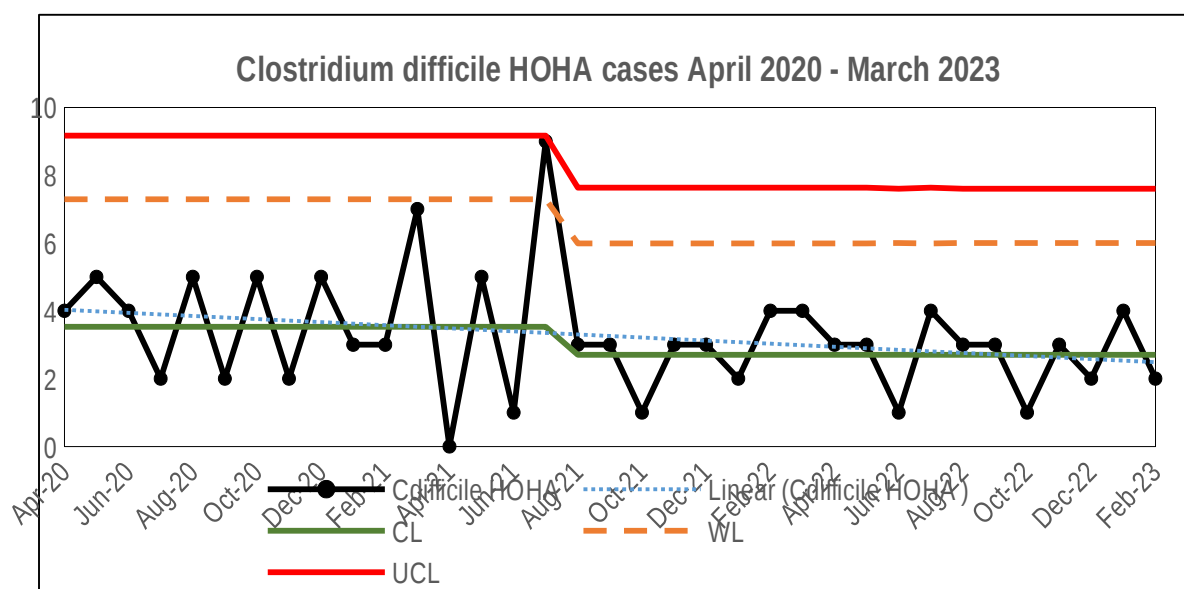
Figure 5. Hospital onset Clostridioides difficile infections diagnosed in HUTHT 2020-23

All cases of *C difficile* infection are actively reviewed by the IPCT and the Health Group responsible for the patients care. There were no reported outbreaks of CDI and no periods of increased incidence. All CDI samples are sent to the reference laboratory for ribotyping, with predominant ribotypes affecting patients across Hull & East Riding being 002, 005, 015 and 023. All cases are subject to a Root Cause Analysis (RCA), led by the senior clinicians (medical and nursing) involved with the care of the patient, and supported by the IPCT. Summary outcomes are presented to the IRC. In most cases there were no significant failures of care apparent that had led to the development of CDI. One identified issue for improvement related to antimicrobial stewardship and adhering to the Trust antimicrobial prescribing guidance, with lapses in practice identified when this was not congruent with Trust guidance. A number of measures driven by SIRC have been adopted to improve compliance with antimicrobial stewardship.

Meticillin sensitive *Staphylococcus aureus* (MSSA) BSI

National data show that the general reduction in MRSA BSI has not been mirrored by a fall in MSSA bloodstream infection. This is of concern as the two organisms have similar epidemiology and pathogenesis. The Department of Health therefore introduced mandatory surveillance of MSSA bacteraemia from January 2011.

Benchmarking for MSSA infections is less developed than for MRSA, and the balance between healthcare-associated and other infection less clear. There have been year to year fluctuations with hospital onset cases reaching a peak in 2018-19 and during 2022-23 HUTHT reported a marked increase in cases of infection, especially during April 2023 and

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remains the one major HAI indicator for which we are significantly worse than the national benchmark.

Nationally, rates of MSSA bacteraemia continued to increase moderately from the April 2011 to March 2012 period, when the surveillance was introduced, until the April 2019 to March 2020 period. Between the financial years April 2019 to March 2020 and April 2020 to March 2021 the rate declined from 21.7 cases per 100,000 population to 20.7 per 100,000 population. However, during the most recent financial year reported by UKHSA (April 2021 to March 2022) the rate of total MSSA bacteraemia has returned to 21.7 cases per 100,000 population.

The hospital-onset rate at Hull University Teaching Hospitals NHS Trust is 18.3 per 100,000 bed-days compared to the England hospital-onset rate of 11.3 per 100,000 bed-days (2021-22 available data).
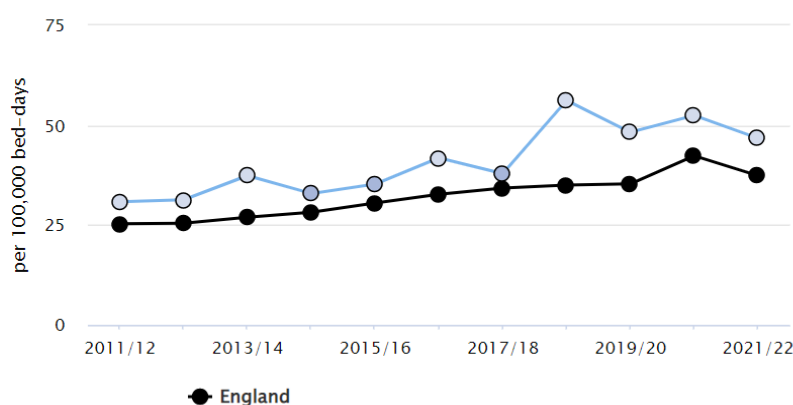
Figure 6. MSSA BSI rates in England 2011 – 2020 in comparison with Hull University Teaching Hospitals NHS Trust (UKHSA Fingertips)
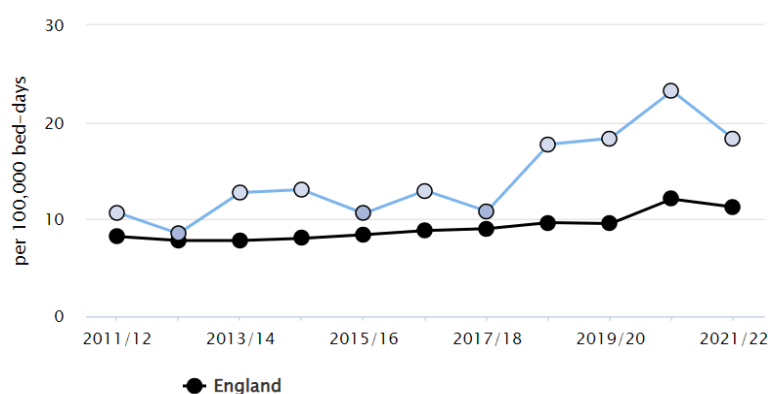
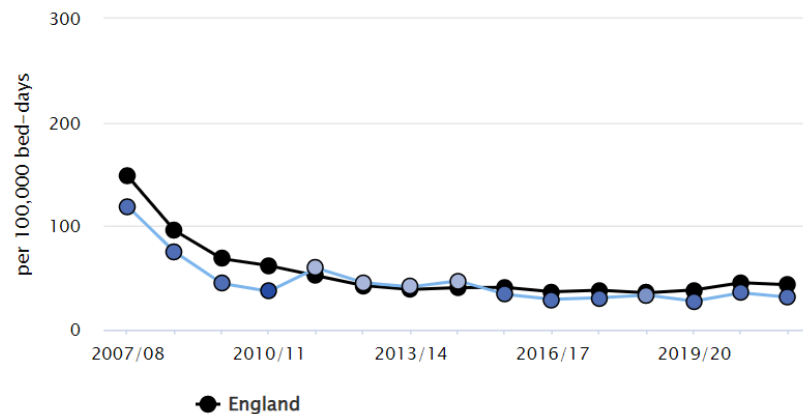*Figure 7. MSSA bacteraemia hospital-onset rates by reporting acute trust and financial year in England 2007-2022 in comparison with Hull University Teaching Hospitals NHS Trust per 100,000 bed-days (UKHSA Fingertips)*

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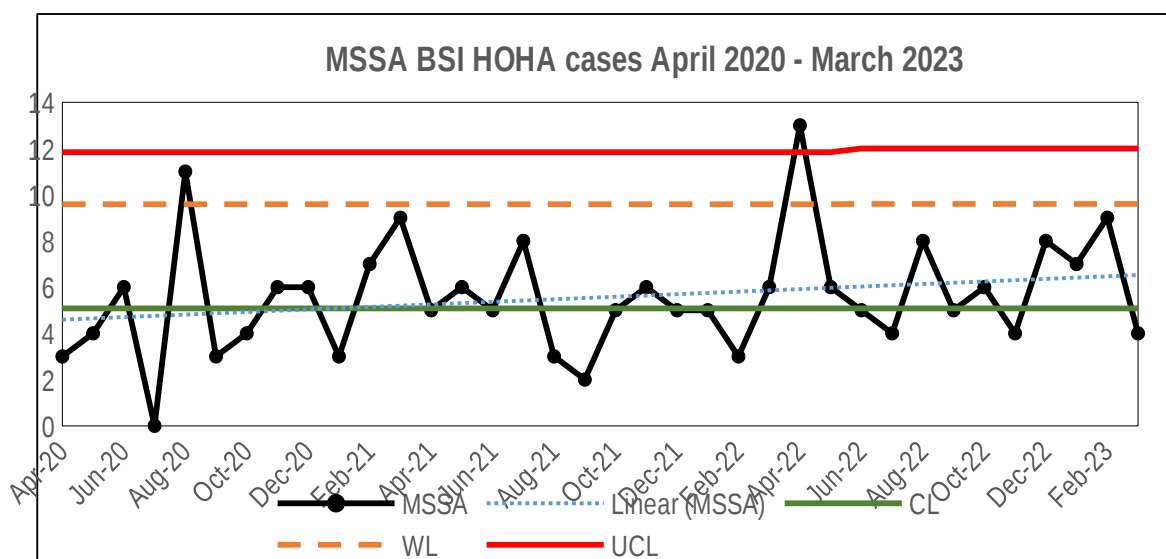
Figure 8. MSSA bloodstream infection HOHA cases diagnosed in HUTHT 2020-23

Financial year	Total number of reported MSSA bacteraemia (HOHA)	Total number of reported MSSA bacteraemia (HOHA&COHA combined)
2019-20	62	Not reported
2020-21	62	75
2021-22	59	81
2022-23	80	97

Currently there is no national threshold for MSSA bacteraemia but as a Trust, a local threshold was agreed with System Partners – sixty HOHA cases which was breached by twenty cases during 2022-23. The majority of reportable cases, 46% were reported in the Medicine Health Group, 34% in Surgery Health Group, 9% in Clinical Support, and latterly 10% in Families & Women's Health Group. There were no reported outbreaks of MSSA BSI.

Thematic analysis

Of the reported HOHA and COHA cases, male patients were affected more than females in line with national prevalence with 56% apportioned to male patients and 44% apportioned to female patients.

Age distribution of the affected patients demonstrates cases of MSSA BSI across all age groups but with a highest percentage reported from fifty – ninety years of age again in line with national prevalence.

Previous history of MSSA/MRSA colonisation and/or infection was reported amongst 38% of patients. Additional research conducted by the Infectious Diseases team has facilitated the screening of patients who are reported with a positive MSSA BSI and although the research remains ongoing at the time of the report, early indication suggests a correlation with the development of a MSSA BSI and colonisation with MSSA nasally or from other body sites.

Skin and soft tissue infections, predominantly found on admission culturing MSSA were reported amongst 21% of patients who developed a MSSA bacteraemia.

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The use of vascular access devices such as central venous catheters (CVCs) and peripheral venous cannulas which likely contributed to the development of a MSSA BSI were a reported feature with 28% of patients having an inserted device at the time of the positive MSSA BSI and of this 28% - 26% were associated with PVCs and the remaining 74% related to CVCs. Patients with hospital and/or ventilator associated pneumonia equated to 15% of patients with MSSA present in their sputum with the infection potentially seeding to the vascular access line site during episodes of care.

Mortality reported at 21% - 25% of the deaths were reported in the community following discharge with the majority of these patients on end of life pathways and cause of death in line with terminal diagnosis, 25% are reported but MCCD not completed and of the ten remaining cases MSSA BSI was reported either as 1a or 1b of the death certificate.

For 2023-24, following agreement with System Partners a focus of the Hull & East Yorkshire HCAI Review Group will be the tabling of MSSA bacteraemia RCAs/ PIRs for discussion and to identify areas for improvement.

Gram- Negative bloodstream infection (GNBSIs)

For the operational period 1st April 2022 to 31st March 2023, UKHSA and NHS England required NHS Trusts to continue to report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa. On the 27th April 2022, NHS England published NHS Standard Contract 2022/23 - Minimising Clostridioides difficile and Gram-negative bloodstream infections (GNBSIs). Trusts were required under the NHS Standard Contract 2022/23 to minimise rates of both C. difficile and of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement. This is to support the government initiative to reduce Gram-negative bloodstream infections by delivering a 50% reduction by 2024-2025, inclusive of Escherichia coli (E.coli), Klebsiella and Pseudomonas Aeruginosa bacteraemia.

The geographical burden of GNBSIs is evident across the North of England
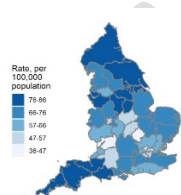
Geographical distribution of E.coli rates per 100,000 population, England April 2021 to March 2022 (Figure 9)
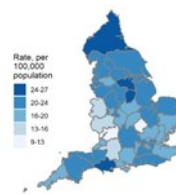
Geographical distribution of Klebsiella rates per 100,000 population, England April 2021 to March 2022 (Figure 10)
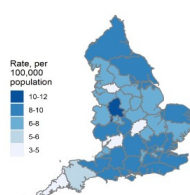
Geographical distribution of P.aeruginosa rates per 100,000 population, England April 2021 to March 2022 (Figure 11)

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GNBSI Thresholds

E.coli BSI 2022/2023 Threshold	Year-end Reported Cases
166 reported cases (HOHA & COHA combined)	221 reported cases (130 HOHA & 91 COHA combined)
Klebsiella BSI 2022/2023 Threshold	**Year-end Reported Cases**
68 reported cases (HOHA & COHA combined)	75 reported cases (51 HOHA & 24 COHA combined)
Pseudomonas aeruginosa BSI 2022/2023 Threshold	**Year-end Reported Cases**
26 reported cases (HOHA & COHA combined)	37 reported cases (23 HOHA & 14 COHA combined)

Escherichia coli bacteraemia

The incidence rate of all reported E. coli bacteraemia increased each financial year between the initiation of the mandatory surveillance of E. coli bacteraemia in July 2011 and the start of the COVID-19 pandemic. This increase was primarily driven by community-onset cases. The incidence rate of hospital-onset cases remained relatively stable except for a sharp reduction observed in April to June 2021, this was followed by a steady return to pre-pandemic rates although remaining lower than the start of E. coli surveillance. A seasonality trend is visible with all reported E. coli bacteraemia, the highest rates are observed between July to September of each year, although more fluctuation during the pandemic years. There is less evidence of the same seasonality among hospital-onset cases.

The hospital-onset rate at Hull University Teaching Hospitals NHS Trust is 29.7 per 100,000 bed-days compared to the England hospital-onset rate of 21.5 per 100,000 bed-days (2021-22 available data).

A review of reporting and assurance around the investigation of E.coli bacteraemia by both the infection prevention & control team (IPCT) and HGs has resulted in an increase in engagement on the timely completion of RCAs but there is still a need to contemporaneously investigate cases and capture learning by both the IPCT and HGs. E.coli bacteraemia are subject to review by the IPCT and following review if an RCA is warranted the request to complete an RCA is forwarded to the respective HGs. There were no reported outbreaks of E.coli BSI.

A notable increase in elective activity was noted from early May 2022 onwards which is reflected in the rise of cases. Peaks in E.coli bacteraemia notably coincided with heat waves which affected Yorkshire & Humber through June to August 2022 resulting in dehydration causing patients to be admitted with constipation, blocked urinary catheters and an increase in urinary tract infections.

The majority of reportable cases, 40% were reported in the Surgery Health Group, 35% in Medicine Health Group, 19% in Clinical Support, and latterly 6% in Families & Women's Health Group.

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Thematic analysis

Of the reported HOHA and COHA cases, male patients were affected more than females in line with national prevalence with 62% apportioned to male patients and 38% apportioned to female patients.

Age distribution of the affected patients demonstrates cases of E.coli bacteraemia BSI across all age groups but with a highest percentage reported from fifty – ninety years of age again in line with national prevalence.

Previous history of E.coli infection and/or colonisation was reported in approximately 50% of cases, with E.coli present predominantly in the urine.

As reported previously the same trends and sources of infection continue to be identified, being biliary, urinary and respiratory.

Mortality reported at 40% - 32% of the deaths were reported in the community following discharge with the majority of these patients on end of life pathways and cause of death in line with terminal diagnosis/evidence of frailty. The remaining 68% of deaths occurred in hospital during the course of the patient's admission with MCCDs reporting E.coli septicaemia, urinary sepsis, biliary sepsis and aspiration pneumonia as 1a or 1b on the death certificate.

Figure 9. E. coli bacteraemia all rates by reporting acute trust and financial year
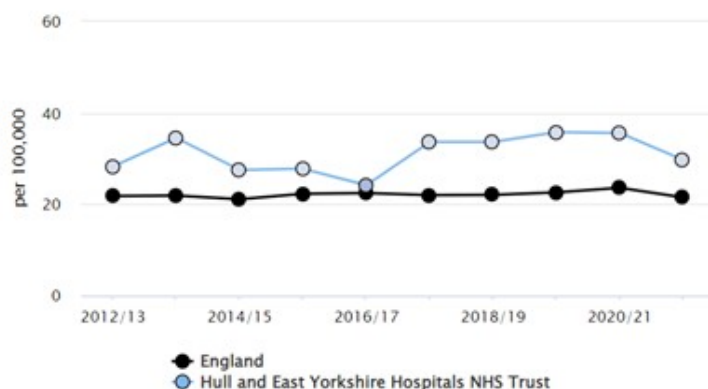
Figure 10. E. coli bacteraemia hospital-onset counts and rates by NHS acute trust and financial year

E.coli bacteraemia HOHA cases April 2020 - March 2023
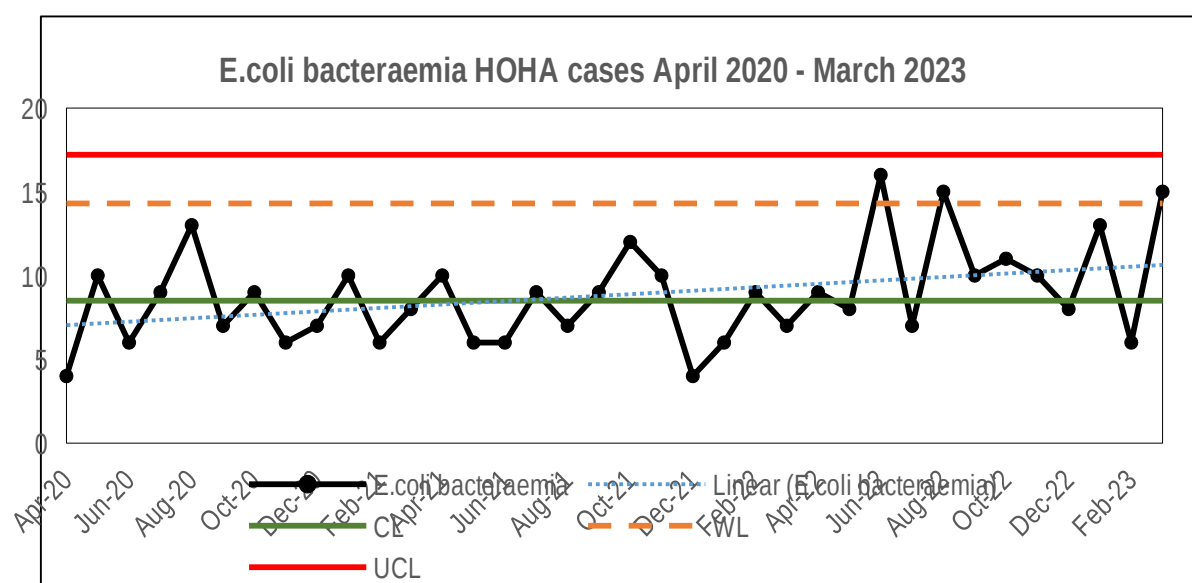
Figure 11. E.coli bloodstream infection HOHA cases diagnosed in HUTHT 2020-23

Klebsiella and Pseudomonas Aeruginosa bacteraemia

Klebsiella and Pseudomonas Aeruginosa bacteraemia demonstrate similar risk factors as those found with E.coli bacteraemia, with both reported in cases of respiratory and urinary tract infections.

Klebsiella bacteraemia
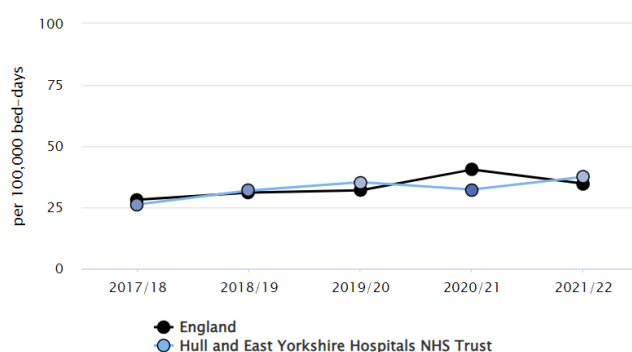
Figure 12. Klebsiella spp. bacteraemia all counts and rates by acute trust and financial year

14
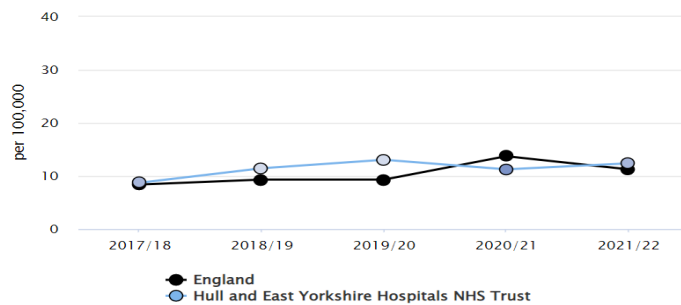
Figure 13. Klebsiella spp. bacteraemia hospital-onset counts and rates by acute trust and financial year

The majority of reportable cases, 39% were reported in the Surgery Health Group, 35% in Medicine Health Group, 22% in Clinical Support, and latterly 4% in Families & Women's Health Group. There were no reported outbreaks of Klebsiella BSI.

Thematic analysis

Of the reported HOHA and COHA cases, male patients were affected more than females in line with national prevalence with 64% apportioned to male patients and 36% apportioned to female patients.

Age distribution of the affected patients demonstrates cases of Klebsiella bacteraemia BSI across all age groups but with a highest percentage reported from fifty – eighty years of age again in line with national prevalence.

As reported previously the same trends and sources of infection continue to be identified, being biliary, urinary and respiratory.

Mortality reported at 50% - 15% of the deaths were reported in the community following discharge often a month or longer following discharge. The remaining 85% of deaths occurred in hospital during the course of the patient's admission with MCCDs reporting Klebsiella septicaemia, urinary sepsis, biliary sepsis and aspiration pneumonia as 1a or 1b on the death certificate.

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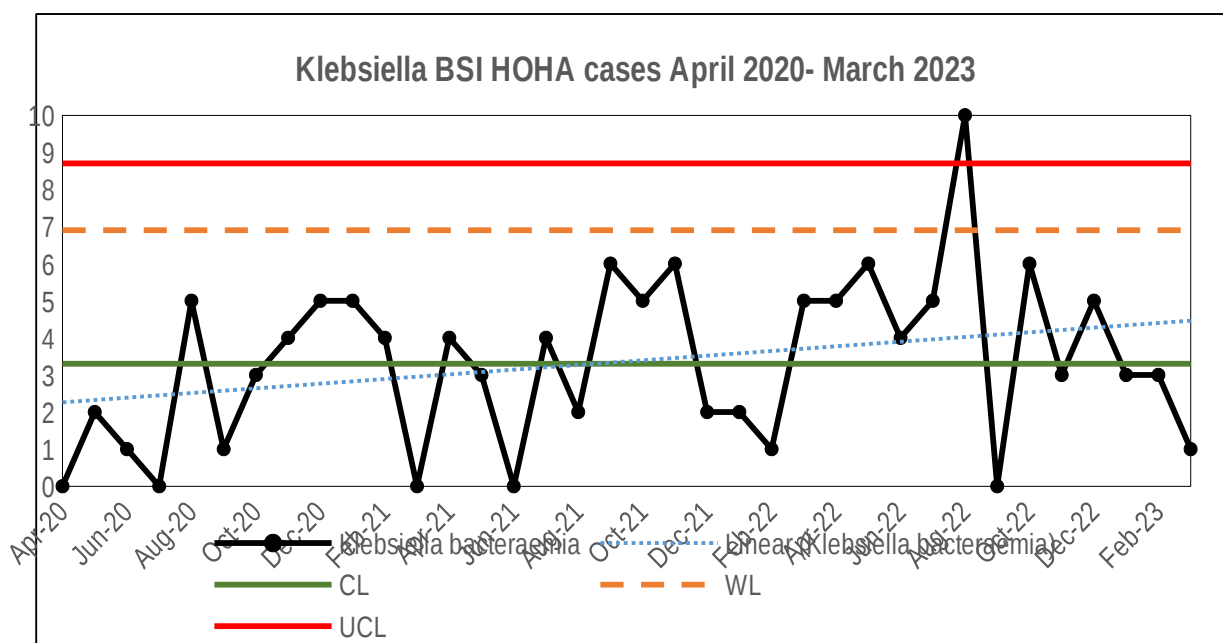
Figure 14. Klebsiella bloodstream infection HOHA cases diagnosed in HUTHT 2020-23

Pseudomonas aeruginosa bacteraemia

In Quarter 1, the Trust was an outlier across Yorkshire and the Humber with a marked increase in Pseudomonas aeruginosa BSIs, these were not linked but isolated cases identified across the Trust – numbers of reportable bacteraemia cases returned to normal baseline levels by Quarter 2 and continued until a reported peak of hospital onset cases in November 2022. This peak represented not linked but isolated cases across the Trust. Thirty seven HOHA & COHA cases were reported from a total of thirty four patients (three patients had a previous pseudomonas aeruginosa BSIs and developed a further BSI within four to eight weeks) in spite of appropriate antibiotics and management. There were no reported outbreaks of Pseudomonas aeruginosa BSI.

The majority of reportable cases, 38% were reported in the Surgery Health Group, 32% in Clinical Support, 24% in Medicine Health Group, and latterly 5% in Families & Women's Health Group.

Thematic analysis

Of the reported HOHA and COHA cases, male patients were affected more than females in line with national prevalence with 59% apportioned to male patients and 41% apportioned to female patients.

Age distribution of the affected patients demonstrates cases of Pseudomonas aeruginosa BSI across all age groups but with a highest percentage reported from fifty – ninety years of age again in line with national prevalence.

The use of vascular access devices such as central venous catheters (CVCs) which likely contributed to the development of a Pseudomonas aeruginosa BSI were a reported feature with 28% of patients having an inserted device at the time of the positive Pseudomonas aeruginosa BSI and of this 28% - 100% were associated with CVCs. Patients with hospital, community and/or ventilator associated pneumonia equated to 26% of patients with Pseudomonas aeruginosa present in their sputum with the infection potentially seeding to the vascular access line site during episodes of care.

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Of the thirty four patients who had a reported Pseudomonas aeruginosa BSI, 21% were associated with urinary catheters and potentially avoidable, 18% with skin and soft tissue infections and 12% with biliary sepsis with the latter mainly being unavoidable. Neutropenic sepsis was reported in 6% of cases and one patient had endocarditis.

Mortality reported at 47% - 15% of the deaths were reported in the community following discharge with the majority of these patients on end of life pathways and cause of death in line with terminal diagnosis. The remaining 85% of deaths occurred in hospital during the course of the patient's admission with MCCDs reporting Pseudomonas aeruginosa septicaemia, urinary sepsis, biliary sepsis and aspiration pneumonia as 1a or 1b on the death certificate.
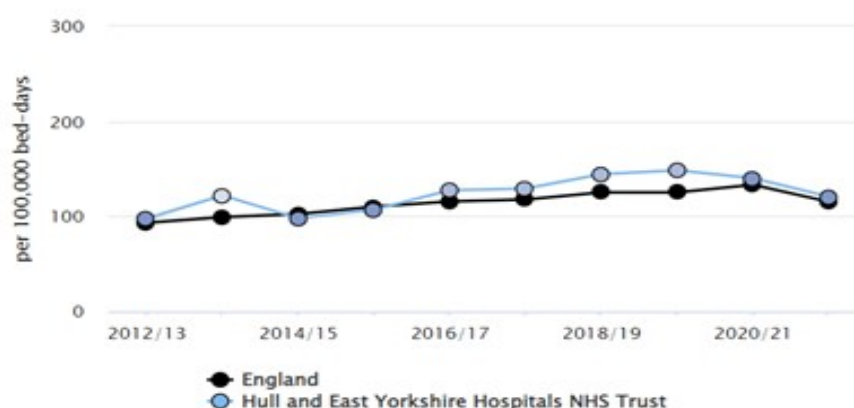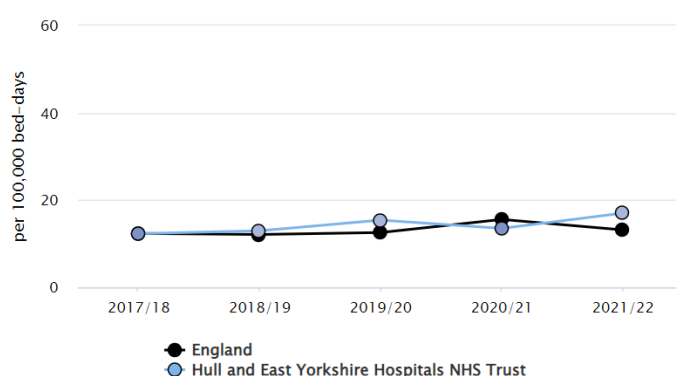

Figure 15. P. aeruginosa bacteraemia all counts and rates by acute trust and financial year
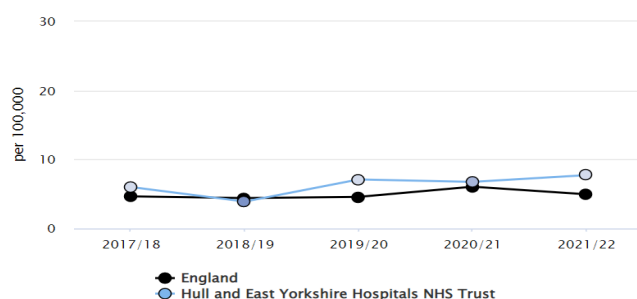
Figure 16. P. aeruginosa bacteraemia hospital-onset counts and rates by acute trust and financial year

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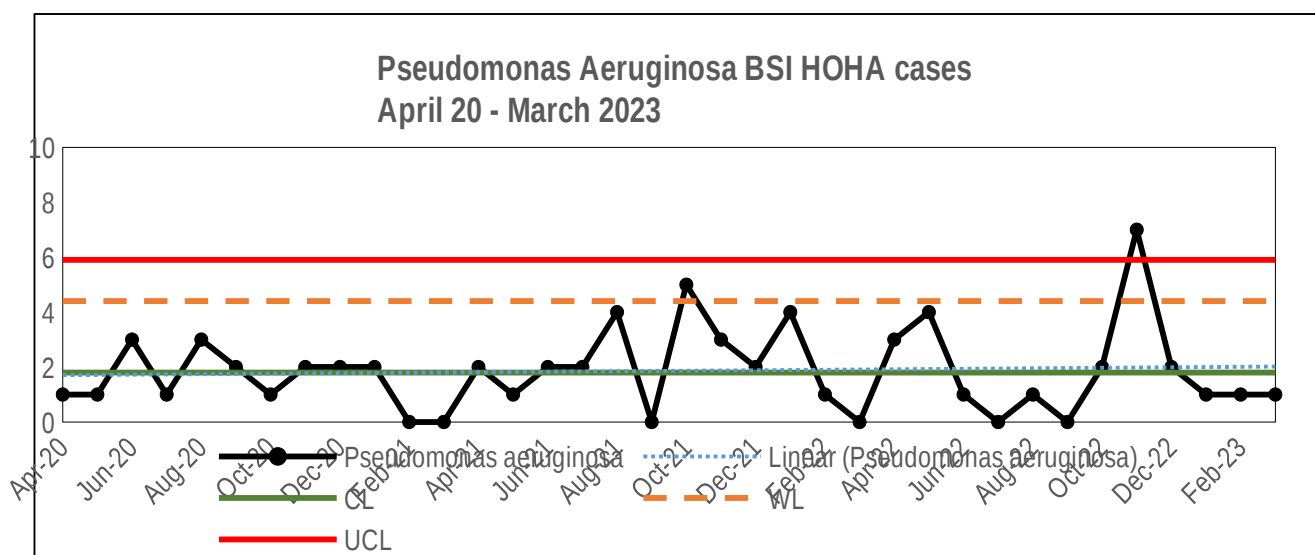
Figure 17. Pseudomonas aeruginosa bloodstream infection HOHA cases diagnosed in HUTHT 2020-23

NHS England nationally and regionally are encouraging Acute Trusts and Integrated Care Boards to scope improvement opportunities when tackling GNBSIs with an initial focus on hydration and the insertion/management of urinary catheters – the Trust IPCT are actively involved in these work streams, a priority for 2023-24.

Blood Culture Pathway

Optimising the blood culture pathway is essential in ensuring the best outcomes for patients with sepsis and in providing the most effective antimicrobial stewardship programs. In June 2022, NHS England produced guidance on improving the blood culture pathway and this was further updated in March 2023, providing the opportunity to improve antimicrobial stewardship (AMS), improve outcomes from sepsis, early identification of a specific organism, supporting a more accurate infection diagnosis, guiding specific investigations and further management, and early identification of infection control and public health implications. At the time of writing this report a review of the Trust blood culture policy and pathway is underway.

Graphical representation of blood culture sets per 1,000 bed-days performed by reporting acute trust and quarter across the ICB included. By the end of quarter 3 2022-23 the counts of blood culture sets varied across the Trusts in the ICB with HUTHT submitting the most – 5448 versus 4941 at York Teaching Hospital NHS Foundation Trust and 2896 at Northern Lincolnshire & Goole NHS Foundation Trust.
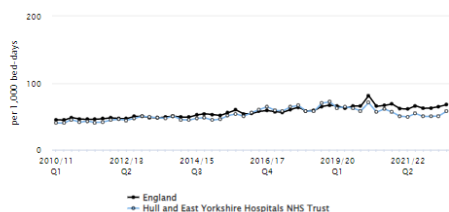
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Hull University Teaching Hospitals NHS Trust
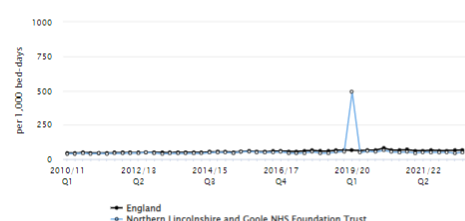
Northern Lincolnshire & Goole NHS Foundation Trust
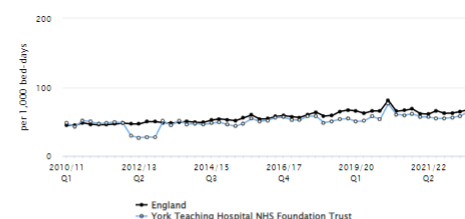
York Teaching Hospital NHS Foundation Trust

Figure 18. Blood culture sets per 1,000 bed-days performed by reporting acute trust and quarter

Surgical Site Surveillance

The Trust continues to participate in both mandatory and voluntary surveillance of surgical site infection: in 2022/23 this included orthopaedic surveillance (fractured neck of femurs) and was commenced during January 2023 – March 2023, providing the opportunity to compare year on year figures.

With regards repair of neck of femur fracture surveillance completed during January – March 2023, one hundred and twenty seven repair of fractured neck of femur operations were surveyed, provisional data suggests four patients developed a surgical site wound infection providing the percentage of surgical site infections (SSIs) at the Trust at 3.1%, and above the national hospital SSI rate. At the time of drafting the report, the surveillance is awaiting sign off and ratification by the UKHSA Surgical Site Surveillance Service (SSISS).

The table below provides an overview of the number of repair of fractured neck of femur operations and reported SSIs.

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2019 Q1	72	2	2.8%	0	0.0%	2	2.8%
2020 Q1	87	1	1.1%	0	0.0%	1	1.1%
2021 Q1	81	0	0.0%	0	0.0%	0	0.0%
2022 Q1	131	3	2.3%	0	0.0%	3	2.3%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

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A previous increase in SSIs were reported for this type of surgical operation from 2018 onwards and a number of changes were made by the Health Group to address this, these included dedicated theatre with ultraclean ventilation, changes in skin preparation and antibiotic prophylaxis along with improved surgical wound dressings. Although these had an impact the Health Group facilitated by the Trauma and Orthopaedic Team are completing a deeper dive into the increasing rate of SSIs and completing root cause analysis to address possible risk factors that could contribute to infection.

8   OUTBREAKS AND RESISTANT ORGANISMS

Diarrhoea & Vomiting/ Norovirus

During 2022-23, there were very few incidences and/or outbreaks of Norovirus reported, during Quarter 1 and Quarter 4, outbreaks of Norovirus occurred on wards on the HRI site. The outbreaks were promptly identified but affected both patients and staff, they were short lived in duration with incident meetings held to discuss control measures. All wards were cleaned and reopened following advice taken from the IPCT.

During 2022-23, outbreaks of diarrhoea & vomiting (D&V), mainly affecting general medical & medical elderly wards were reported. In the majority of cases, only bays were affected and following applied control measures and sampling, closures was short-lived.

In accordance with national guidance hospital outbreaks of D&V/ Norovirus were managed with partial restrictions but some complete ward closures were necessary.

Tuberculosis

During 2022-23, the identification of Tuberculosis (TB) in inpatients, resulting in contact tracing of both staff and patients continued. One incident, involving two patients admitted separately but linked due to provenance were diagnosed with TB resulting in contacts identified, screened and followed up successfully with treatment if required. The infection prevention and control team have worked closely with the community TB nursing team, infectious diseases consultants, respiratory consultants and UKHSA to reduce ongoing risks to patients and staff. These incidences have provided the opportunity to reinforce the importance of appropriate isolation of 'at risk' patients, use of appropriate personal protective equipment (PPE) e.g. FFP3 facemasks and also communication of cases and incidents to local System Partners both on the North & South Bank.

Carbapenemase producing Enterobacteriaceae (CPE)

During Quarter 2 an outbreak of carbapenemase-producing Enterobacterales (CPE) was reported, affecting 4 patients across 3 clinical areas at CHH, incident meetings were held which supported the hypothesis of transmission occurring as a result of direct care but also indirect transmission and the impact of the environment as a vehicle for transmission.

During 2022-23, single cases of CPE were identified in patients admitted from abroad and/or other hospitals across the UK but managed in accordance with Trust policy and did not result in onward transmission.

A task and finish group was formed as a result of the CHH outbreak, patients admitted with CPE and the published national framework on containing CPE infections which was updated

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in September 2022. A gap analysis identified that our Trust processes were not aligned, therefore a business case was drafted to ensure polymerase chain reaction (PCR) screening processes were optimal for prudent patient management with the inclusion of screening for Vancomycin Resistant Enterococci (VRE). At the time of writing, that business case has been approved providing greater assurance for patient safety.

Vancomycin Resistant Enterococci (VRE)

During Quarter 3 a marked increase in VRE cases were reported, predominantly in the Surgery Health Group. Cases were initially reported in both intensive care units at Hull Royal Infirmary, Wards H4 & H40 and Ward H7, following further investigation these cases were found to be linked to time and place with patients being transferred to and from these clinical areas during their hospital stays, providing transmission opportunities. Clinical isolates were sent for typing to UKHSA which confirmed an indistinguishable VRE infection. Reactive and proactive screening for VRE was initiated as was appropriate isolation and cohorting. Reinforcement of prudent IPC measures were taken as was opportunities to effectively clean and decontaminate the environments and in some cases restrict access to affected wards and units. Incident meetings were convened and held with System Partners, UKHSA and NHS England. Control of the outbreak was achieved within eight weeks with specific screening maintained as a precaution.

Unfortunately, by Quarter 4 it was evident a further outbreak of VRE was affecting wards H12 and H120, initiated by a cluster of VRE positive wound infections. The same IPC recommendations and measures were instigated and incident meetings convened, however, further cases were identified, all of which demonstrated rectal carriage and ongoing transmission. Opportunity to decontaminate using Hydrogen Peroxide Vapours were taken and monitoring of cleaning and IPC practices have been undertaken daily. This has been a multifactorial protracted outbreak and at the time of writing this annual report remains an active infection incident.

Influenza

Cases of Influenza were reported from September 2022, peaking in November & December 2022. During December 2022, a noted increase was reported in the identification of Influenza A cases amongst patients due in part to PCR testing for viral respiratory infections identifying Influenza A. Managing high risk immunocompromised patients as contacts again identified asymptomatic Influenza A cases on repeat screening who were managed separately to any COVID-19 positive patients. This marked rise in Influenza A was expected due to similar experiences in the Southern hemisphere.

Cases of Influenza B were reported on point of care testing (POCT) from January 2023 but due to a national quality control issues with POCT these were deemed false positive with

Patients were proactively screened for influenza, along with COVID-19, during admission and/or treatment when presenting with flu-like symptoms which is to be commended and encouraged, ensuring patient and staff safety.

The majority of cases were reported on admission to the Trust and were identified as Influenza A as the predominant circulating strain.

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Influenza Activity 2022/23 at Hull University Teaching Hospitals NHS Trust
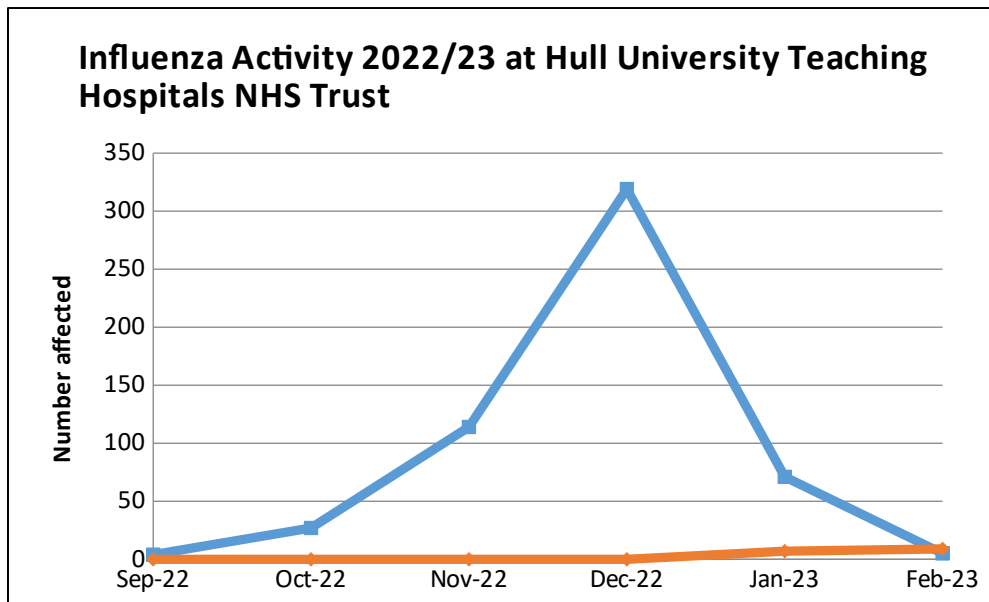
Figure 19. Represents influenza activity at the Trust during 2022-23
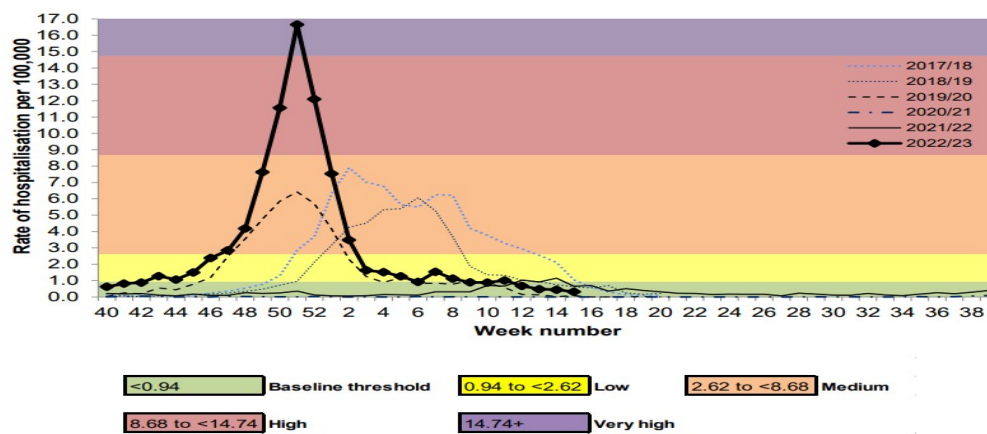
* MEM thresholds are based on data from the 2016 to 2017 to the 2021 to 2022 seasons (data from 2020 to 2021 was excluded due to the COVID-19 pandemic).

Figure 20. Weekly overall influenza hospital admission rates per 100,000 trust catchment population with MEM thresholds, SARI Watch, England

22
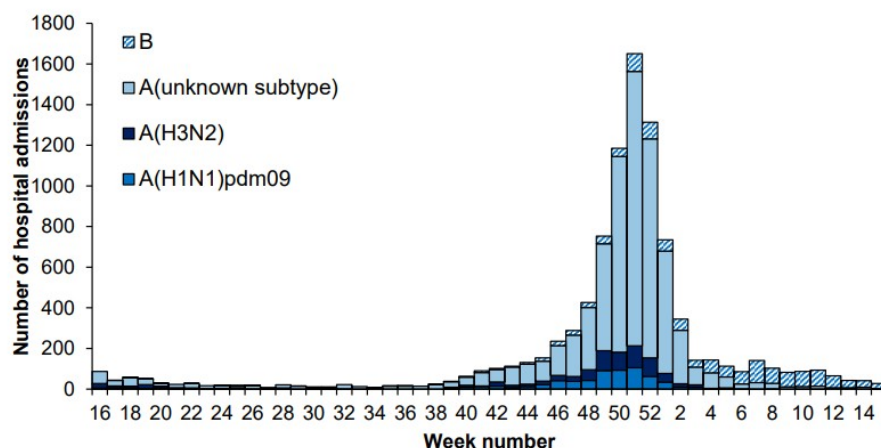
*Number of influenza hospital admissions based on sentinel NHS trusts

Figure 21. Weekly influenza hospital admissions by influenza type, SARI Watch, England

COVID-19

During 2022-23, COVID-19 remained the largest challenge for the organisation alongside resistant infections adept at causing outbreaks but this was comparable with the volume of patients whom medically fit for discharge, had subsequently no criteria to reside, resulting in a number of wards dedicated to their care.

The pandemic during 2022-23 was punctured with different COVID-19 variants which resulted in peaks and troughs of reported COVID-19 cases, resulting in high prevalence and incidence within the community and subsequently an increase in hospital admissions and resulting outbreaks of infection.

The grey line indicates proportion of cases sequenced. The first red dashed line denotes the start of England's 'Living with COVID' plan at the start of April 2022 and the second indicates the pause of asymptomatic testing for high-risk settings at the end of August 2022. The dashed red vertical line denotes changes in PCR testing in April 2023. The data used in this graph can be found in the accompanying spreadsheet.

Figure 22. Variant prevalence (UKHSA designated variant definitions only) of available sequenced cases for England from 18 April 2022 to 2 April 2023

On the 1st April 2022, UKHSA published Living safely with respiratory infections, including COVID-19 and NHS England published updated associated guidance for health and social care. Changes in further guidance resulted in routine asymptomatic COVID19 testing pausing in August 2022, affecting both case and positivity rates. During 2022-23, the Infection Prevention & Control team responded to updates in guidance providing a pragmatic

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approach to the management of patients and staff across the Trust. Asymptomatic screening to facilitate discharge to social care remained in place during 2022-23 and in some cases identified asymptomatic carriage of COVID19 and as such reported as hospital onset cases due to the patient length of stay. On average the rate of hospital onset infection equated to 25% although with the absence of asymptomatic testing it was difficult to illicit if the infection occurred prior to admission and the patient remained asymptomatic throughout.

The impact of COVID-19 vaccination and associated boosters resulted in patients being affected by COVID-19 differently, patients did not require escalation of treatment requiring level 2 or 3 care as previously seen in the first waves of the pandemic and less requiring supportive treatment, although this was still prescribed, as per Trust Guideline for the Clinical Management of Proven / Suspected COVID-19 in Adults.

Outbreaks of COVID-19 resulted in convened multidisciplinary incident meetings to improve decision making and escalation locally, regionally and nationally via reporting routes. To improve communication further a daily IPC report was drafted and circulated to ensure clinical and site teams were apprised of IPC recommendations with regards bay and ward closures along with IPC advice.
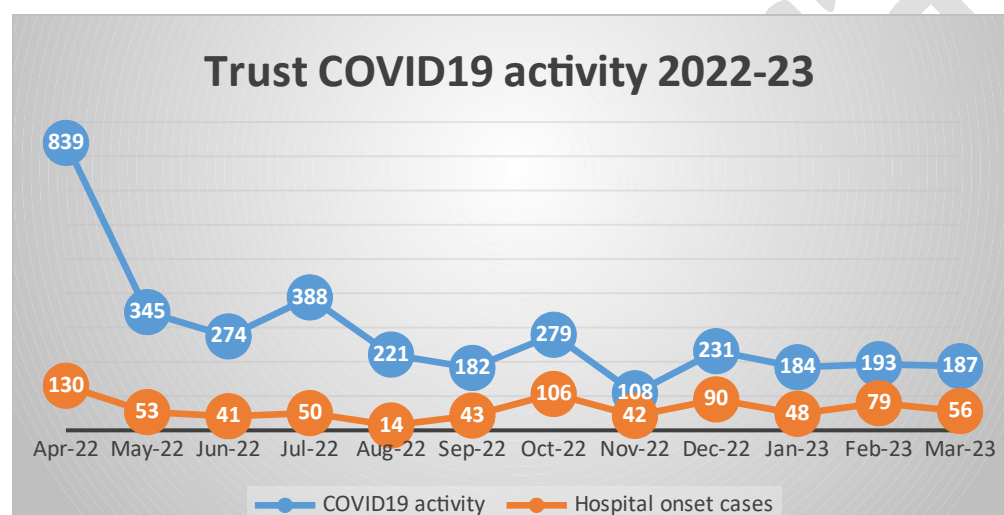
Figure 23. The graph demonstrates COVID19 activity at the Trust and the number of hospital onset cases
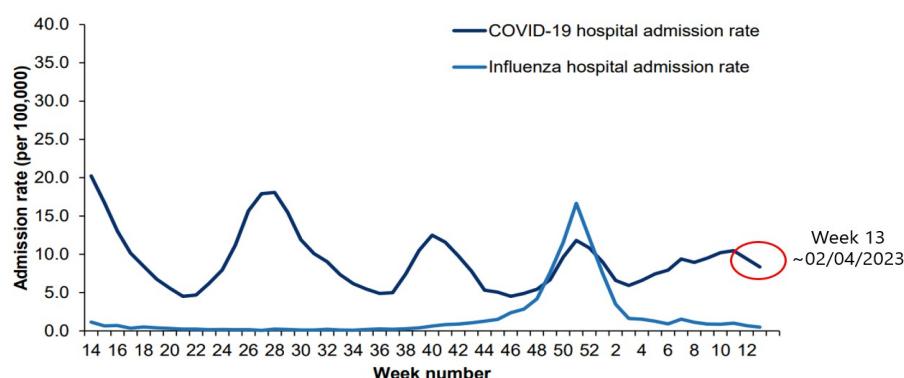
Figure 24. Weekly overall hospital admission rates of new COVID-19 and Influenza positive cases per 100,000 population reported through SARI Watch, England
(COVID-19 hospital admission rate based on 88 NHS trusts for week 15/ Influenza hospital admission rate based on 21 sentinel NHS trusts for week 15)

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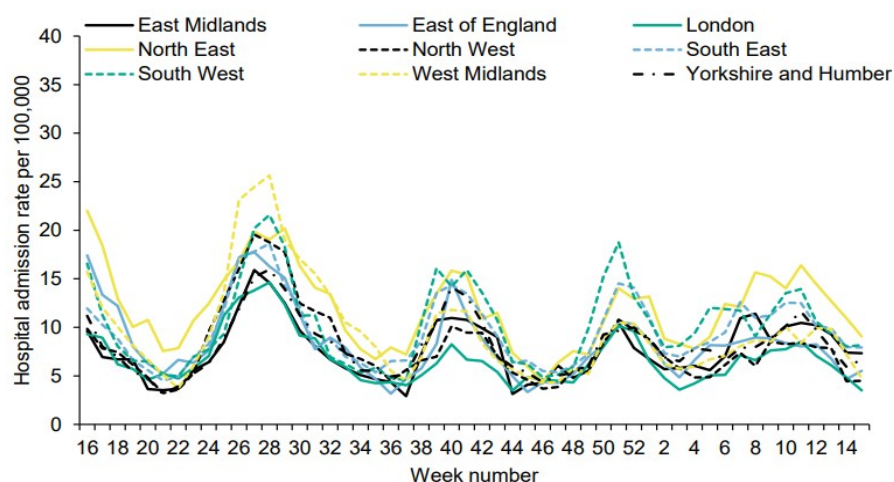
Figure 25. Weekly hospital admission rate by UKHSA centre for new COVID-19 positive cases reported through SARI Watch*

9   ISOLATION FACILITIES

There have been, for many years, concerns about the Trust's isolation facilities. Like many other NHS trusts with older estate there is a general shortage of single rooms suitable for isolating patients with potentially contagious conditions. This is a long-standing issue, and there is no simple solution.

Ward C7 has had a positive impact on patient management, particularly those patients with difficult to treat infections and infectious diseases requiring specialist isolation facilities. The Trust can manage several patients at once with conditions requiring long term isolation, for example multidrug resistant tuberculosis. The ward also forms part of a network of high consequence infectious disease facilities across the UK which can be utilised as and when required.

Compliant isolation facilities on intensive care units across the Trust expanded on the opening of the ICU on the HRI site during December 2021 resulting in increased accessibility for patients requiring isolation and improving care for patients nursed in intensive care.

There remained concern with regards the adequate isolation of children especially those with airborne infections and during 2021-22, with IPC input and involvement, multi-disciplinary meetings were held and work commenced on a new paediatric inpatient, high dependency unit and outpatient facility. Improved isolation capacity and smaller bedded areas e.g. 2 bedded bays enable prudent management of paediatric patients and minimise the risk but not totally exclude the transmission of infections. Although the scheme was delayed by the COVID19 pandemic the new paediatric facilities opened in January 2023.

The Neonatal Intensive Care Unit (NICU), a tertiary level 3 unit, has had a number of incidents and outbreaks with the environment cited as being a contributory factor and significant work has been undertaken on the unit to mitigate risks. The 'blue room' although reduced by two cot spaces requires further work to reconfigure the space following a recommendation from the Department of Infection for this to be addressed as soon as is

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practicable. Although the reconfiguration has been approved, additional allocated funding has been secured a delay was incurred due to changes expected once the paediatric scheme was completed, allowing NICU to review parental accommodation and reconfigure the unit accordingly.

The lack of a decant facility and the flexibility with which to close a ward in the event of an outbreak is also an issue for the organisation and must be considered alongside isolation facilities.

10   ANTIMICROBIAL STEWARDSHIP

Ongoing emphasis is being placed nationally on the importance of antimicrobial stewardship as part of an infection prevention and control plan. This is useful in reducing the development of C difficile infection, but is even more important in limiting the emergence of bacterial resistance. The Trust has for many years had a good record in antimicrobial stewardship. During 2022-23, Dr Debbie Wearmouth, Consultant Microbiologist and ICD was the clinical lead for antimicrobial stewardship.

The World Health Organisation created the Access, Watch and Reserve antibiotic categories to assist antimicrobial stewardship and to reduce antimicrobial resistance, although there is variation in categorisation across the UK where some antibiotics are in the Watch category rather than Access e.g. Cephalexin and Co-amoxiclav. The three AWaRe categories divide antibiotics as follows:

•   Reserve – antibiotics that need to be reserved for very complex infections with limited treatment options due to antimicrobial resistance

•   Watch – broad spectrum antibiotics with higher potential for driving resistance

•   Access – key antibiotics most of which are narrow spectrum and used as first-line treatment options.
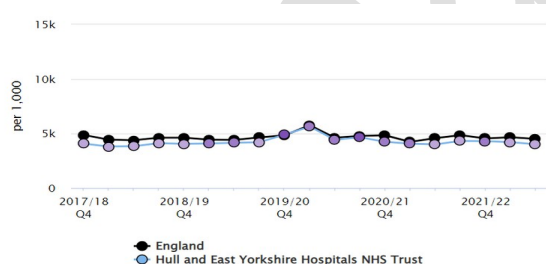
Figure 26. Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust

Total Antibiotic Consumption (March 2023)

Target: TOTAL ANTIBIOTIC CONSUMPTION	
Total DDDs per 1000 Admissions – Baseline (Calendar Year 2018)	4005.68
Total DDDs per 1000 Admissions – Financial Year 2022/23, April to March	4223.05
% Change – Baseline Year vs. Financial Year 2022/23, April to March	+5.4%

HUTH continues to use more antibiotics (per 1000 admissions) compared to the 2018 baseline year. At the end of March 2023 the increase was 5.4%.

Figure 27. Trust Total Antibiotic Consumption by March 2023

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Total DDD Figures

Following introduction of MicroGuide and CAP guidance changes there has been a shift in the prescribing of a number of agents. Most notably is the decrease in co-amoxiclav prescribing and the increase in doxycycline.
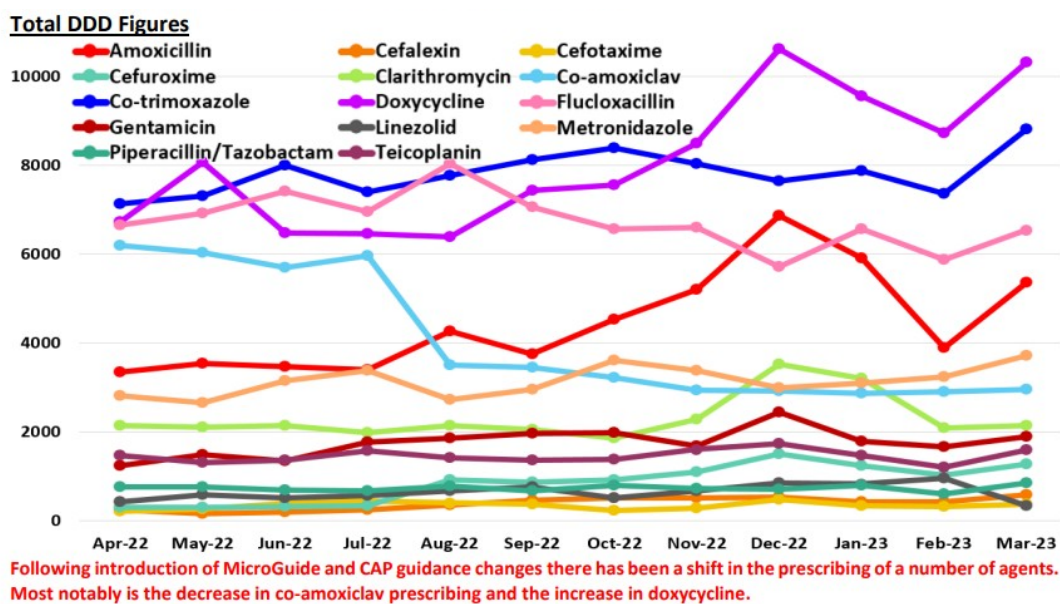
Figure 28. Trust Total DDD Figures by March 2023
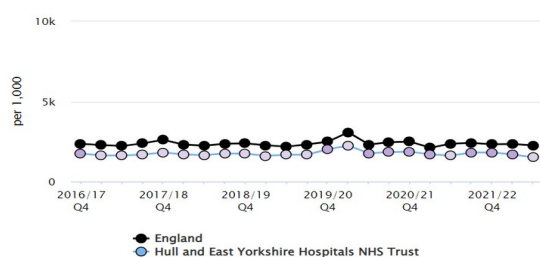
Figure 29. Antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO essential Medicines List AWaRE index; DDDs per 1000 admissions by quarter and trust (Please note slight differences exist between what is reported on Fingertips/ Define and the Trust's our local data)

2022/23 National Contract (March 2023)

Target: 4.5% REDUCTION IN WATCH AND RESERVE (NHS Adapted LIST) ANTIBIOTICS FROM 2018 CALENDAR YEAR	
Total Watch and Reserve DDDs per 1000 Admissions – Baseline (Calendar Year 2018)	1731.43
Total Watch and Reserve DDDs per 1000 Admissions – Financial Year 2022/23, April to March	1585.47
% Change – Baseline Year vs. Financial Year 2022/23, April to March	-8.4%

Broad spectrum antibiotic use has reduced over 22/23. Target reductions were met by the end of March 23.

Figure 30. Performance against National Contract (2022/23)
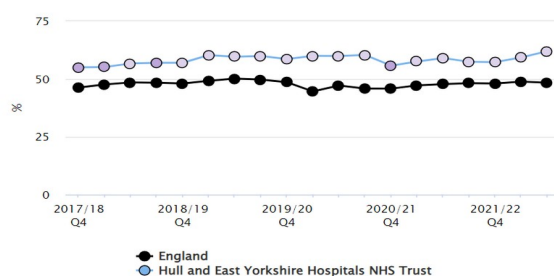
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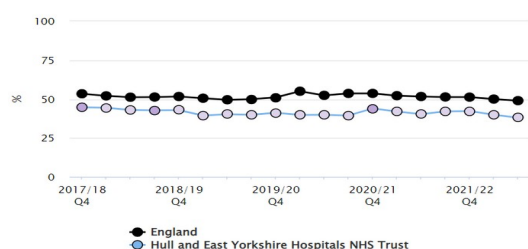
Figure 32. Proportion of total antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO Essential Medicines List AWaRE index
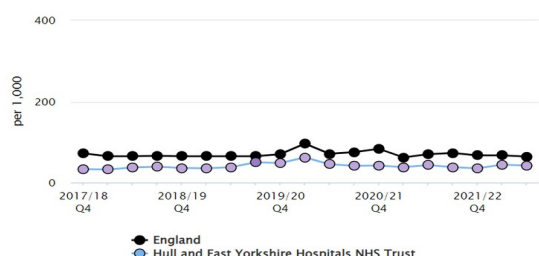
Figure 33. Carbapenem prescribing DDDs per 1000 admissions; by quarter and acute trust

The Antibiotic Control and Advisory Team (ACAT) continues to work on improving antibiotic usage within the Trust. In addition to an innovative antibiotic formulary (promoting less use of broad spectrum agents) ACAT has produced guidelines on empiric antibiotic prescribing, antibiotic 'streamlining', and surgical antibiotic prophylaxis. All this guidance is available both in hard copy and on Pattie. The Antibiotic Pattie page has been reviewed and improved so that each specialty has their own section. Closer links with the specialties concerned is integral to the development of the updates which will hopefully encourage guideline adherence. To support ACAT, a Trust Antibiotics Stewardship Task & Finish group was formed as a developmental SIRC meeting from May 2022 – this provided the impetus to convene a group integral to making positive change to embed antimicrobial stewardship. The task and finish group focused on a number of elements

A theme of CDI RCAs predominantly included non-compliance with Trust antimicrobial guidance resulting in lapses in practice and deemed potentially avoidable. To further support this observation, the Trust's Pharmacy Department completed HG audits focusing on prescribing as per Trust guidance and found in a third of cases prescribing was not in line with Trust guidance. During 2021-22, funding was secured to purchase the MicroGuide application, suitable for mobile device use, enabling clinical teams to access in real time Trust antibiotic guidelines, enabling greater compliance and improved antimicrobial stewardship. The app went live in July 2022 and the below chart provides an overview on its usage:

Category	Count	Additional Info, data by end of March 2023
Total Profiles	1,436	This is the total number of profiles set up since HUTHT went live with MicroGuide, with new users downloading every month. The largest staff groups are Junior Doctors (662), Nurses (292), Consultants (157) and Pharmacists (102)
Page Hits	67,854	This is the total number of individual pages opened since August 2022, with monthly pages hits averaging at ~7,000. Adult antimicrobial guide makes up for the bulk of these page hits, with a total of 60,625 for the same time period (average of ~6,000 per month)
Downloads	4,425	The three guides have been downloaded a total of 4,425 times, with the busiest month being November 2022 (938). Again, the Adult antimicrobial guide accounts for the majority of this with 3406 downloads
Most Opened Guide	7,798	Lower Respiratory Tract Infections in the adult antimicrobial guide is the most accessed section, with CAP being the most accessed condition (3,686). CAP is also the most searched for page (1,580 searches)

This has markedly improved access to HUTHT antimicrobial guidance. There has been a slight improvement in antibiotic prescribing as per guidance (45% compared to 36% a year ago) and overall prescribing as per guidance or with clinical justification has increased from 62% to 69%. However, all parameters are still below the audit target (90%) which is potentially unrealistic and requires further scrutiny/ explanation.

ACAT meets regularly to review antibiotic usage, and reports to IRC. ACAT and antibiotic pharmacy team have altered the reports that are reviewed at IRC and ACAT, tabling the updated reports throughout the financial year, these include quarterly Health Group reports looking at antibiotic consumption, performance against national contract, top five broad spectrum prescribed agents, overall usage and inpatient prescribing indication and duration reporting, antibiotic related incident reporting via DATIX and bi-annual specialty reports. Also inpatient antibiotic prescribing audits continued during 2022-23 focussing on prescribing as per guidance/ clinical justification replaced the monthly indication and duration audits and provides more qualitative data that allows for more targeted interventions. This audit has helped get the conversations started with the Health Groups/ speciality and hopefully better engagement and MDT working on antimicrobial stewardship alongside the AMS Task & Finish Group.

Electronic Prescribing and Medicines Administration (EPMA) has now been fully implemented across inpatient areas within the Trust with the exception of paediatric areas, obstetrics and ophthalmology and since its introduction to the remaining wards on the Hull Royal Infirmary site there has been a decrease in indication and more notably duration/ review date documentation on the drug chart. This will be an area for ongoing monitoring and additional reinforcement on the importance of appropriate documentation embedded within EPMA.

During 2022-23, a significant change was made to the Community Associated Pneumonia (CAP) antimicrobial prescribing guidance, moving from the use of Co-amoxiclav to Cefuroxime in severe cases (CURB65≥3). The rate of Cefuroxime use compared to the marked reduction in Co-amoxiclav prescriptions is evident in the graph below.

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Co-amoxiclav – DDDs per 1000 Admissions – Financial Year 2021/22 vs. Financial Year 2022/23

CAP guidance was changed in August 22. In severe infections co-amoxiclav was changed to cefuroxime. The drop in DDDs for co-amoxiclav was 42% (from over 500 to 300 per 1000 admissions). Cefuroxime use increased but not to the same degree as the co-amoxiclav reduction.
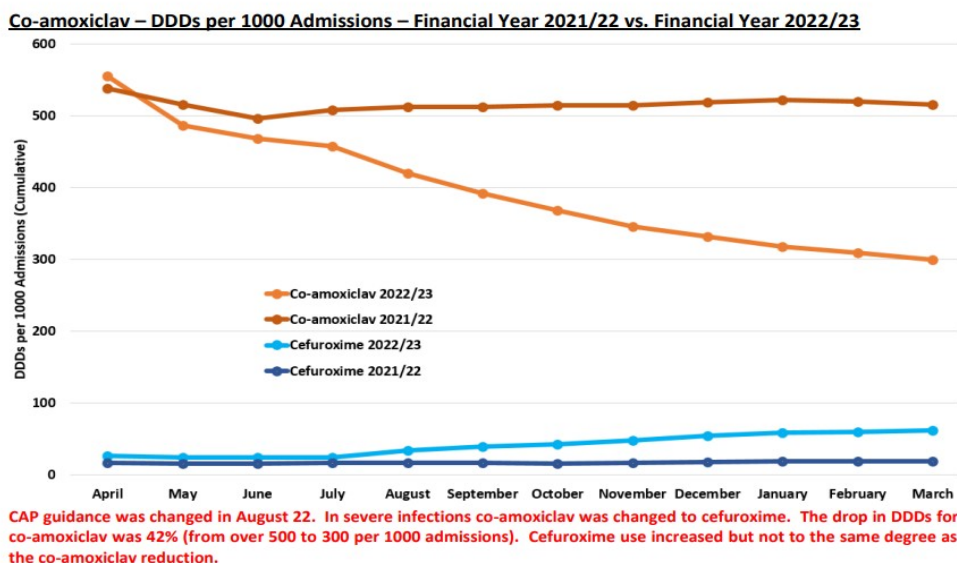
Figure 34. Trust data on Co-amoxiclav to Cefuroxime switch for severe CAP

During February 2023, UKHSA produced guidance on antimicrobial Intravenous-to-Oral Switch (IVOS) which is an important antimicrobial stewardship intervention and one that has been included as a Quality Indicator within the Commissioning for Quality and Innovation (CQUIN) Indicators and will be a focus for Pharmacy and IPC during 2023-24.

Along with conventional antimicrobial stewardship, the benefit of an outpatient parenteral antimicrobial therapy (OPAT) service to manage the delivery of intravenous and complex oral antibiotics to patients who are medically stable, within an outpatient setting eliminates the need to either admit or keep in hospital patients whose only reason to stay in hospital is to receive IV / complex oral antibiotic therapy. All OPAT patients continue to have their medical condition and therapy closely supervised by a multidisciplinary team with a proven record that this service contributes to reducing patient's length of stay in hospital, promotes early discharges and improves patient experiences. It improves quality of life for patients and reduces the risk of hospital-acquired infection. Feedback from OPAT patients is overwhelmingly positive, citing the benefits of receiving treatment as an outpatient, the ability to return to work, and the care, support and expertise of the OPAT team. During 2021-22 the OPAT service worked in close unison with City Health Care Partnership (CHCP) in delivering an OPAT service from Marfleet Community Centre, this ended following a 6-month pilot and the OPAT service returned to delivering an OPAT service from the Trust. During 2022-23 the OPAT service moved from being based at CHH to a base at HRI.

11   SEPSIS

The Trust Sepsis service consists of 1PA of Infectious Diseases consultant time as the clinical lead for the service and 2 Sepsis specialist nurses. An innovative wrap around review service for patients with Sepsis was designed aimed at prevention and safety netting in case of infection and commenced during 2022-23 having being delayed due to the COVID19 pandemic. A five-year Sepsis Strategy was developed in December 2021 with the aim of reducing sepsis mortality rates with key elements including audit & quality improvement projects, launch of a new sepsis pathway, training needs analysis and evidenced based

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educational package, prevention inclusive of outpatient follow up clinic. There are a number of quality improvements programmes inclusive of medical and nursing teams on sepsis throughout the Trust and a sepsis audit dashboard was launched to demonstrate compliance and highlighted areas of improvement inclusive of recognising sepsis in patients in ED and during an inpatient stay. A Sepsis Steering Group was formed during 2022-23 with key Trust representatives and focus on the above elements along with CQC recommendations.

12 DECONTAMINATION

The Trust Decontamination Committee convened and chaired by the Surgical Health Group covers decontamination in Sterile Services, Endoscopy, decontamination of medical devices and patient equipment and environmental cleaning. The Committee has met quarterly and the Trust endoscopy users, sterile services department and theatre report into this group and during 2022-23, escalation of concerns has been reported via the IPCT and Surgical Health Group to OIRC.

A focus during 2022-23 has been the development of an asset register to document patient care equipment and the required decontamination including responsibility, process, frequency and traceability and this will form the basis of the committee's direction for 2023-24.

Central Sterile Services Department (CSSD) continues to meet the requirements of disinfection, assembly, packing, moist heat and gas plasma sterilisation of theatre trays and procedure packs and supplementary instruments in accordance with ISO 13485:2003 and ISO 9001:2008.

For moist heat and gas plasma sterilisation of theatre trays, procedure packs and supplementary instruments in accordance with Medical Devices Directive 93/42/EEC Annex V, Article 12 (Sterility Aspects Only).

Clinical teams complete DATIX reports should sterile equipment fall short of the required standards and investigated by CSSD accordingly.

During 2022-23, embedded support for CSSD, theatres and endoscopy by the Infection Prevention and Control team, in respect to surgical instrumentation, cleaning and disinfection and advice on quarantining instruments and scopes has continued.

13 WATER SAFETY

As per national guidance on water safety Health Technical Memorandum 0401 (HTM0401), during 2022-23, water safety was monitored by the Water Safety Group (WSG), reporting to OIRC & SIRC, as and when required. The Trust have a Water Safety Plan (WSP) which provides a risk-management approach to the safety of water and establishes good practices in local water usage, distribution and supply.

The Estates team continue a consistent and comprehensive regime of water testing especially in augmented care areas and areas managing immunocompromised patients. Any positive water samples culturing both Legionella and/ or Pseudomonas are reported by UKHSA to both the Estates team and key members of the Infection Prevention and Control Team with prompt action to reduce risks to patients, including escalation and control of infection incident meetings.

Flushing of infrequently used outlets, a requirement of HTM0401, on both Trust sites is now firmly established, with improved compliance now seen. The Estates department utilise a software database to record flushing. This improved the ease with which clinical staff recorded flushing in real time. The system creates compliance reports but will also escalate non-compliance through a pre-determined electronic cascade system. The system continues to be embedded by the Estates Department and respective Health Groups and is reliant on contemporaneous contact details of key team members and reliance on paper records is markedly reducing.

14 CLEANING SERVICES

Hull University Teaching Hospitals NHS Trust has a responsibility to provide and maintain a clean and appropriate environment for healthcare. With a higher profile on improving cleanliness in hospitals this is now a key element of how each hospitals performance is judged and it is assessed in a number of ways which feature in the Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

During 2022-23, Outsourced Client Solutions (OCS) has been responsible for providing cleaning services for Hull University Teaching Hospitals NHS Trust. The COVID-19 pandemic has brought challenges with regards cleaning services, especially during surges of infection. Enhanced cleaning with additional hours needed and an increased staffing resource over and above the existing Trust contract has been required, in addition an increase of post-infection (Amber) cleans have been required along with specialist cleans involving Hydrogen Peroxide Vapours (HPV).

During the financial year the IPCT attended operational meetings to share information with regards risk and/or issues related to respiratory infections, HCAIs and outbreaks but also to acquire assurance that hospital cleanliness remained a priority.

National Standards of Healthcare Cleanliness (2021) apply to all healthcare environments and replace the National specifications for cleanliness in the NHS 2007 (and amendments) published by the National Patient Safety Agency. To encourage continuous improvement they combine mandates, guidance, recommendations and good practice. The standards incorporate significant changes such as the "percentage scoring" system which was not clear to patients/visitors, replaced with cleanliness ratings from zero – 5, similar as seen in the hospitality industry. A zero star rating equates to "urgent improvement necessary" while a 5 star rating confirms the cleanliness in the area concerned as "very good". Environmental auditing remains a priority for both the Trust Facility Team, OCS and IPCT to ensure the Trust remains compliant with the standards. All clinical areas display 'Our Commitment to Cleanliness Charter' and cleaning ratings. Efficacy auditing is required if a ward / department scores 3 or below and during 2022-23 this occurred in two clinical areas with remedial action taken to improve the ratings.

During 2022-23, due to an increase in resistant infections affecting patients both at Hull Royal Infirmary and Castle Hill Hospital, additional specialist cleaning and decontamination processes were required. These processes involved the use of HPV and in some circumstances Ultraviolet (UV-C) and were delivered predominantly during 2022-23 by Inivos on an ad-hoc call out basis. However, the IPCT explored other companies capable of delivering a 'like for like' service and from January 2023, Sanondaf have been facilitating HPV decontamination across the Trust, again on an ad-hoc call out basis. There is a

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significant cost burden associated with this, regardless of provider which year on year has increased as per table below.

Company Name	Dates	Cost
Inivos	From April 2022 – January 2023	£220,000
Sanondaf	From January 2023 – 5th May 2023	£60,325

At the time of writing this annual report an options appraisal paper has been drafted to scope acquiring a Trust HPV decontamination service, enabling reactive and proactive decontamination.

During 2022-23, Synergy Linen Management Services has been responsible for providing linen services for the Trust from the 1st August 2021. The IPCT continue to work closely with facilities and the linen contractor to ensure that the contract meets the requirements of the HTM 01-04 and reduces the risk of hospital linen being a source of infection transmission and that adequate safe linen supplies are maintained.

During 2022-23 ongoing construction work at both HRI and CHH, resulted in the need for prudent pest control by both the IPCT, Estates & Facilities teams and external pest control contractors and this will be monitored as ongoing construction continues into 2023-24.

15   PLACE INSPECTIONS

The annual PLACE programme was suspended in 2020 and 2021 and PLACE-Lite remained open for healthcare organisations to undertake assessments which the Trust completed and in 2022 the annual PLACE programme was reintroduced. The 2022 PLACE assessments were undertaken at Castle Hill Hospital between 7th September and 12th October 2022 and at Hull Royal Infirmary between 18th October and 3rd November 2022 by a multidisciplinary Trust Team and trained patient assessors. The two pertinent PLACE inspection elements to include within the DIPC Annual Report are Cleanliness and Condition, Appearance and Maintenance. For Cleanliness the score is above the national average (98.00%) at both sites and above the cleanliness scores of regional peers, scoring 99.38% and for Condition, Appearance and Maintenance the organisational score is higher than the national average (95.79%) and in line with regional peers, scoring 98.91%.

16   AUDIT

An annual programme of audit is agreed as part of the annual IPC/ Fundamental Standards programme. The audit programme is a combination of policy and general IPC audits carried out as part of an unannounced visit schedule. Audits of both practice and environment are also undertaken following incidents/outbreaks of infection. Audit results are collated and fed back to the clinical area and action plans are requested as appropriate. During 2022-23 audits were presented to the respective Infection Reduction Committees by the reporting Health Group, summarising all of the audit activity and high level findings.

During 2022-23, the IPCT focused on the timely completion of IPC Fundamental Standards audits and audit documentation with an updated audit form to reflect introduced electronic

nursing records. Thematic audit analysis highlights an improvement in audit compliance and associated scoring with exceptions including lack of storage facilities resulting in cluttered environments, gaps in cleaning checklists especially at weekends/ bank holidays, lack of compliance with effective hand hygiene/use of PPE and gaps in electronic nurse documentation. Fundamental Standard audits overview as of March 2023 included (Appendix 7).

At ward / departmental level audit processes were reviewed to ensure ownership of and compliance with IPC practice. During 2022-23 updated audit format, audit schedule and process utilising MyAssurance was developed and rolled out along with a live dashboard, thereby allowing Health Groups and the IPCT to identify trends and required action to improve compliance and practice. It was noted that changes in audit processes were slow to embed at ward level but at year end an increase in compliance is reported.

17   POLICIES

The Trust has a programme for development, review and revision of core IPC policies as required by the Health and Social Care Act 2008 Code of Practice (2015). All policies are available to staff on PATTIE and many are also available to the public on the main internet web page. During 2022-23, NHS England published the National Infection Prevention & Control Manual (NICPM), with the premise that generic IPC policies used by NHS Trusts, including HUTHT e.g. CP178 Standard Precautions Policy could be replaced by the national manual providing standardisation of key IPC policies. The NICPM is a live document, updated as evidence dictates. Alongside the manual a compendium of HCAI guidance and resources was updated and published by NHS England in February 2023, to complement and/or replace Trust HCAI specific policies, currently being scoped by the IPCT.

18   TRAINING AND EDUCATION

The Infection Prevention and Control (IPC) education framework has recently been published in March 2023 by NHS England. It sets out a vision for design and delivery of IPC education and sets core requirements for clinical and non-clinical staff working in healthcare settings in 6 core standards:

Standard: 1. IPC Practitioners must inform the development of IPC learning and practice development

Standard: 2. Applying standard IPC Precautions (SICPs) and evidence-based practice for preventing HCAI associated with invasive devices and procedures will be incorporated into all health and social care related education programmes

Standard: 3. Antimicrobial resistance (AMR) and Antimicrobial Stewardship (AMS) is an integral part of education programmes.

Standard: 4. Transmission based IPC precautions (TBPs), screening programmes, Hierarchy of controls (HOC) and IPC risk assessment will be incorporated into relevant education programmes

Standard: 5. IPC will be appropriately incorporated into all health and social care related education programmes in a contextually relevant approach. This will support the promotion of appropriate IPC in the delivery of care

Standard: 6. Management, maintenance and planning of the built environment is incorporated into related education programmes.

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The overall aim is to strengthen IPC knowledge, skills and behaviours, and to provide a standardised approach to IPC education. With clear individual objectives for IPC learning and development; strong IPC leadership at Board and Executive level; IPC training is developed with IPC experts; within the introduction of Levels 1, 2 & 3 (previously only known as level 1 & 2). Level 1 is for everyone working in health and social care setting; Level 2 is for all staff working directly with/ providing care to patients and / or who work in the patient environment; and Level 3 is for all staff who are responsible for an area of care.

The IPC team are currently undertaking a piece of work as part of the annual IPC work-plan, to update the training and delivery for IPC across the Trust for Nursing in the first instance and linking in with other professionals in relation to other disciplines, and developing teaching and education for these, this is being done through a trainee needs analysis.

The Trust is currently undertaking a Learning Needs Analysis Task and Finish Group (LNA) through education and development, IPC are linking in as part of this, to confirm the minimum requirement for IPC throughout the Trust – this work will be delivered in year 2023-24.

The Trust is also undertaking a Training Needs Analysis Task and Finish Group (TNA) through education and development for the Trust, reviewing what mandatory / statutory training is being undertaken currently and what training needs reviewing, such as IPC aligned to the new standards.

The IPC team have been delivering face to face training as well as Skills for Health continuing online through HEY24/7. The face to face training is currently aimed at non-registered staff new to the Trust and working in clinical areas, newly qualified nurses and apprentices. The IPCT have delivered to over 450 staff face to face since commencing in August 2022, the IPCT would like to see continued support for this through clinical unit managers encouraging their staff to attend. The IPCT have delivered an IPC link day last year and plan to arrange a link day for later this year. Members of the IPCT have further face to face training booked with ward Housekeepers and Hygienists planned for July and November 2023, and the IPCT are linking in with OCS in relation to the education of the new NHS cleaning standards. The overall plan is to continue to expand this work in the coming twelve months.

During 2022-23, training and educational opportunities were offered regionally and nationally by NHS England & UKHSA inclusive of IPC practices, tackling GNBSIs, CPE and antimicrobial stewardship. The National IPC Team funded places for the Rosalind Franklin Programme with the Senior Matron IPCT successfully completing the programme. Non-registered staff at the Trust also benefitted from a bespoke IPC course again funded by the national team, places were limited regionally but at least two non-registered staff completed the course and found the content helpful and clinically applicable.

19   OTHER ACHIEVEMENTS IN 2022-23

- The inclusion of a developmental SIRC alongside the existing meeting structure has provided the benefit of discussing pressing topics, providing the impetus to form task and finish groups to pursue improvements in systems, processes and ultimately patient care
- During 2022-23, the national IPC BAF was utilised by the IPCT and Quality & Assurance Team to prioritise work streams but the BAF was respiratory infections/ winter planning centric and therefore limited in its scope. On the 17th April 2023, an updated national IPC BAF was published, encompassing the criterion in the Health

and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, resulting in a new IPC BAF Task & Finish Group being formed co-opting key teams and services to provide evidence and assurance. Any gaps in evidence and assurance will be incorporated within the IPC Risk Register. Completed IPC BAF, although acknowledged as a 'live' document to be presented at Trust Board during 2023-24.

- During 2022-23, a multi-disciplinary group/ Think Tank worked alongside the Trust Operational Improvement Team on reviewing vascular access, initially PICC line placement and ongoing management this was driven by variation in standards and a rise in reported bacteraemia associated with vascular access devices. During the course of the year the group expanded and reviewed other vascular access devices including central lines with the understanding the Trust is the highest placer of vascular lines in the region. However, there is presently no single point of contact for vascular access, causing delays in placement of the most appropriate lines for the most appropriate use. This causes delays in patient discharge and an in increase in bed days. Concerns were also raised with regards competency of nurses and doctors to both insert and manage/ manipulate these devices. At the time of writing this report a business case to support this work is currently being collated which will provide a significant number of benefits including a reduction of bacteraemia associated with vascular access devices.

- During 2022-23 the Infection Prevention & Control team have been involved in local, regional and national IPC priorities via NHS England and UKHSA including supporting the development of the National Infection Prevention & Control Manual and the refresh of the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, supporting educational pathways and improvement initiatives along with presenting to regional and national peers.

- During 2022-23 the IPCT continued to work alongside the Health & Safety team to ensure Trust employees required to wear a filtering face piece (FFP3 facemask) were provided with adequate training and fit testing opportunities nationally commissioned and delivered free of charge by Ashfield Healthcare. The Trust were successful in achieving the highest percentage of staff fit tested from the Trust across England by year-end. Unfortunately, Ashfield Healthcare supporting Trusts with fit testing was time limited, ending on the 31st March 2023, subsequent solutions will need to be delivered to maintain standards but with a cost pressure.

- A Trust recommendation by NHS England in 2021 was to provide a robust digital platform with which the IPCT can function effectively, the current IPC database is on the Trust risk register and is not viable in its current state. During 2022-23 with the support of the Chief Nurse Information Officer, the IPCT drafted a business case to purchase ICNET and were successful. The implementation of ICNET is expected during 2023-24 but currently paused due to a delay in the roll out of the laboratory information management system (LIMS) shared with York and Scarborough Teaching Hospitals NHS Foundation Trust which is expected later in the year.

20   OTHER RISKS IN 2022-23

Mycobacteria chimaera

During 2022-23, the IPCT continued to work closely with the cardiac perfusion team to mitigate the risks associated with Mycobacterium chimaera. In 2016, following a worldwide rise in patients developing this infection following cardiac bypass surgery, the Medicines & Healthcare products Regulatory Agency (MHRA) published a medical device alert with regards cardiac perfusion machines and the risks associated with this organism. The issue was compounded in that the majority of cardiac perfusion machines were contaminated during manufacture which was only identified once a rise in cases was noted.

Since 2016, the Infectious Diseases team and IPCT have worked alongside the perfusion team and cardiac surgeons to safeguard patients, undertaken water sampling from the machines and acting on positive results, removing affected machines from use, following PHE and manufacturers guidance and if required contact tracing patients, alerting GPs and providing a follow up service to patients. Although improvements were made to the environment to facilitate safe physical decontamination and cleaning of the perfusion machines, during 2022-23 issues with Mycobacteria chimaera contamination continued. When required incident meetings have been held with the Surgical Health Group and relevant System Partners with 2022-23 providing the opportunity to explore other manufacturers of perfusion machines to mitigate the risk further.

Nationally, the risk of delaying cardiothoracic surgery now far outweighs the risk of developing Mycobacteria chimaera but until a change in national guidance is published the Trust will continue to respond accordingly when positive results are reported.

Pseudomonas aeruginosa

During 2022-23, cases of Pseudomonas Aeruginosa colonisation were detected in neonates nursed on the Neonatal Intensive Care Unit found on twice weekly screening. No bacteraemia cases have been detected on the unit since August 2018. Extensive investigation regarding a possible source related to the environment had previously taken place with no known source found. Measures to improve water safety and mitigate environmental contamination have previously taken place and all affected neonates are isolated until discharge.

Prudent communication with UKHSA and local System Partners has taken place as has ongoing screening. All samples are submitted to UKHSA for variable number tandem repeats (VNTR) profiling to enable links to be identified. This resulted in a cluster of cases on the unit being identified from June 2022 with a unique VNTR profile and linked to other isolates reported across the UK prompting UKHSA to investigate the possibility of a common source. Representatives of UKHSA and NHS England visited the unit on the 3rd February 2023 and commended the IPCT and NICU on managing this current cluster and being part of a larger outbreak management group. At the time of writing the report this remains an active investigation.

Environmental

During 2022-23, the IPCT have continued to support the annual Trust theatre maintenance programme and provide air sampling for conventional theatres both at HRI and CHH to assure the Trust of theatre air quality. In addition, air sampling of theatre environments has been provided as and when requested by the Estates & Facilities team.

During 2022-23, the IPCT have continued to support and advise on new build programmes, this is imperative from the outset of a scheme and historically focused on the clinical services utilising a new build / renovated site rather than IPCT but 2022-23 has seen an improvement in early liaison to ensure clinical environments are in line with national guidance, Infection control in the built environment (HBN 00-09).

Risk registers

During 2022-23, Trust risk registers have been reviewed to ensure IPC risks are captured and incorporated into the IPC Risk Register, updating with new risks and removing those which have been addressed. The IPC risk register is monitored via SIRC and OIRC. Risks identified following the Care Quality Commission (CQC) inspection and those highlighted when updating the IPC BAF will be included.

21 EXTERNAL INSPECTIONS/ VISITS

The Trust during 2022-23 at regular intervals were required to provide assurance to the CQC on a number of measures inclusive of IPC in the absence of a formal inspection regime. The CQC announced in 2022 a return of regulatory inspections for Acute Trusts and from the 1st November 2022 the CQC commenced an inspection of the Trust with the subsequent report published on the 23rd March 2023. A summary of findings and recommendations associated with infection prevention & control include the development of systems to allow for the assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. Services must ensure that staff adhere to infection prevention and control guidance and the environment is suitable to promote safe care and services must ensure a robust audit plan is in place and key audits are conducted including those relevant to infection prevention & control. An action plan to address these recommendations is in place and will be monitored by OIRC & SIRC.

Additional visits:

5th May 2022 – Follow up assurance visit by NHS England regional IPC team and System Partners

21st September 2022 – Visit by Andy Gardiner, Infection Prevention and Control & AMR Programmes Manager, Department of Health and Social Care & Suzie Singleton, Consultant Nurse Health Protection & IPC, Pan Regions National Lead UKHSA

3rd February 2023 – Visit to NICU by representatives from UKHSA and NHS England

21 KEY POINTS AND RECOMMENDATIONS

- *During 2022-23, the Trust continued to monitor healthcare associated infection case numbers and trends. The Trust performed at or better than the benchmark in all cases with the exception of hospital onset MSSA BSIs and GNBSIs which will be a priority for 2023-24.*

- *The Trust via an antimicrobial stewardship programme continues to collaborate with clinical teams to develop antimicrobial prescribing guidance in line with national guidance and continues to monitor compliance with regards antimicrobial prescribing and escalate to improve patient outcomes.*

- *The Trust is the highest placer of vascular lines in the region and with it the increased risk of suboptimal management and ensuing line related infections – this too is a priority for 2023-24.*

- *The identification of sepsis on admission and during inpatient care along with the impact on morbidity and mortality is a much needed area for quality improvement and priority for 2023-24*

- *The findings from the CQC inspection associated with suboptimal IPC practice are a driver for improvement not only in the areas inspected but Trust-wide*

- *Utilisation of the national IPC BAF during 2023-24 as a means to provide assurance*

- *The identification and management of resistant infections with the propensity to cause outbreaks are and will be a priority for the IPCT and Trust*

- *Ownership of patient outcomes associated with surgical site infections will be multi-disciplinary and not confined to the IPCT*

- *During 2022-23 patients medically fit but unable to be discharged continued to increase alongside the Trust ensuring elective recovery was prioritised. This continued to create other issues such as caring for patients on wards across the Trust with finite staffing resource. Patients with no criteria to reside remain in hospital longer and with it the potential to develop healthcare associated infections during protracted hospital stays.*

- *The lack of robust digital systems to support an effective IPCT is a significant risk both from a governance and quality perspective and relies heavily on the IPCT managing with the outdated systems, which with time will affect the quality of data collected, the functionality of the team and potentially impact on patient safety. This will be mitigated by the introduction of funded ICNET during 2023-24 but to date is delayed due to the LIMS project*

- *Working alongside Northern Lincolnshire & Goole Hospitals NHS Foundation Trust, York and Scarborough Teaching Hospitals NHS Foundation Trust, Integrated Care Boards, System Partners, NHS England and UKHSA will continue during 2023-24*

Greta Johnson

Director of Infection Prevention and Control

May 2023

Appendix 1 HCAI benchmarking data via UKHSA Fingertips 2022-23

Indicator	Period	Hull and East Yorkshire Hospitals			Trust type	England		England	
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
E. coli									
E. coli bacteraemia all rates by reporting acute trust and financial year	2021/22	→	390	120.7	107.9	115.4	0.0		206.6
E. coli bacteraemia hospital-onset counts and rates by NHS acute trust and financial year	2021/22	→	96	29.7	23.7	21.5	0.0		69.2
E. coli bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month `New data`	Feb 2023	→	320	89.4	81.0	87.9	0.0		166.1
E. coli hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month `New data`	Feb 2023	→	123	34.4	25.3	22.4	0.0		70.5
E. coli bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month `New data`	Feb 2023	→	443	123.8	106.3	110.4	0.0		192.2
E. coli completion of risk factor information, by NHS acute trust `New data`	Feb 2023	–	30	100.0%	34.4%	45.1%	0.0%		100.0%
E. coli known risk factor information, by NHS acute trust `New data`	Feb 2023	–	179	94.7%	73.9%	70.7%	0.0%		100.0%
E. coli completion of antibiotic information, by NHS acute trust `New data`	Feb 2023	–	30	100.0%	31.2%	40.1%	0.0%		100.0%
E. coli known antibiotic information, by NHS acute trust `New data`	Feb 2023	–	145	99.3%	76.5%	73.1%	0.0%		100.0%
Klebsiella spp.									
Klebsiella spp. bacteraemia all counts and rates by acute trust and financial year	2021/22	→	121	37.4	36.6	34.7	0.0		74.3
Klebsiella spp. bacteraemia hospital-onset counts and rates by acute trust and financial year	2021/22	→	40	12.4	14.1	11.2	0.0		38.1
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month `New data`	Feb 2023	→	122	34.1	35.0	33.7	0.0		94.0
Klebsiella spp. hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month `New data`	Feb 2023	→	55	15.4	13.4	11.1	0.0		57.0
Klebsiella spp. bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month `New data`	Feb 2023	→	67	18.7	21.6	22.6	0.0		44.8
P. aeruginosa									
P. aeruginosa bacteraemia all counts and rates by acute trust and financial year	2021/22	→	55	17.0	13.8	13.2	0.0		45.0
P. aeruginosa bacteraemia hospital-onset counts and rates by acute trust and financial year	2021/22	→	25	7.7	6.4	4.9	0.0		29.4
P. aeruginosa bacteraemia cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month `New data`	Feb 2023	→	35	9.8	7.4	7.7	0.0		25.5
P. aeruginosa hospital-onset cases counts and 12-month rolling rates, by reporting acute trust and month `New data`	Feb 2023	→	22	6.1	6.2	4.9	0.0		31.9
P. aeruginosa bacteraemia cases counts and 12-month rolling rates, by reporting acute trust and month `New data`	Feb 2023	→	57	15.9	13.7	12.6	0.0		57.4
MRSA									
MRSA bacteraemia all rates by reporting acute trust and financial year	2021/22	→	6	1.9	2.3	2.0	0.0		8.1
MRSA hospital-onset counts and rates by reporting acute trust and financial year	2021/22	→	2	0.6	0.8	0.7	0.0		5.2
MRSA bacteraemia all cases counts and 12-month rolling rates, by acute trust and month `New data`	Feb 2023	→	8	2.2	2.3	2.2	0.0		5.2
MRSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month `New data`	Feb 2023	→	2	0.6	1.3	1.4	0.0		4.4
MRSA cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month `New data`	Feb 2023	→	6	1.7	1.0	0.8	0.0		3.3
MSSA									
MSSA bacteraemia all rates by reporting acute trust and financial year	2021/22	→	151	46.7	37.1	37.3	0.0		58.1
MSSA hospital-onset rates by reporting acute trust and financial year	2021/22	→	59	18.3	12.5	11.3	0.0		29.0
MSSA cases counts and 12-month rolling rates of community-onset, by reporting acute trust and month `New data`	Feb 2023	→	89	24.9	24.8	26.1	0.0		52.2
MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset, by reporting acute trust and month `New data`	Feb 2023	→	82	22.9	11.9	11.2	0.0		36.9
MSSA total cases counts and 12-month rolling rates, by reporting acute trust and month `New data`	Feb 2023	→	171	47.8	36.7	37.3	0.0		67.1
C. difficile									
C. difficile all rates by reporting acute trust and financial year	2021/22	→	101	31.3	42.9	43.3	0.0		138.4
C. difficile hospital-onset rates by reporting acute trust and financial year	2021/22	→	35	10.8	17.6	16.2	0.0		53.6
C. difficile infection counts and 12-month rolling rates of all cases, by reporting acute trust and month `New data`	Feb 2023	→	92	25.7	45.1	44.0	0.0		137.1
C. difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases, by reporting acute trust and month `New data`	Feb 2023	→	33	9.2	21.7	20.2	0.0		78.1
C. difficile infection counts and 12-month rolling rates of community onset-healthcare associated, by reporting acute trust and month `New data`	Feb 2023	→	24	6.7	7.2	7.1	0.0		38.8
C. difficile infection Hospital-Onset Healthcare Associated (HOHA) counts and rates, by acute trust and financial year	2021/22	→	38	11.8	19.7	18.3	0.0		59.0
C. difficile infection community-Onset Healthcare Associated (COHA) counts and rates, by acute trust and financial year	2021/22	→	14	4.0	6.6	6.7	0.0		22.0
C. difficile toxin tests per 1,000 bed-days carried out by reporting acute trust and quarter	2022/23 Q3	→	1,129	12.0	0.0*	18.5	–	Insufficient number of values for a spine chart	–
Miscellaneous									
Blood culture sets per 1,000 bed-days performed by reporting acute trust and quarter	2022/23 Q3	→	5,448	57.8	65.7*	67.6	–	Insufficient number of values for a spine chart	–
Surgical Site Infection Hip Prosthesis by acute NHS trust and financial year	2021/22	–	-	*	0.5	0.5	0.0		2.8
Surgical Site Infection Knee Prosthesis by acute NHS trust and financial year	2021/22	→	-	*	0.4	0.4	0.0		2.3

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Appendix 2 Antimicrobial prescribing data via UKHSA Fingertips 2022-23

Indicator	Period	Hull and East Yorkshire Hospitals			Trust type	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Total antibiotic prescribing DDDs per 1000 admissions; by quarter and trust	2022/23 Q2	➡	162,420	4,013.0	4,688.0	4,508.0	13,840.0		946.0
AWaRe & broad-spectrum prescribing									
Antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO essential Medicines List AWaRe index; DDDs per 1000 admissions by quarter and trust	2022/23 Q2	➡	61,122	1,510.0	2,400.0	2,255.0	6,324.0		408.0
Proportion of total antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO Essential Medicines List AWaRe index	2022/23 Q2	➡	61,122	38.0%	49.0%	49.0%	78.0%		23.0%
Proportion of total antibiotic prescribing from the "Access" category of the WHO Essential Medicines List AWaRe index; by quarter and acute trust	2022/23 Q2	➡	100,788	62.1%	46.1%	48.4%	21.9%		74.8%
Proportion of total antibiotic prescribing from the "Watch" category of the WHO Essential Medicines List AWaRe index	2022/23 Q2	➡	52,861	32.5%	45.0%	46.2%	64.9%		22.5%
Proportion of total antibiotic prescribing from the "Reserve" category of the WHO Essential Medicines List AWaRe index	2022/23 Q2	➡	8,261	5.1%	3.9%	3.0%	27.7%		0.0%
Carbapenem prescribing DDDs per 1000 admissions; by quarter and acute trust	2022/23 Q2	➡	1,703	42.0	77.0	64.0	526.0		0.0
AMR CQUIN									
Percentage of antibiotic prescriptions for lower UTI in older people meeting NICE NG109 guidance and UKHSA Diagnosis of UTI guidance in terms of diagnosis and treatment; by quarter `<60%` `60% to 90%` `≥90%`	2019/20 Q4	—	-	*	47%	56%	16%		100%
Percentage of single dose surgical antibiotic prophylaxis prescriptions that meet the NICE NG125 guidance regarding the choice of antibiotic for patients who have undergone elective colorectal surgery; by quarter `<60%` `60% to 90%` `≥90%`	2019/20 Q4	—	0	-	91%	90%	60%		100%

Appendix 3 Antimicrobial Resistance via UKHSA Fingertips

Indicator	Period	Hull and East Yorkshire Hospitals			Trust type	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Rolling quarterly average proportion of gentamicin resistant E. coli blood specimens; by quarter	2022 Q3	➡	6	11.0%*	10.7%*	10.6%*	50.0%		0.0%
Rolling quarterly average proportion of ciprofloxacin resistant E. coli blood specimens; by quarter	2022 Q3	➡	8	14.0%*	20.7%*	18.6%*	75.0%		0.0%
Rolling quarterly average proportion of piperacillin/tazobactam resistant E. coli blood specimens; by quarter	2022 Q3	➡	5	8.0%*	11.2%*	10.5%*	50.0%		0.0%
Rolling quarterly average proportion of 3rd generation cephalosporin resistant E. coli blood specimens; by quarter	2022 Q3	➡	3	6.0%*	15.4%*	14.3%*	75.0%		0.0%
Percentage of E. coli blood specimens with susceptibility tests to gentamicin; by quarter `<70%` `70% to 95%` `≥95%`	2022 Q3	—	11	9.0%*	12.1%*	13.1%*	-	Insufficient number of values for a spine chart	-
Percentage of E. coli blood specimens with susceptibility tests to ciprofloxacin; by quarter `<70%` `70% to 95%` `≥95%`	2022 Q3	—	11	9.0%*	12.2%*	12.9%*	-	Insufficient number of values for a spine chart	-
Percentage of E. coli blood specimens with susceptibility tests to piperacillin/tazobactam; by quarter `<70%` `70% to 95%` `≥95%`	2022 Q3	—	11	9.0%*	12.0%*	12.2%*	-	Insufficient number of values for a spine chart	-
Percentage of E. coli blood specimens with susceptibility tests to a 3rd generation cephalosporin; by quarter `<70%` `70% to 95%` `≥95%`	2022 Q3	➡	11	9.0%*	12.4%*	13.2%*	-	Insufficient number of values for a spine chart	-
Percentage of E. coli blood specimens with susceptibility tests to a carbapenem; by quarter `<70` `70 to <100` `=100`	2022 Q3	—	10	8.0%*	12.5%*	13.3%*	-	Insufficient number of values for a spine chart	-

Appendix 4. Infection Prevention & Control Metrics via UKHSA Fingertips

Indicator	Period	Hull and East Yorkshire Hospitals			Trust type	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Proportion of single rooms available within NHS Acute Trusts by financial year	2019/20	➡	332	30.7%	31.6%*	30.3%*	11.5%		99.7%
Proportion of single rooms with ensuite available within NHS Acute Trusts by financial year	2019/20	➡	189	17.5%	21.1%*	20.8%*	4.8%		99.7%
PLACE Cleanliness Scores; by NHS Acute Trust	2018	—	-	0.99	-	0.98	0.92		1.00
Percentage of frontline healthcare workers vaccinated with the seasonal influenza vaccine by NHS Acute Trust `<60%` `60% to 70%` `≥70%`	2018/19	➡	5,476	82.8%	73.0%*	72.6%*	49.4%		95.4%

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Appendix 5

UKHSA HCAI trends analysis 2021/22

MRSA bacteraemia
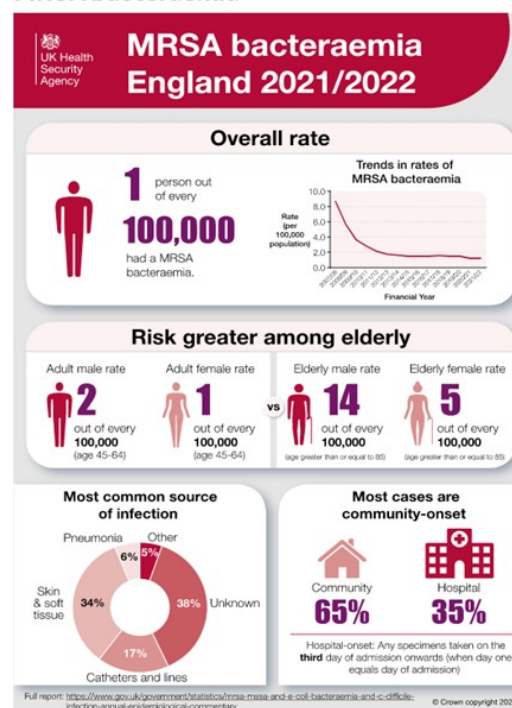
MSSA bacteraemia
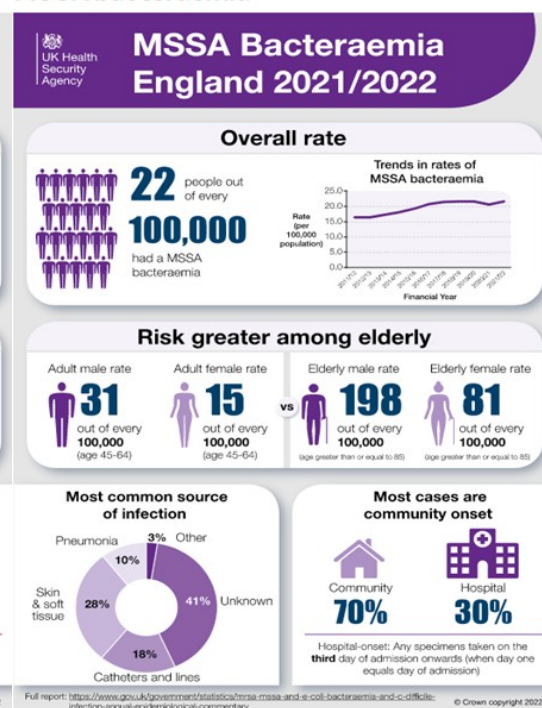
Clostridioides difficile
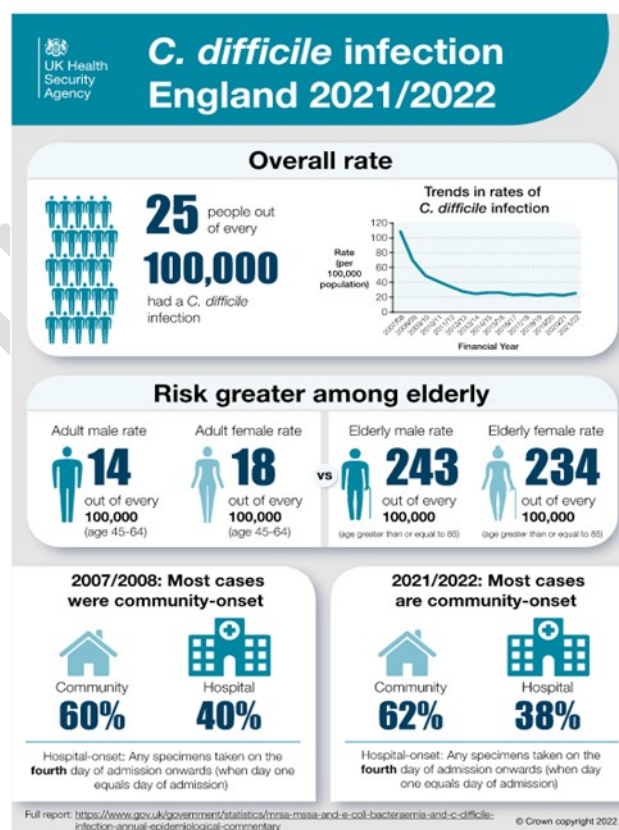
Appendix 6

UKHSA GNBSI trends analysis 2021/22

Pseudomonas aeruginosa bacteraemia
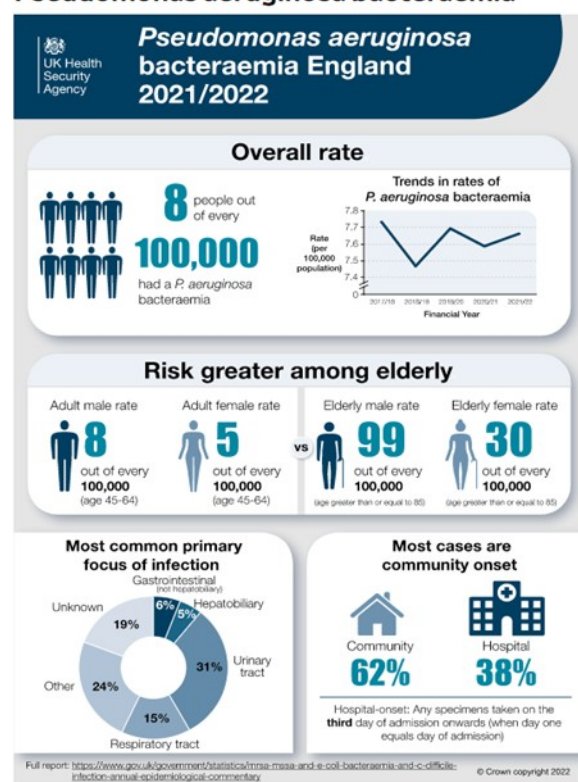
E. coli bacteraemia
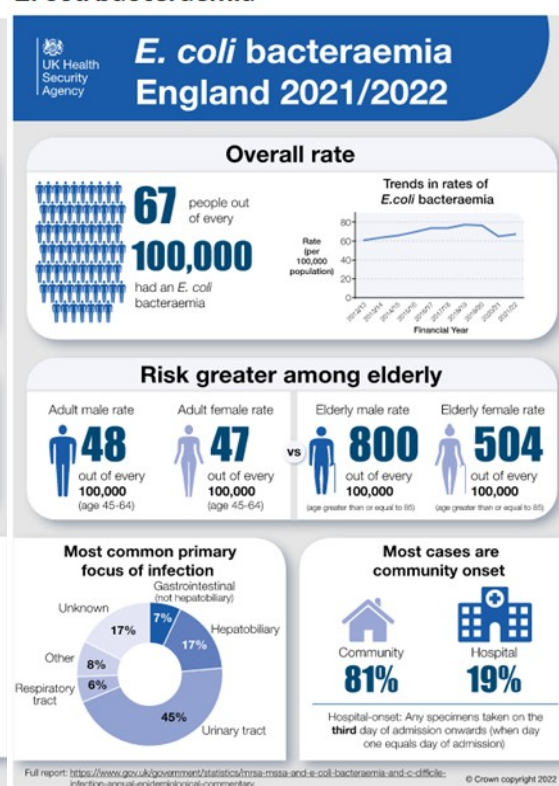
Klebsiella spp. bacteraemia
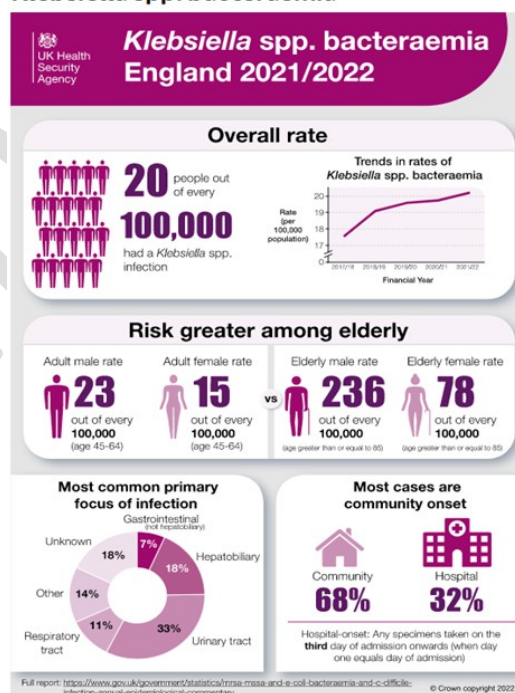
Appendix 7

NHS England ICB AMS and HCAI data

AMS Summary (ICB)

Antibacterial Items per STAR PU, by SICBL in ICB.
12 months data to Feb-23

% Co-amoxiclav, Cephalosporins & Quinolones Items, by SICBL in ICB.
12 months data to Feb-23

Watch & Reserve DDDs / 1000 Total Admissions (12 months to Apr-23)

These charts show SICBL performance against the NHS Oversight Framework (NOF) 22/23 metrics and Acute Trust performance against the Standard Contract 23/24 metric.

Antibacterial Items per STAR PU (NOF 22/23)

Antibacterial Items per STAR PU, by Region.
12 months data to Feb-23

Antibacterial Items per STAR PU, by ICB in Region.
12 months data to Feb-23

Antibacterial Items per STAR PU, by SICBL in ICB.
12 months data to Feb-23

Antibacterial Items per STAR PU, by month.
12 months data to Mar-23

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% Co-amoxiclav, Cephalosporins & Quinolones Items (NOF 22/23)

NHS England

% Co-amoxiclav, Cephalosporins & Quinolones Items, by Region. 12 months data to Feb-23

- % Co-amoxiclav, cephalosporins and quinolones
- - - Target (10%)

Region	Value
East of England	8.7%
London	8.2%
Midlands	7.7%
North East and Yorkshire	6.3%
North West	7.4%
South East	8.6%
South West	8.0%

% Co-amoxiclav, Cephalosporins & Quinolones Items, by ICB in Region. 12 months data to Feb-23

- % Co-amoxiclav, cephalosporins and quinolones
- - - Target (10%)

ICB	Value
NHS Humber and North Yorkshire ICB	5.7%
NHS North East and North Cumbria ICB	7.1%
NHS South Yorkshire ICB	6.3%
NHS West Yorkshire ICB	5.7%

% Co-amoxiclav, Cephalosporins & Quinolones Items, by SICBL in ICB. 12 months data to Feb-23

- % Co-amoxiclav, cephalosporins and quinolones
- - - Target (10%)

SICBL	Value
East Riding of Yorkshire SICBL	4.5%
Hull SICBL	3.9%
North East Lincolnshire SICBL	7.9%
North Lincolnshire SICBL	9.0%
North Yorkshire SICBL	6.3%
Vale of York SICBL	4.6%

% Co-amoxiclav, Cephalosporins & Quinolones Items, by month. 12 months data to Mar-23

Legend:
- East Riding of Yorkshire SICBL
- Hull SICBL
- North East Lincolnshire SICBL
- North Lincolnshire SICBL
- North Yorkshire SICBL
- Vale of York SICBL
- - - Target (10%)

NHS Standard Contract 23/24 (Regional overview)

NHS England

Data reporting against NHS Standard Contract 2023/24 12 months data to Apr-23

Scatter plot — X-axis: Total DDDs / 1000 Total Admissions (2,500 to 7,500); Y-axis: Watch & Reserve DDDs / 1000 Total Admissions (1,000 to 4,000). Labelled points include: Leeds Teaching Hospitals, The Rotherham, Northern Lincolnshire and Goole, Barnsley Hospital, Sheffield Children's, Mid Yorkshire Hospitals, North Cumbria Integrated Care, South Tees Hospitals, Doncaster and Bassetlaw, Newcastle Hospitals, Sheffield Teaching Hospitals, County Durham and Darlington, Bradford Teaching Hospitals, Calderdale and Huddersfield, South Tyneside and Sunderland, Northumbria Healthcare, Hull Teaching Hospitals, Gateshead Health, Airedale, Harrogate and District, York and Scarborough Teaching Hospitals.

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Antibacterial oral to IV ratio (DDD%) (Secondary Care)

NHS England

Inpatient antibacterial IV DDDs as percentage of total inpatient antibacterial DDDs

Legend:
- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

X-axis: May-22, Jun-22, Jul-22, Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23, Feb-23, Mar-23, Apr-23

C. difficile cases (NHS Standard Contract 22/23) – Secondary Care

NHS England

C. difficile cases by Region (Apr-22 to Mar-23)

Legend: Total cases (ICBs) | HOHA and COHA cases (acute Trusts) | Plan (YTD)

Region	Total cases	HOHA/COHA	(lower value)	(lower value)
East of England	1,722	989	1,917	1,138
London	1,422	989	1,547	1,166
Midlands	2,495	1,368	2,983	1,761
North East and Yorkshire	2,290	1,437	2,493	1,623
North West	2,251	1,378	2,744	1,807
South East	1,974	1,026	2,212	1,265
South West	1,602	833	1,677	976

C. difficile cases by ICB in Region (Apr-22 to Mar-23)

Legend: Total cases (ICB) | HOHA and COHA cases (Acute trusts) | Plan (YTD)

ICB	Total cases	HOHA/COHA	(lower value)	(lower value)
NHS Humber and North Yorkshire ICB	446	236	470	259
NHS North East and North Cumbria ICB	888	589	982	673
NHS South Yorkshire ICB	384	257	431	310
NHS West Yorkshire ICB	572	355	610	381

C. difficile cases by Organisation in ICB (Apr-22 to Mar-23)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Legend: YTD Cases | YTD Plan

Organisation	YTD Cases (top)	(lower)
Harrogate and District NHS Foundation Trust	40	27
Hull University Teaching Hospitals NHS Trust	58	57
Northern Lincolnshire and Goole NHS Foundation Trust	21	
York and Scarborough Teaching Hospitals NHS Foundation Trust	117	151

C. difficile cases by Organisation in ICB (by month)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Legend:
- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

X-axis: Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23, Feb-23, Mar-23

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E. coli cases (NHS Standard Contract 22/23) – Secondary Care

NHS England

E. coli cases by Region (Apr-22 to Mar-23)

Legend: Total cases (ICBs) ▪ HOHA and COHA cases (acute Trusts) — Plan (YTD)

Region	Total cases	HOHA/COHA	Plan values
East of England	3,877	1,069	4,276 / 1,254
London	4,461	1,682	5,115 / 1,948
Midlands	6,984	2,232	7,263 / 2,353
North East and Yorkshire	6,446	2,363	6,904 / 2,535
North West	4,609	1,565	5,344 / 1,947
South East	5,813	1,772	6,044 / 1,930
South West	3,693	1,156	3,791 / 1,227

E. coli cases by ICB in Region (Apr-22 to Mar-23)

Legend: Total cases (ICB) ▪ HOHA and COHA cases (Acute trusts) — Plan (YTD)

ICB	Total cases	HOHA/COHA	Plan values
NHS Humber and North Yorkshire ICB	1289	413	1,427 / 478
NHS North East and North Cumbria ICB	2451	937	2,571 / 965
NHS South Yorkshire ICB	1046	432	1,160 / 462
NHS West Yorkshire ICB	1660	581	1,746 / 630

E. coli cases by Organisation in ICB (Apr-22 to Mar-23)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Legend: YTD Cases — YTD Plan

Organisation	YTD Cases	YTD Plan
Harrogate and District NHS Foundation Trust	24	30
Hull University Teaching Hospitals NHS Trust	166	221
Northern Lincolnshire and Goole NHS Foundation Trust	65	65
York and Scarborough Teaching Hospitals NHS Foundation Trust	158	162

E. coli cases by Organisation in ICB (by month)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Legend:
- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

Pseudomonas aeruginosa cases (NHS Standard Contract 22/23) – Secondary Care

NHS England

Pseudomonas aeruginosa cases by Region (Apr-22 to Mar-23)

Legend: Total cases (ICBs) ▪ HOHA and COHA cases (acute Trusts) — Plan (YTD)

Region	Total cases	HOHA/COHA	Plan values
East of England	475	232	538 / 268
London	803	608	767 / 544
Midlands	820	443	849 / 441
North East and Yorkshire	617	353	634 / 367
North West	376	222	461 / 251
South East	754	394	801 / 388
South West	371	191	359 / 183

Pseudomonas aeruginosa cases by ICB in Region (Apr-22 to Mar-23)

Legend: Total cases (ICB) ▪ HOHA and COHA cases (Acute trusts) — Plan (YTD)

ICB	Total cases	HOHA/COHA	Plan values
NHS Humber and North Yorkshire ICB	142	59	147 / 82
NHS North East and North Cumbria ICB	219	141	234 / 143
NHS South Yorkshire ICB	99	60	109 / 62
NHS West Yorkshire ICB	157	93	144 / 80

Pseudomonas aeruginosa cases by Organisation in ICB (Apr-22 to Mar-23)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Legend: YTD Cases — YTD Plan

Organisation	YTD Cases	YTD Plan
Harrogate and District NHS Foundation Trust	1	2
Hull University Teaching Hospitals NHS Trust	26	37
Northern Lincolnshire and Goole NHS Foundation Trust	7	15
York and Scarborough Teaching Hospitals NHS Foundation Trust	25	28

Pseudomonas aeruginosa cases by Organisation in ICB (by month)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Legend:
- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

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Klebsiella cases (NHS Standard Contract 22/23) – Secondary Care

NHS England

Klebsiella cases by Region (Apr-22 to Mar-23)

Total cases (ICBs) ▪ HOHA and COHA cases (acute Trusts) — Plan (YTD)

Region	Total cases	HOHA/COHA
East of England	1,203 / 1,318	510 / 559
London	1,874 / 1,950	1,212 / 1,159
Midlands	2,041 / 2,073	904 / 890
North East and Yorkshire	1,903 / 2,100	931 / 1,073
North West	1,348 / 1,545	678 / 729
South East	1,648 / 1,852	725 / 762
South West	1,012 / 980	416 / 402

Klebsiella cases by ICB in Region (Apr-22 to Mar-23)

Total cases (ICB) ▪ HOHA and COHA cases (Acute trusts) — Plan (YTD)

ICB	Total cases	HOHA/COHA
NHS Humber and North Yorkshire ICB	356 / 383	156 / 174
NHS North East and North Cumbria ICB	781 / 829	415 / 444
NHS South Yorkshire ICB	324 / 389	159 / 223
NHS West Yorkshire ICB	442 / 499	201 / 232

Klebsiella cases by Organisation in ICB (Apr-22 to Mar-23)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

YTD Cases — YTD Plan

Organisation	YTD Cases / YTD Plan
Harrogate and District NHS Foundation Trust	6 / 15
Hull University Teaching Hospitals NHS Trust	68 / 75
Northern Lincolnshire and Goole NHS Foundation Trust	25 / 23
York and Scarborough Teaching Hospitals NHS Foundation Trust	57 / 61

Klebsiella cases by Organisation in ICB (by month)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Legend:
- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

MRSA cases (NHS Standard Contract 22/23) – Secondary Care

NHS England

MRSA cases by Region (Apr-22 to Mar-23)

Total cases (ICBs) ▪ HOHA and COHA cases (acute Trusts)

Region	Total cases	HOHA/COHA
East of England	101	45
London	134	97
Midlands	129	49
North East and Yorkshire	115	56
North West	110	60
South East	113	45
South West	85	36

MRSA cases by ICB in Region (Apr-22 to Mar-23)

Total cases (ICB) ▪ HOHA and COHA cases (Acute trusts)

ICB	Total cases	HOHA/COHA
NHS Humber and North Yorkshire ICB	19	11
NHS North East and North Cumbria ICB	34	17
NHS South Yorkshire ICB	18	6
NHS West Yorkshire ICB	44	22

MRSA cases by Organisation in ICB (Apr-22 to Mar-23)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Organisation	Cases
Harrogate and District NHS Foundation Trust	1
Hull University Teaching Hospitals NHS Trust	6
Northern Lincolnshire and Goole NHS Foundation Trust	1
York and Scarborough Teaching Hospitals NHS Foundation Trust	3

MRSA cases by Organisation in ICB (by month)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Legend:
- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

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MSSA cases (NHS Standard Contract 22/23) – Secondary Care

NHS England

MSSA cases by Region (Apr-22 to Mar-23)

Total cases (ICBs)   HOHA and COHA cases (acute Trusts)

Region	Total cases	HOHA and COHA
East of England	1,276	493
London	1,648	771
Midlands	2,451	964
North East and Yorkshire	2,442	1,084
North West	1,868	851
South East	2,002	729
South West	1,421	601

MSSA cases by ICB in Region (Apr-22 to Mar-23)

Total cases (ICB)   HOHA and COHA cases (Acute trusts)

ICB	Total cases	HOHA and COHA
NHS Humber and North Yorkshire ICB	486	216
NHS North East and North Cumbria ICB	954	451
NHS South Yorkshire ICB	351	158
NHS West Yorkshire ICB	651	259

MSSA cases by Organisation in ICB (Apr-22 to Mar-23)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Organisation	Cases
Harrogate and District NHS Foundation Trust	7
Hull University Teaching Hospitals NHS Trust	98
Northern Lincolnshire and Goole NHS Foundation Trust	21
York and Scarborough Teaching Hospitals NHS Foundation Trust	90

MSSA cases by Organisation in ICB (by month)
Total cases shown for SICBLs. HOHA and COHA cases shown for Acute Trusts.

Legend:
- Harrogate and District NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- York and Scarborough Teaching Hospitals NHS Foundation Trust

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Appendix 8 – Fundamental Standards Audit Overview

FUNDAMENTAL STANDARDS March 2023

CLINICAL SUPPORT

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C7	96%	Dec 23	95%	Oct 23	93%	April 23	88%	May 23	97%	May 23	53%	Mar 23	96%	Aug 23	79%	Jan 23	97%	Jan 24
C1	97%	Dec 23	98%	Nov 23	89%	April 23	89%	April 23	97%	Apr 23	96%	Mar 23	95%	Sept 23	97%	June 23	100%	July 23
C30	98%	Sept 23	98%	Oct 23	96%	Mar 23	88%	Feb 23	92%	Oct 23	96%	Aug 23	95%	Dec 23	86%	May 23	100%	Nov 23
C31	92%	April 23	95%	Mar 23	88%	June 23	100%	Aug 23	90%	Feb 23	80%*	Aug 23	98%	Dec 23	83%	May 23	96%	Aug 23
C32	91%	Sept 23	92%	Dec 22	80%*	April 23	92%	July 23	85%	June 23	80%*	Aug 23	92%	Sept 23	66%	Aug 23	98%	Aug 23
C33	98%	Sept 23	95%	Oct 23	96%	Dec 23	91%	Aug 23	81%	June 23	85%	June 23	92%	May 23	77%	Feb 23	99%	July 23

FAMILY & WOMENS

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C16	99%	July 23	95%	Mar 23	81%	May 23	100%	May 23	90%	July 23	80%*	July 23	85%	March 23	74%	Feb 23	95%	Dec 21
Cedar H30	95%	Jan 24	92%	Sept 23	80%*	April 23	96%	Sept 23	95%	Oct 23	83%	Aug 23	95%	Jan 23	81%	Jan 23	91%	Sept 23
H31Maple	97%	Jan 21	96%	Nov 23	96%	July 23	92%	Feb 23	89%	May 23	80%*	May 23	100%	Jan 20			97%	Nov 22
H33Rowan	95%	Nov 19	98%	Nov 23	80%*	April 23	95%	Oct 23	92%	Aug 23	80%*	Mar 23	100%	Jan 20			98%	Dec 23
ACORN	98%	Oct 23	98%	Nov 23	86%	June 23	100%	Oct 23	92%	July 23	90%	Sept 23	85%	April 23	85%	Feb 23	91%	Apr 23
Woodlands	92%	May 23	95%	Feb 24	95%	Aug 23	99%	Oct 23	96%	May 23	80%*	May 23	80%	April 23	72%	Mar 23	94%	May 23
Labour	94%	Nov 20	98%	Nov 23	92%	Oct 23	92%	Oct 23	92%	May 23	90%	Nov 23	96%	July 20			98%	Dec 23
NICU	100%	Feb 24	98%	Nov 23	80%	July 23	98%	Oct 23	87%	May 23	80%*	Aug 23			89%	Feb 23	100%	Aug 23
PHDU	96%	July 23	95%	Feb 24	95%	Nov 23	96%	Aug 23	92%	Aug 23	100%	Dec 23	98%	Jan 23	78%	Ded 22	100%	May 22

SURGERY CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C9	95%	Feb 24	89%	May 23	84%	Aug 23	85%	May 23	90%	June 23	80%*	July 23	89%	May 23	67%	May 23	95%	Dec 23
C10	96%	Feb 24	92%	Oct 23	80%*	April 23	100%	June 23	73%	Mar 23	76%	April 23	92%	Sept 23	63%	April 23	95%	Dec 23
C11	98%	Dec 23	90%	July 23	90%	May 23	100%	June 23	92%	April 23	91%	Oct 23	92%	May 23	82%	Aug 23	100%	Aug 23
C14	95%	Aug 23	95%	Mar 23	59%	May 23	87%	May 23	88%	June 23	92%	Oct 23	89%	May 23	86%	Aug 23	100%	June 23
C15	97%	Aug 23	92%	July 23	92%	May 23	96%	Nov 23	90%	April 23	80%	July 23	82%	June 23	61%	Mar 23	100%	June 23
C27	95%	Sept 23	97%	July 23	89%	June 23	84%	May 23	88%	May 23	80%*	June 23	80%	Feb 23	73%	Dec 22	98%	June 23
CICU1	98%	July 23	95%	Mar 23	92%	May 23	90%	June 23	94%	April 23	80%*	Mar 23	94%	July 23	90%	June 23	100%	Oct 23
CICU2	89%	April 23	100%	Mar 23	89%	June 23	90%	Oct 23	85%	Mar 23	85%	Aug 23	90%	July 22	92%	June 23	100%	Nov 23

SURGERY HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
H4	96%	Feb 24	97%	Jan 24	80%*	Mar 23	92%	April 23	93%	April 23	80%*	July 23	86%	June 23	72%	Mar 23	99%	Jan 24
H40	98%	Nov 23	92%	June 23	77%	April 23	96%	Feb 24	85%	June 23	77%	Mar 23	87%	June 23	83%	June 23	98%	Oct 22
H6	92%	Nov 23	97%	Apr 23	80%*	May 23	92%	Aug 23	92%	Oct 23	80%*	Oct 23	86%	Feb 23	74%	April 23	95%	Oct 23
H60	100%	Mar 24	97%	Oct 23	80%*	Mar 23	96%	Aug 23	92%	Sept 23	80%*	May 23	92%	May 23	67%	Mar 23	98%	Aug 23
H7	99%	July 22	97%	Oct 23	80%*	Mar 23	98%	May 23	95%	Nov 23	80%*	Aug 23	88%	Feb 23	96%	June 23	95%	Nov 22
H12	98%	July 22	95%	Sept 23	71%	May 23	89%	Aug 23	87%	May 23	80%*	Aug 23	84%	Feb 23	87%	Feb 23	87%	Aug 22
H120	100%	July 22	92%	Nov 23	89%	May 23	89%	Aug 23	82%	July 23	80%*	Feb 24	94%	May 23	91%	April 23	96%	Oct 23
H100	98%	July 23	100%	Mar 23	82%	June 23	91%	Aug 23	90%	July 23	74%	May 23	87%	Feb 23	100%	May 23	92%	April 23
HICU1	93%	Nov 23	96%	Nov 23	86%	Aug 23	96%	Dec 23	90%	June 23	80%*	Mar 23	99%	Nov 21	88%	June 23	100%	May 22
HICU 2	93%	Nov 23	96%	Nov 23	80%*	Jan 24	93%	Sept 23	87%	Mar 23	80%*	Mar 23	97%	Oct 23	90%	April 23		

MEDICINE CHH

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
C28	98%	Dec 23	92%	Jul 23	94%	Apr 23	96%	May 23	90%	April 23	79%	April 23	91%	Sept 23	78%	May 23	100%	July 23
C26	98%	June 23	96%	Oct 23	83%	Aug 23	96%	May 23	92%	Oct 23	80%*	Mar 23	87%	Feb 23	93%	April 23	100%	Aug 23
C20	96%	Jan 24	96%	Feb 24	94%	April 23	91%	Sept 23	90%	May 23	80%*	Aug 23	85%	Mar 23	90%	Aug 23	92%	Oct 23
C5DU	97%	Dec 23	95%	July 23	97%	Feb 23	95%	June 23	97%	Oct 23	100%	Feb 23	99%	Dec 23			98%	May 23

MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due
AMU	88%	Aug 20	95%	Jan 24	80%*	Mar 23	91%	June 23	81%	July 23	80%*	June 23	89%	Jan 23	85%	June 23	96%	Nov 23
H36	94%	April 20	97%	May 23	80%*	Mar 23	89%	July 23	90%	Aug 23	79%	Mar 23	95%	Dec 23	91%	April 23	98%	Nov 23
FAB (Frailty Assessment Beds)	96%	Feb 21	97%	Jan 24	80%*	May 23	82%	June 23	92%	April 23	80%*	Oct 23	92%	May 23	94%	Mar 23	100%	Oct 23
H37	96%	Feb 24	97%	Mar 23	65%	May 23	90%	Aug 23	85%	May 23	75%	Mar 23	89%	Sept 23	91%	April 23	100%	May 22
H38	97%	Mar 20	95%	Mar 23	98%	Apr 23	84%	June 23	90%	June 23	75%	Mar 23	80%	Feb 23	79%	Mar 23	96%	May 22
H5	98%	Jan 24	97%	Jan 24	94%	May 23	96%	May 23	85%	April 23	80%*	Aug 23	80%	June 23	86%	July 23	93%	Oct 23
H50	95%	April 20	97%	Mar 23	89%	Nov 23	98%	May 23	87%	Aug 23	80%*	May 23	80%	Feb 23	91%	Sept 23	95%	Aug 23
H500	100%	Oct 23	95%	Sept 23	80%*	Mar 23	100%	Sept 23	84%	July 23	80%*	Aug 23	80%	June 23	85%	July 23	98%	Jan 24
H70	86%	Jan 22	95%	Mar 23	80%*	April 23	88%	Mar 23	90%	June 23	71%	May 22	50%	Mar 23	98%	June 23	100%	Nov 22
H8	93%	July 23	97%	Mar 23	80%*	Mar 23	100%	Aug 23	95%	Jan 24	80%*	Oct 23	68%	Mar 23	81%	July 23	96%	Nov 22
PDU/H80	94%	Nov 23	95%	Sept 23	80%*	Mar 23	97%	Oct 23	97%	Jan 24	91%	Nov 23	53%	Mar 23	91%	April 23	96%	Oct 23
H9	96%	July 22	90%	Oct 23	80%*	Mar 23	98%	Aug 23	92%	Oct 23	66%	May 23	62%	Mar 23	88%	Aug 23	91%	Sept 23
H90	95%	Feb 24	95%	Jan 24	80%*	Mar 23	95%	Feb 24	90%	Oct 23	80%*	Oct 23	42%	Mar 23	91%	Apr 23	95%	Feb 24
H10	94%	Oct 20	95%	Sept 23	90%	April 23	95%	Mar 24	90%	July 23	77%	April 23	89%	Sept 23	86%	May 23	97%	Mar 22
H11	98%	July 22	90%	June 23	80%*	Mar 23	95%	May 23	90%	Oct 23	77%	April 23	63%	Feb 23	92%	May 23	97%	Nov 22
H110	98%	Nov 23	95%	Oct 23	66%	May 23	100%	July 23	90%	Oct 23	80%*	May 23	89%	Aug 23	92%	May 23	96%	Oct 23

EMERGENCY MEDICINE HRI

Clinical Area	Staff Experience		Patient Environment		Infection Control		Safeguarding		Medicines Management		Tissue Viability		Patient Centred Care		Nutrition		Patient Experience	
	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Next due	Rating	Rating	Next due		Rating	Next due			Rating	Next due
Majors ED	83%	Mar 22	92%	Oct 23	100%	Oct 23	100%	Nov 23	84%	May 23			91%	Nov 22			87%	Mar 23
Paeds ED	89%	April 22	92%	Sept 23	91%	May 23	100%	April 23	90%	April 23			90%	Dec 22			98%	Sept 23
Emergency Care	85%	Dec 21	95%	Jan 24	80%*	Mar 23	90%	June 23	93%	Aug 23			93%	Nov 22			89%	June 23

REFERENCES

📕 Quality Strategy cover sheet Board - July 2023.pdf

📕 Quality Strategy 22-25 - update 23 - final draft.pdf

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Board	**Meeting Date**	11 July 2023
Title	Annual Review of the Quality Strategy 2022-2025				
Lead Director	Suzanne Rostron, Director of Quality Governance, Jo Ledger, Chief Nurse and Prof Makani Purva, Chief Medical Officer				
Author	Michela Littlewood – Associate Director of Quality Kelly Northcott-Orr – Head of Continuous Quality Improvement				
Report previously considered by (date)	This report has not previously been considered				

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

Key Recommendations:
The Board is requested to: • Discuss and approve the proposed content to the strategy   • Decide if any further information is required   • Confirm that it is satisfied with the 'next steps   • Consider the wider Trust strategy ambition of achieving a CQC rating of outstanding within the next three years.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
Annual Review of the Quality Strategy
Board Meeting 11 July 2023

1. PURPOSE

The purpose of this report is to request endorsement from the Board for proposed amendments to the Trust Quality Strategy 2022-2025 following its first annual review.

The annual review has taken into consideration the findings from the CQC inspection alongside performance in the first year of the strategy, and local governance information, such as incidents, complaints, surveys and clinical audits.

A paper outlining the proposal was taken to the Quality Committee in October 2022 and it was discussed again at the April 2023 meeting. The review was also discussed at the Patient Safety Clinical Effectiveness committee in June 2023.

2. PROPOSED CHANGES

The annual review has been undertaken by the Director of Quality Governance and the Associate Director of Quality for the initial phase. Comments were invited from Executive Directors and work-stream leads.

The majority of changes have been in relation to the CQC inspection. Feedback has been sought from each of the Health Group Triumvirates along with key stakeholders which have been incorporated into the Quality Strategy.

The main changes that have been discussed and changed are as follows:

2.1: Increasing the six harms to seven harms to include Sepsis in its own right, following the CQC inspection (originally p16).

The harms would then be:

- Hospital acquired pressure ulcers
- Catheter associated UTI
- Avoidable venous thromboembolism (VTE)
- Harm from falls
- Hospital acquired infection
- Medication errors
- Early treatment of the deteriorating patient and treatment of sepsis

2.2: Changing 'YOUnique' to simply 'staff as patients' following feedback (originally p18).

The new Patient Experience Lead has been asked to lead on this work and to be implemented during year 2 of the strategy. Many staff use Trust services but do not always provide feedback. This will enable us to capture areas of good practice in addition to areas that will inform improvement work.

2.3: Expanding on Year 2 outcomes (this will be extended further following all baseline reviews) (originally p21).

The original six harms had assigned work-streams which commenced in year 1 of the Quality Strategy. Performance indicators in these areas are to be reviewed with the leads for each of the work-stream along with the ambitions outlined as part of the year 2 outcomes.

2.4: Moving the PSIRF narrative and replacing with approved PSIRP as an appendix (originally p26).

There was not an approved PSIRP for the original Quality Strategy launch in June 2022 as the national change in policy was not officially published until August 2022. If the link for this is included, as opposed to the full plan, then readers will always get the latest version.

2.5: Adding the requirement for Health Groups to have a minimum of 3 work-streams associated with the Quality Strategy (originally p28).

Each Health Group (HG) has been asked to select three key areas to work on as part of the strategy update for example pressure ulcers/ GIRFT. To avoid duplication, the HGs have been asked to select initiatives that align with the CQC actions.

A table has been added to 'Appendix 1 – monitoring and evaluation of quality priorities' detailing the agreed quality areas for improvement identified for each of the health groups.

2.6: Adding the quarterly review meetings with allocated Board members and work-stream leads (originally p28).

These meetings will be an opportunity for work-stream leads to show case their work and to escalate any concerns. The outputs will form part of the regular Quality Strategy update reports to the Quality Committee.

2.7 Adding the relevant Non-Executive Directors to each quality priority (originally p32-35).

Non-Executive directors were approached in November 2022 with the request to take on this responsibility in year 2. As some positions have been changed, we will seek confirmation that this is still the case.

2.8 Addition of a contents page, glossary, ways to provide feedback and other formats and a document control page

Following feedback from external partners, the addition of a contents page, a glossary of definitions, ways to provide feedback and request other formats and a document control page have been included to aid the reader with understanding acronyms and abbreviations. Hyperlinks have also been included throughout to aid the reader to navigate to specific sections within the strategy

2.9 Document assessed against Accessibility standards

It had been highlighted that the Trust Strategy did not meet accessibility standards by the Government Digital Service. The previous version of the Quality Strategy had followed a similar style and did not meet the standards.

Changes have been made to simplify the layout, removal of text over images, inclusion of alt text on images and tables, use of headings to aid navigation of the document and changes to the font used throughout. The updated strategy complies with accessibility standards and an easy read version will be developed to further support with accessibility standards.

2.10 Document reviewed for errors

The strategy has been reviewed for all errors including spelling mistakes, grammar amended where appropriate following feedback from various stakeholders alongside an internal review. All errors noted have been rectified.

3. NEXT STEPS

If approved by the board the further actions to be undertaken include:

- Communications team to format the attached document taking into account; fonts, style and layout alongside accessibility standards
- Creation of an Easy Read version
- Approved documents be uploaded onto the Trust website

4.   RECOMMENDATIONS

The Board is recommended to:

- Discuss and approve the proposed content to the strategy
- Decide if any further information is required
- Confirm that it is satisfied with the 'next steps
- Consider the wider Trust strategy ambition of achieving a CQC rating of outstanding within the next three years.

QUALITY STRATEGY

2022-2025

*When this document is viewed as a paper copy, it is the reader's responsibility to ensure that it is the most current version.

CONTENTS

EXECUTIVE SUMMARY

We are proud to be the largest teaching hospital trust in the Humber and North Yorkshire Health and Care Partnership, with 9,900 staff providing great care to over one million patient each year.

This Quality Strategy sets out our approach to ensuring each of those patient contacts is safe and effective. It details our objectives and the outcomes we want for our patients and it details the support we have put in place for our teams and our workforce in their constant pursuit to improve services and the care we provide.

Even against the most challenging backdrop the NHS has ever faced, our remarkable people continue to do extraordinary work. We pride ourselves on innovation, on releasing the creativity of our staff and in giving them the skills to use their initiative and deliver evidence-based improvements.

We believe in our values and that investing in a motivated and engaged workforce is the key to delivering the best care possible. We are ambitious in our aims - this strategy provides a framework for achieving an overall CQC rating of Outstanding.

GREAT STAFF – GREAT CARE – GREAT FUTURE

FOREWORD FROM THE CHAIR AND CHIEF EXECUTIVE

We are delighted to present Hull University Teaching Hospitals NHS Trust's Quality Strategy, which sets out our quality and safety ambitions for 2022 to 2025 and is linked with our Big Ambitions detailed in the Trust Strategy 2019 to 2024. Patient care and safety sit at the heart of this strategy, with our aims for outstanding quality of care, staff experience and clinical services.

The Trust employs 9,900 people and has a comprehensive care portfolio covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services are provided primarily to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area. The Trust provides specialist services to a catchment population of between 1.05 million and 1.8 million, extending from York and Scarborough in North Yorkshire, to Grimsby and Scunthorpe in Northern Lincolnshire. Providing outstanding care for patients is our vision and this is reflected in our ambitions and commitment to improving services and outcomes for our patients.

The Trust is on a journey to achieving an overall rating of 'Outstanding' with the CQC, whilst increasing harm-free care, implementing a strong culture of team-led continuous improvement and having one of the most engaged and satisfied staff in the NHS. This Quality Strategy will set out the approach and direction of improvement in achieving our ambitions.

This strategy has been developed in consultation with our staff and stakeholders who have shared their views and indicated what they believe our priority areas for improvement should be. We have taken into account their views and that of our commissioners and regulators in developing this strategy.

We will lead by example through highly-visible, compassionate leadership and promote a culture of quality improvement by supporting our staff to make quality their priority and remove barriers to ensure that change and improvement is sustainable and really makes a difference to patients using our services.

Mr Sean Lyons Chairman   **Mr Chris Long**
(Joint Chair with NLAG)   **Trust Chief Executive**

GREAT STAFF

– HONEST, CARING AND ACCOUNTABLE CULTURE
– VALUED, SKILLED AND SUFFICIENT WORKFORCE

GREAT CARE

– HIGH QUALITY CARE
– GREAT CLINICAL SERVICES
– PARTNERSHIP AND INTEGRATED SERVICES

GREAT FUTURE

– RESEARCH AND INNOVATION
– FINANCIAL SUSTAINABILITY
– ESTATES AND INFRASTRUCTURE
– DIGITAL DEVELOPMENT
– ENVIRONMENTAL SUSTAINABILITY

INTRODUCTION

We have been saying this for some time: 'Great staff, deliver great care'. This is the bedrock of our approach and the underlying principle of our Quality Strategy.

We believe in a values-based approach to our work, where compassionate leadership leads to innovation through, inspirational vision, good team working, inclusion and participation, support and autonomy. Our people need to thrive in a fair and just culture where openness and learning are promoted and encouraged, and where control and blame are nowhere to be found.

Our approach of effective collaborative team-working within multidisciplinary teams is based on creating the right culture where our colleagues feel safe and valued, and where shared learning and continuous improvement, are the keys to delivering high quality care.

We cannot do this alone. In an environment of limited resources we have to work with our most important partners. Our strength lies in the effectiveness of patient pathways across the Humber. This Quality Strategy is a demonstration of our commitment to working in partnership with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and other regional partners.

We are setting out a quality management system approach, with the aim to put high quality care at the centre of every process, every discussion, every decision we take. The priorities within this strategy have been determined by our patients, staff, commissioners and the public through regular consultation, and will be used to inform our annual Quality Accounts. All of our ambitions have a series of quality indicators to enable effective monitoring of our work programmes with measurable outcomes.

We will create the right culture for our Trust to be rated 'Outstanding', where staff engagement, staff development and staff wellbeing are the foundations of everything we do. Achieve this, and our ambition to put every patient who needs our care, expertise and support at the heart of everything we do, will be a reality.
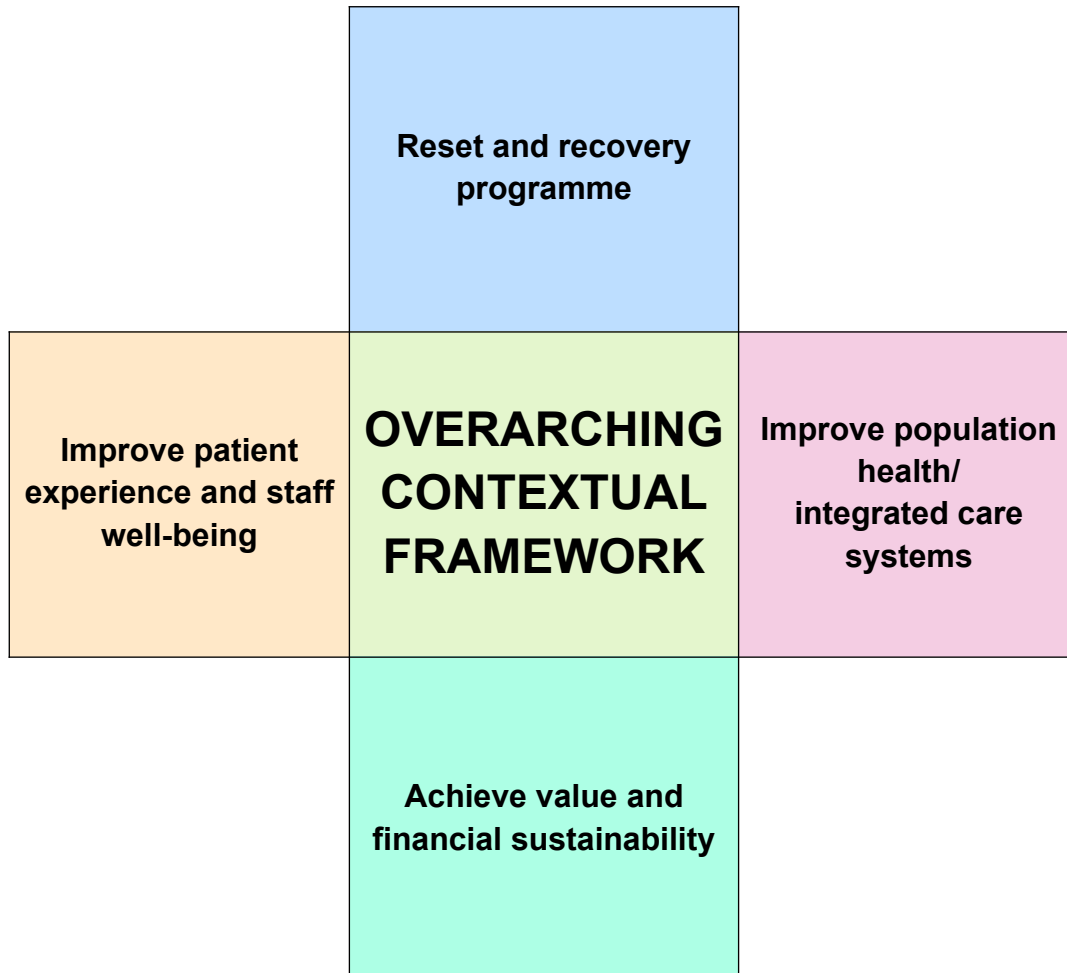
ENABLING QUALITY MANAGEMENT SYSTEM

QUALITY DESIGN
Organisational structure / Committees Governance systems and processes

QUALITY IMPROVEMENT
QSIR programme CQI initiative CQI forum

HIGH QUALITY PATIENT CARE

QUALITY ASSURANCE
Local and national standards National guidelines and best practices

QUALITY CONTROL
Patients and staff feedback BI dashboard / SPC charts / KPI review
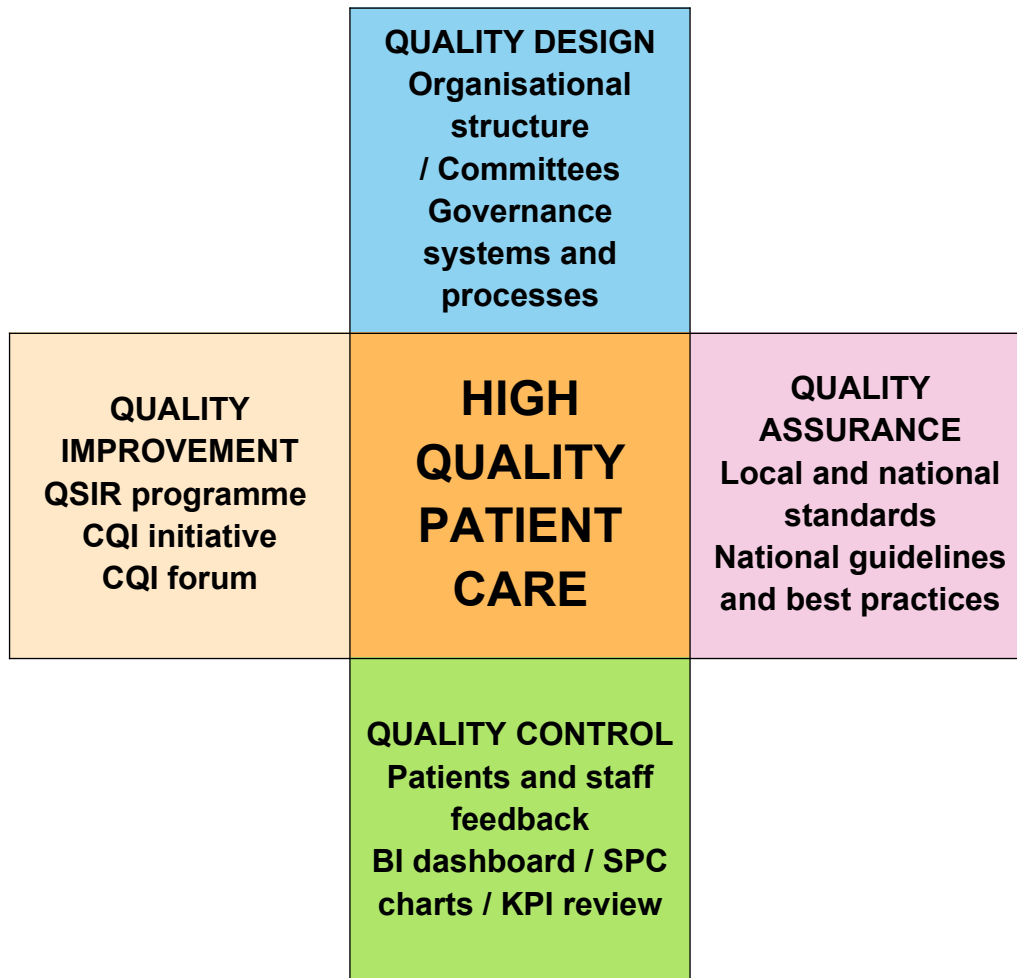
*Diagram 1. Quality Management System approach to deliver our overarching Quality Aim.

BETTER BRIGHTER GREENER FAIRER

STRATEGIC CONTEXT AND OBJECTIVES

Through implementing this strategy, we will:

	Reset and recovery programme	
Improve patient experience and staff well-being	**OVERARCHING CONTEXTUAL FRAMEWORK**	Improve population health/ integrated care systems
	Achieve value and financial sustainability	

*Diagram 2. Our Strategic Context that influences the development of this Quality Strategy.

KEY EXTERNAL CONTEXT

> NHS Long Term plan
> National patient safety strategy
> Integrated care systems / partnership i.e., Humber Acute Service Review (HASR)
> Regulatory and accreditation standards
> Getting It Right First Time (GIRFT)
> NHS People Plan

STRATEGIC CONTEXT

The landscape is changing, but what an opportunity. As part of the Humber and North Yorkshire Integrated Care System, we are adapting and innovating. We are working with new teams and services and reinventing patient pathways to ensure Continuous Quality Improvement is at the heart of everything we do.

We have multiple competing demands: deliver the reset and recovery programme; improve the health of our population within our integrated care system, achieve financial sustainability, and improve patient experience and staff well-being.

These four aims can be achieved if we get our strategies right and work with our partners on this journey.

Our Quality Strategy builds on our accomplishments and improvements including all that we have learned during the pandemic.

We have a strong foundation to build upon. We are an accredited Quality, Service Improvement and Redesign (QSIR) Faculty with a pool of accredited QSIR Associates from a variety of clinical and non-clinical backgrounds. Alongside our QSIR Faculty, we continue to build our Medical Quality Improvement Leadership which is supported by the Chief Medical Officer.

The Quality Strategy provides a framework to develop, standardise and innovate in order to achieve our vision of Great Staff, Great Care, Great Future and an overall CQC rating of Outstanding in the next three years.

QUALITY PRIORITIES

Our quality ambition to be a regional centre of excellence as one of the leading major teaching hospitals in the country will see us provide evidence based, efficient and cohesive healthcare pathways. This strategy defines our priorities as follows:

SAFETY

- – Harm-free care
- – Learning from events

EFFECTIVE

- – Right patient, right place, right time
- – Best clinical outcomes

LEARNING

- – Learning from patients and staff experience
- – Improve engagement with staff, patients, and the public

FOCUSED

- – Person centered care
- – End of life care
- – Mental health, learning disabilities and autism
- – Dementia care
- – Identification of the deteriorating patient

In order for us to deliver on this we have identified a number of measurable outcomes. Each outcome will have an accountable lead and an improvement plan which will report into our established committee structure.

SAFE CARE

STRATEGIC AMBITIONS

All patients receiving harm-free care as measured by the following seven harms:

1. Hospital acquired pressure ulcers
2. Catheter associated Urinary Tract Infection (UTI)
3. Avoidable venous thromboembolism (VTE)
4. Harm from falls
5. Hospital acquired infection
6. Medication errors
7. Early identification of the deteriorating patient and treatment of sepsis

OUTCOMES

– Reduction in Trust preventable infections and complications e.g., sepsis, acute kidney infection, pressure sores, VTE
– Accelerate rollout of the Trust's Patient Safety Incident Response Plan (PSIRP) and Patient Safety Improvement Programmes (PSIP)
– Reduction in patient falls and other identified major incident categories, implementation of theatre work streams including National Safety Standards for Invasive Procedures (NaTSSIPs) work
– Develop a safety culture / learning from events e.g., safety huddles, compliance with medication reviews/controlled drug checks, ward accreditation programme

EFFECTIVE CARE

STRATEGIC AMBITIONS

1. Develop outcome measures for each speciality and used for clinical improvement (best clinical outcomes) including National Audits and 'Getting It Right First Time' (GIRFT) programme
2. Establish and embed actionable local audits with clear improvement and monitoring programmes
3. Deliver consistent, evidence based quality care - right patient, right place, right time
4. Develop and deliver an audit tool to support the Emergency Department to ensure safe care is provided in line with deteriorating patients, sepsis care, mental health and tissue viability

OUTCOMES

– Utilise quality measurement tools to support and develop meaningful improvements. Using these measures to seek improvements in areas such as Sentinel Stroke National Audit Programme (SSNAP), Trauma Audit Response Network (TARN) and GIRFT
– Develop and implement improvement plans for clinical indicators
– Work with partners to develop Pathway 0, (where a patient no longer has any care needs requiring additional support) developing initiatives to support patient with No Criteria to Reside (NCTR) status, thereby reducing length of hospital admissions.
– Ensure compliance with National Institute for Care and Excellence (NICE) guidance and other best practices appropriate to the Trust
– GIRFT outcome measures to demonstrate improvements
– National audits to be completed and identifying improvement programmes following results of national audits
– Identify additional opportunities to improve services from Trauma Audit and Research Network (TARN) and Sentinel Stoke National Audit Programme (SSNAP) audits
–

LEARNING (EXPERIENCE)

STRATEGIC AMBITIONS

1. Develop a public and patient engagement strategy (learning from experience)
2. Work in partnership with patients and the public to develop and improve services
3. Gain learning from local Integrated Care Boards (ICB), Healthwatch and other partners who collect health care information from the public to further improve services
4. Develop staff health and well-being tools to support staff to manage early resolutions and complaints

OUTCOMES

– Reduction in formal complaints, particularly in Trust top categories e.g., staff attitude, dignity and respect, and communication
– Reduction in the number of complaints that are re-opened for a second response.
– Increased Friends and Family response rates across the Trust
– Implementation of 'Staff as Patients' (staff as patients CQI programme) to listen, learn and act from patients' perspectives - patients and staff feedback forum
– The new complaints PHSO framework implemented locally as part of the Patient Experience Policy
– Improved implementation of Schwartz rounds, including improving medical engagement in well-being programmes

FOCUSED (PERSON CENTERED-CARE)

STRATEGIC AMBITIONS

1. Develop an End of Life Care Strategy aimed at improving the quality of care for patients and their families at the end of life with clear priorities and work programmes
2. Develop improvements in dementia care, mental health, learning disabilities and autism at all levels within the organisation
3. Develop specialist services focused on continuity of care in all care settings - maternity and neonatal care, vascular, cardiology services, Emergency Department and major trauma
4. Roll out 'Always Events' initiative (focused on the things we should always aim to do well)
5. Continue to integrate Health Inequality work across all work-streams within the Trust

OUTCOMES

–   Quality Improvement programme established in line with NHS England End of Life collaboration
–   Reduction in formal complaints relating to End of Life Care, establish targets
–   Continued delivery of the Mental Health, Learning Disability and Autism strategy and the Dementia Care Strategy
–   Resolve end of life complaints in real time, preventing escalation to formal complaints and improving patient and families experiences
–   Improve compliance with specialist service specifications and national standards relevant to HUTH
–   Delivery of the Maternity and neonatal improvement programme, incorporating Better Births programme

STRATEGY TARGETS AND MILESTONES

YEAR 1: 2022/23

SAFETY, EXPERIENCE

– Increase in proportion of harm-free incidents, working on preventing the seven harms
– Become an accredited QSIR faculty / academy

YEAR 2: 2023/24

ENCOMPASSES ALL PRIORITIES

– Establish training programme for CQI
– Improve self-assessment ratings against CQC Key Lines of Enquiry (KLOE) and standards
– Launch Human Factors Hub, provide in house Human Factors training
– Appoint Patient Safety Partners
– Expand learning forums/ learning responses
– Agree target positions based on Year 1 baselines for original 7 harms
– Work together with NLAG as part of the group model on joint quality strategy initiatives across both organisations

YEAR 3: 2024/25

EFFECTIVE, EXPERIENCE, PERSON-CENTRED CARE

– Year on year improvements for the following Clinical Outcome indicators; GIRFT, SSNAP, NNAP, NPDA, ACS, MINAP, FFFAP and other national audits programme (please see Appendix 2 – glossary for definitions)
– Increase positive patient and experience, feedback and review outcomes

YEAR 4: 2025/26

ENCOMPASSES ALL PRIORITIES

– Deliver best practice more consistently
– Achieve outstanding overall CQC Rating
– Patients at the very heart of our improvements; coproducing CQI programmes

- All specialities and committees have rolling programmes of improvement with clear measurement indicators
- Established group model with NLAG
- Incorporate national quality improvement programmes within the CQI framework

QUALITY IMPROVEMENT FRAMEWORK

The 22/23 outcomes included for the Trust to become a Quality, Service, Improvement and Redesign (QSIR) Faculty, ensuring we have to create a fair and just culture where learning and Continuous Quality Improvement (CQI) are at the heart of our approach to providing care.

Working with NHS England, we train staff to become Improvement Practitioners to be able to lead improvement initiatives throughout the organisation. Once staff have become Improvement Practitioners, staff can then complete an assessment to become a QSIR Associate and support with teaching the QSIR curriculum, this supports with delivery of the training programme, enriches the learning experience for staff with and supports with embedding a culture of improvement across the Trust.

QSIR training has now been embedded across the organization and we continue to equip colleagues with the skills to undertake quality improvement projects through:

- A Trust-wide QSIR Programme sponsored by the Executive Management Committee
- Quality Governance and clinical/non-clinical members of staff as QSIR Associates
- Quality priorities and CQI training needs defined for each of the Health Groups
- Frontline staff members training and involvement of improvement projects

In collaboration with our ICS partners and NHSE/I regional system improvement leaders, we will hold a joint CQI celebration or learning events that cultivates shared learning of our improvements and best practices.

CURRICULUM FOR DELIVERING QUALITY, SERVICE IMPROVEMENT AND REDESIGN (QSIR)

- Leading improvement
- Project management
- Measurement for improvement
- Sustainability of improvement
- Engaging and understanding others
- Creativity in improvement
- Process mapping
- Demand and capacity

Diagram 3. Enabling systematic quality improvement approach through the QSIR training programme.

CQI CAPACITY AND CAPABILITY DEVELOPMENT:

This Strategy will focus on the development of our systematic approach to delivering Trust wide Continuous Quality Improvement (CQI) with the executive-led quality improvement enablers as shown in diagram 4.

Over the next four years, our Trust's Quality Improvement Programme will focus on the following key areas of work, which will address current challenges faced across the whole health system and also build on the ongoing improvement priorities and accomplishments made so far:

1. Introduce a new CQI academy programme based on QSIR tools for our team leaders, frontline staff and non-clinical staff members in line with their CQI training needs and quality priorities in each health group
2. Focus on the systematic scaling up and spreading of interventions, which have been shown to work in one service area and which are applicable to other service areas or health groups
3. Evaluate different ways to expand the involvement of patients, their representatives and other service users in our CQI work within the Trust
4. Promote the wider application of CQI within corporate services and engage with ICB/ partners with our CQI approach.
5. Work with Business Intelligence and Digital partners who support our information systems so that staff have better access to the data they need to understand quality, performance and accountability and to support their CQI projects with meaningful data and measurable outcomes;
6. Continue to build improvement CQI capability across the organisation, integrating the programme into our governance systems and operational delivery;
7. Develop learning framework across the quality management system in line with our CQI monitoring and evaluation processes towards achieving our strategic ambitions on our quality priorities.

SUMMARY OF CQI FRAMEWORK

CQI Engagement monitoring and evaluation	**Executive sponsored CQI programme**	**Enhanced CQI capacity and capacity building**
	CQI FRAMEWORK ENABLERS	
Patient Safety Improvement Collaborative Programmes	**Develop Systems Thinking CQI approach**	**Collaborate with Regional CQI Strategic Partners**

*Diagram 4. Summary of CQI Framework Enablers to support systematic approach to Trustwide Quality Improvement Programme

MONITORING, EVALUATION AND REVIEW

The implementation of this Strategy will be monitored with clear performance measures and evidential results through various work streams with corresponding committees and assigned accountable areas of leadership both Executive and Operational.

The Quality Committee will seek assurance of the delivery of the strategy and undertake deep dives of priorities as part of its annual work plan.

DIVISIONAL AND HEALTH GROUP ACCOUNTABILITY:

To ensure that all staff are committed to the success of our Quality Strategy, there will be various levels of monitoring and reporting starting from individual division and health group.

Each Health Group (HG) will establish a minimum of three priority quality initiatives to work on as detailed in Appendix 1 – Health Group quality areas for improvement. Each HG will monitor their elements of the quality strategy implementation plan. These will be reported to their HG Governance boards and monitored at Performance and Accountability meetings. This will enable lessons to be learned from successes and additional support or intervention to be provided in areas that are not demonstrating quality improvement through the identified indicators.

Each quality priority detailed within this strategy has an accountable lead (executive and operational) as detailed in Appendix 1. The Trust Board will hold the named leads to account on the delivery of the work streams and outcomes for the quality priority.

A Non-Executive Director sponsor and work stream leads will also provide additional challenge and support to the delivery of each priority. Quarterly meetings will be held with the nominated Board members and work-stream leads to inform the reports to Quality Committee. Each quality priority states which reporting committee is aligned to, please see Appendix 1.

LINK WITH ANNUAL QUALITY ACCOUNTS:

The Trust will continue to update its Quality Account in our public facing website and hold stakeholder events to ensure that progress is reported as one of our mechanisms for prioritising and reporting publicly as widely as possible. The Trust's Quality Accounts, and the process that accompanies them, is the key tool for delivering this strategy and maintaining stakeholder involvement.

TRUST BOARD

QUALITY COMMITTEE

Seeks assurance of the delivery

SUB-COMMITTEES

Monitor specific work streams

STRATEGIC DEVELOPMENT GROUP

Provides progress reports

EQUALITY IMPACT ASSESSMENT

This document forms part of the Trust's commitment to create a positive culture of equality, diversity and inclusion for all staff and service users. The aim is to identify, remove or minimise discriminatory practice in relation to the protected characteristics (race, disability, gender, sexual orientation, age, religious or other belief, marriage and civil partnership, gender reassignment and pregnancy and maternity), as well as to promote positive practice and value the diversity of all individuals and communities.

As part of its development this document and its impact on equality has been analysed and no detriment identified.

PATIENT SAFETY INCIDENT RESPONSE PLAN

Following the launch in July 2019 of the NHS Patient Safety Strategy (Safer Culture, Safer Systems, Safer Patients) by NHS England, which describes how the NHS will continually improve patient safety over the next 5-10 years. The three strategic aims focuses on insight, involvement and improvement.

Our Quality Strategy supports our local delivery of the NHS patient safety strategy and the implementation framework through developing the Trust's Patient Safety Incident Response Plan (PSIRP).

For further information on the Trusts PSIRP, please use the following link: Patient Safety Incident Response Plan

INSIGHT

- – Introduction to PSIRP
- – Triangulation of data to identify key patient safety priorities

INVOLVEMENT

- – Introduction Patient Safety Partners
- – Engagement strategies such as patient councils, patient forums, Family and Friends Test and staff feedback
- – Collaboratively working within the ICS to understand and meet the needs of the local population

IMPROVEMENT

- – Patient Safety Specialists
- – Moving from Safety I to Safety II
- – Learning from excellence

ENABLING STRATEGIES AND POLICIES

Our Quality Strategy is also supported through other key strategies and associated policies:

- – Clinical Services Strategy (currently under development)
- – People Strategy
- – Risk Management Strategy
- – Nursing, Midwifery and AHP Strategy
- – Patient Safety Incident Response Plan (PSIRP)
- – Digital Strategy
- – Research and Development Strategy
- – Mental Health, Learning Disability and Autism Strategy
- – Dementia and Delirium Strategy

APPENDIX 1: MONITORING AND EVALUATION OF QUALITY PRIORITIES

QUALITY PRIORITY 1: SAFE CARE

STRATEGIC AMBITIONS

All patients receiving harm-free care as measured by the following seven harms:

1. Hospital acquired pressure ulcers
2. Catheter associated Urinary Tract Infection (UTI)
3. Avoidable venous thromboembolism (VTE)
4. Harm from falls
5. Hospital acquired infection
6. Medication errors
7. Early identification of the deteriorating patient and treatment of Sepsis

ACCOUNTABLE BOARD LEAD(S)

- Chief Medical Officer (CMO)
- Director of Quality Governance
- Chief Nurse
- Non-Executive Director – Chair of Quality Committee

ACCOUNTABLE OPERATIONAL LEAD(S)

- Deputy Chief Medical Officer
- Deputy Chief Nurse
- Health Group Triumvirates
- Chief Pharmacist
- Head of Patient Safety and Improvement
- Head of Continuous Quality Improvement
- Medical Quality Improvement Lead
- Associate Director of Quality
- Falls Lead
- Tissue Viability Lead
- Director Infection Prevention Control

MONITORING COMMITTEE

- Patient Safety and Clinical Effectiveness Sub-Committee Quality Committee

QUALITY PRIORITY 2: EFFECTIVE CARE

STRATEGIC AMBITIONS

1. Develop outcome measures for each speciality and used for clinical improvement (best clinical outcomes) including National Audits and 'Getting It Right First Time' (GIRFT) programme.
2. Establish and embed actionable local audits with clear improvement and monitoring programmes
3. Deliver consistent, evidence-based quality care - right patient, right place, right time
4. Develop and deliver an audit tool to support the Emergency Department to ensure safe care is provided in line with deteriorating patients, sepsis care, mental health and tissue viability

ACCOUNTABLE BOARD LEAD(S)

- Chief Medical Officer
- Chief Nurse
- Chief Operating Officer
- Non-Executive Director – Chair of Performance and Finance Committee

ACCOUNTABLE OPERATIONAL LEAD(S)

- Associate Chief Medical Officer for Quality and Safety
- Deputy Chief Nurse
- Deputy Chief Operating Officers
- Health Group Triumvirates
- Head of Patient Safety and Improvement
- Head of Continuous Quality Improvement
- Medical Quality Improvement Lead
- Associate Director of Quality

MONITORING COMMITTEE

- Patient Safety and Clinical Effectiveness Sub-Committee

QUALITY PRIORITY 3: LEARNING (EXPERIENCE)

STRATEGIC AMBITIONS

1. Develop a public and patient engagement strategy (learning from experience)
2. Work in partnership with patients and the public to develop and improve services
3. Gain learning from local Integrated Care Boards (ICB), Healthwatch and other partners who collect health care information from the public to further improve services
4. Develop staff health and well-being tools to support staff to manage early resolutions and complaints

ACCOUNTABLE BOARD LEAD(S)

- Chief Medical Officer
- Chief Nurse
- Director of Quality Governance
- Director of Workforce
- Chief Operating Officer
- Non-Executive Director – Chair of Workforce, Education and Culture Committee

ACCOUNTABLE OPERATIONAL LEAD(S)

- Deputy Chief Medical Officer
- Deputy Chief Nurse
- Associate Director of Quality
- Health Group Triumvirates
- Head of Quality Compliance and Patient Experience
- Head of Continuous Quality Improvement
- Medical Quality Improvement Lead
- Head of Organisational Development/ Learning
- End of Life Lead

MONITORING COMMITTEE

- Patient Experience Sub-Committee (external partners in attendance including ICB, Healthwatch and other partners)
- Quality Committee
- Workforce Transformation
- Workforce, Education and Culture Committee

QUALITY PRIORITY 4: FOCUSED (PERSON-CENTRED CARE)

STRATEGIC AMBITIONS

1. Develop an End of Life Care Strategy aimed at improving the quality of care for patients and their families at the end of life with clear priorities and work programmes
2. Develop improvements in dementia care, mental health, learning disabilities and autism at all levels within the organisation
3. Develop specialist services focused on continuity of care in all care settings - maternity and neonatal care, vascular, cardiology services, major trauma
4. Roll out 'Always Events' initiative (focused on the things we should always aim to do well)
5. Continue to integrate Health Inequality work across all work-streams within the Trust

ACCOUNTABLE BOARD LEAD(S)

– Chief Medical Officer
– Chief Nurse
– Director of Quality Governance
– Chief Operating Officer
– Non-Executive Director - Safeguarding/ Mental Health

ACCOUNTABLE OPERATIONAL LEAD(S)

– Associate Chief Medical Officer for Quality and Safety
– Deputy Chief Operational Officers
– Deputy Chief Nurse
– Assistant Chief Nurse
– Health Group Triumvirates
– Director of Midwifery
– Head of Quality Compliance and Patient Experience
– Head of Continuous Quality Improvement
– Medical Quality Improvement Lead
– Associate Director of Quality
– Falls Lead
– Tissue Viability Lead
– Director Infection Prevention Control

MONITORING COMMITTEE

– Patient Experience Sub-Committee

HEALTH GROUP QUALITY AREAS FOR IMPROVEMENT

Health Group	Quality areas for Improvement		
ED	Improve the percentage of patients receiving the sepsis bundle	Improved experience for patients requiring mental health care in ED	Patients attending with major trauma, receive the levels of care expected as outlined in local policies and procedures and NICE Guidance
	Measured by • Monthly ED sepsis data • Monthly ED Assurance Audits	**Measured by** • Patients receiving timely mental health risk assessments and referrals • Mental Health assessment compliance rates • Monthly ED Assurance Audits	**Measured by** • Trauma Audit Research Network (TARN) results • Trauma Peer Review
Medicine	Reduce the number of patients with pressure ulcers	Improve the outcomes for patients presenting with stroke symptoms	Reduce patient harm from falls
	Measured by • Reduction in incidents reporting hospital acquired pressure ulcers	**Measured by** • Sentinel Stroke National Audit Programme (SNAPP) results • Reduction in incidents causing harm relating to stroke care	**Measured by** • Reduction in incidents reporting patient harm from falls
Surgical	Embed outcomes from Getting it Right First Time (GIRFT) surgical specific reports	Reduce avoidable venous thromboembolism (VTE) incidents causing harm	Improvements in the following theatre work stream: consent, medicine management, IPC, never events, NatSSIPs 2 (WHO Checklist)

BETTER
BRIGHTER
GREENER
FAIRER

Health Group	Quality areas for Improvement		
	Measured by • Reduction in Same-day cancelled operations • Reduced complaints regarding cancelled surgery • Improvements in GIRFT audits	**Measured by** • Reduction in the number of VTE incidents causing harm	**Measured by** • TARN network audit results • Reduction in Never Events
Family/ Women's	Reduce still births rates and Neonatal deaths by 2023	Reduce the wait to scan time for patients with suspected miscarriages in line with NICE guidance to improve patient experience	All children and young people with mental health illnesses are kept safe whilst as an inpatient in the Trust
	Measured by • National guidelines	**Measured by** • Compliance with NICE guidance • Improved patient feedback	**Measured by** • Staff trained in therapeutic restraint • Risk assessments to identify needs • Work force dedicated to meet patient's needs
Clinical Support	Reduce hospital acquired infections, and catheter associated UTI's	Reduce Medication errors	Improved end of life care for patients
	Measured by • IPC committee • Quality committee • BAF IPC Assurance framework	**Measured by** • Reduction in medication incidents causing harm reported • Increase in medicine related incidents reported as near misses	**Measured by** • Reduction in the number of complaints received relating to end of life care • Increase in the number of RESPECT forms

Health Group	Quality areas for Improvement		
			being completed
			• Patients dying in their preferred place of death

APPENDIX 2: GLOSSARY

The below table is a list of abbreviations and definitions used throughout the Quality Strategy:

Abbreviation	Definition
Always Events	Always Events are defined as "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system".
Audit	A check to make sure that care is being provided in the way that it should be. An audit lets the care provider and people who use the service know what is being done well and where there could be improvements.
Better Births Programme	The Better Births Programme focuses on improving outcomes of maternity services in England
Clinical Outcomes	Specific changes in your health or quality of life, as a result of the medical treatment or care you receive.
CQC	An organisation set up by the Government to make sure that all hospitals, care homes, dentists, GPs and home care agencies in England provide care that is safe, caring, effective, responsive and well-led.
CQI	Continuous Quality Improvement is about looking at how we can improve the quality and safety of patient care, improve patient and staff experience by looking at different ways and approaches to how things can be done better.
Data Quality	Ensuring that the data used by the organisation is accurate, timely and informative.
Engagement	This is the use of all resources available to us to work with staff, patients and visitors to gain knowledge and understanding to help develop patient pathways and raise staff morale. It also means involving all key stakeholders in every step of the process to help us provide high quality care.
FFFAP	The Falls and Fragility Fracture Audit Programme is a national clinical audit programme, commissioned by the Healthcare Quality Improvement Partnership (HQIP) and managed by the Royal College of Physicians (RCP).
Friends and Family Test	The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.
GIRFT	Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.
HASR	The Humber Acute Services Review focuses on the future of hospitals that will describe how we will provide modern health care for the population of the

Abbreviation	Definition
	Humber region.
Health Groups	Health Groups are the areas of the Trust delivering care to our patients. There are four Health Groups; Clinical Support, Family and Women's, Medicine, and Surgery. These four Health Groups are headed by a Consultant (Medical Directors) who is the Accountable Officer. They are supported in their role by a Director of Nursing and an Operations Director.
Healthwatch	A national organisation that represents people who use health and care services in England. It is independent, and exists to gather and represent the views of the public, but does not have the power to change how things are done. It reports problems and concerns to the Care Quality Commission, which has the power to make changes. There is a local Healthwatch in every council area.
Human Factors	Human Factors encompasses all of the factors that can influence the behaviour and performance of human beings in a system. It allows us to understand how people perform under different circumstances and why errors happen.
HUTH	Hull University Teaching Hospitals NHS Trust
ICS/ICB	ICSs are partnerships of NHS bodies and local authorities, working with other relevant local organisations that come together to plan and deliver joined up health and care services to improve the lives of people in their area.
Just culture	A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution.
KLOE	The key lines of enquiry (KLOEs), prompts and sources of evidence in this section help our inspectors to answer the five key questions: is the service safe, effective, caring, responsive and well-led?
MINAP	The Myocardial Ischaemia National Audit Project (MINAP) is a domain within NCAP that contains information about the care provided to patients who are admitted to hospital with acute coronary syndromes (heart attack). Data are collected and analysed to illustrate the 'patient journey' from a call to the emergency services or their self-presentation at an Emergency Department, through diagnosis and treatment at hospital, to the prescription of preventive medications on discharge. Provision of care by staff practising in participating hospitals, and, where relevant, ambulance trusts, is expressed through clinically-important quality improvement/assurance indicators.
NHS	National Health Service
NHS England	NHS England acts as a direct commissioner for healthcare services, and as the leader, partner and enabler of the NHS commissioning system.
NHS England	The organisation that decides what the most important health issues in England are and how NHS money should be spent. It is given money by the Department of Health and shares this out to local areas and clinical commissioning groups.

Abbreviation	Definition
NHS Impact	NHS Impact is the new, single, shared NHS improvement approach, creating the right conditions for continuous improvement and high performance, systems to support organisations to deliver better care for patients and give better outcomes for communities.
NHS Long Term Plan	A detailed 10-year plan for the future of the NHS from 2019 to 2029, setting out what the main priorities are and how the budget will be spent. The aim is to improve the quality of care people receive. Priorities include improving care for children and young people, cancer, heart disease and mental health.
NHS People Plan	The NHS People Plan sets out what the people of the NHS can expect from their leaders and from each other.
NICE	The National Institute for Health and Care Excellence (NICE) An organisation that provides advice and guidance to improve health and social care services in England and Wales. It looks at all the evidence on what works and what doesn't and how much it costs, and advises on what treatment and care should be offered to people. It doesn't have the power to insist that its guidance is followed in local areas.
NNAP	The National Neonatal Audit Programme (NNAP) is a national clinical with the aim to helps neonatal units improve care for babies and their families by identifying areas for quality improvement in relation to the delivery and outcomes of care.
NPDA	National Paediatric Diabetes Audit work with UK hospitals to measure the health outcomes and experiences of children with diabetes in England and Wales.
Patient Safety Specialists	Patient Safety Specialists are individuals in healthcare organisations (predominantly in NHS providers and Integrated Care Boards (ICBs), who have been designated to provide dynamic senior patient safety leadership.
PHSO	Parliamentary Health Service Ombudsman is an independent complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments.
Pressure Ulcers	Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin.
PSIRP	Patient Safety Incident Response Plan (PSIRP) sets out how NHS organisations will seek to learn from patient safety incidents reported by staff and patients, their families and carers in order to continually improve the quality and safety of the care provided
QSIR	Quality Service Improvement and Redesign is a training programme which is delivered in a variety of formats to suit different levels of improvement experience and are supported by publications that guide participants in the use of tried and tested improvement tools, and featured approaches, as well as

Abbreviation	Definition
	encouraging reflective learning.
Safety I	Safety I is the term given to traditional or current approaches to safety management including incident reporting, investigations, guidelines, targets and root cause analysis. Safety I practice is largely reactive and designed to retrospectively identify what went wrong after harm has occurred and then put measures in place to prevent similar occurrences in the future.
Safety II	Safety II refers to a new approach which seeks to understand the ability of staff to adapt to problems and pressures. It is based on the view that healthcare is a complex adaptive system that is constantly changing in unexpected and unpredictable ways.
Schwartz	Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare.
Sepsis	Sepsis is a medical condition that is characterised by a whole body inflammatory state and the presence of a known infection.
SSNAP	The Sentinel Stroke National Audit Programme (SSNAP) is a major national healthcare quality improvement programme. They measure how well stroke care is being delivered in the NHS in England, Wales and Northern Ireland and provide timely information to clinicians, commissioners, patients and the public so it can be used to improve the quality of care for patients.
Stakeholders	People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions. When an organisation such as your local council or NHS trust is planning to make changes to the way it works or the services it offers, it may hold a consultation with stakeholders, to find out what you think and what your experiences are.
TARN	The Trauma Audit and Research Network (TARN) is a national organisation that collects data on moderately and severely injured patients in England and Wales. This allows networks, major trauma centres, trauma units, ambulance services and individual clinicians to benchmark their trauma service with other providers.
Tissue viability	Tissue viability is a speciality that primarily considers all aspects of skin and soft tissue wounds including surgical wounds, pressure ulcers and all forms of leg ulceration.
Trust Board	The Trust's Board of Directors, made up of Executive and Non-Executive Directors.
UTI	Urinary tract infections (UTIs) affect your urinary tract, including your bladder (cystitis), urethra (urethritis) or kidneys (kidney infection).
VTE	Venous thromboembolism (VTE) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis,

Abbreviation	Definition
	DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE).

APPENDIX 3: HOW TO PROVIDE FEEDBACK AND OTHER FORMATS

We would like to hear your views on our Quality Strategy. If you have any feedback regarding the Quality Strategy, you can:

- E-mail your comments to: hyp-tr.qualityimprovement@nhs.net
- Post your comment to the following address:
  The Continuous Quality Improvement Team
  Quality Governance and Assurance Department
  Medical Education Centre
  Hull Royal Infirmary
  Anlaby Road
  Hull
  HU3 2JZ

This document can also be made available in various languages and different formats including Braille, audio tape and large print.

For more information, please contact Corporate Affairs:

- Call: (01482) 674828
- Email: hyp-tr.qualityimprovement@nhs.net
- Write to: Corporate Affairs
                Alderson House
                Hull Royal Infirmary
                Hull
                HU3 2JZ

APPENDIX 4: DOCUMENT CONTROL

Document Title:	**Quality Strategy 2022 - 2025**
Document Purpose:	The Quality Strategy sets out the Trusts approach to ensuring each patient contact is safe and effective. The strategy details the objectives and the outcomes the Trust wants for its patients along with the support put in place for staff within the Trust to improve services and the care provided.
First Published:	June 2023
Current Version Published:	1
Review Date:	July 2024
Version:	2
Ratification Committee(s):	Quality Committee and Trust Board
Lead Director:	Suzanne Rostron
Date EIA Completed:	4 July 2023
Document Managed by Name:	Michela Littlewood
Document Managed by Title:	Associate Director of Quality
Contact details for further information:	hyp-tr.qualityimprovement@nhs.net
Consultation Process	Medical Directors, Non-Executive Directors, Executive Directors, Nursing Directors, Health Group Directorates, Healthwatch, ICB, Heads of Services within Quality Governance

Date	Version	Author	Revision description *(Provide a brief outline of the changes made to the document)*
June 2023	1	Ernesto Quider	Development and release of the Quality Strategy

July 2023	2	Michela Littlewood	• Changes to ambitions and outcomes for each of the priorities
			• Review and amendments to the strategy targets and milestones for each of the yearly outcomes
			• Updates to PSIRP following release of national changes to policy
			• Clear guidance on monitoring, evaluation and review of the strategy moving forward
			• Addition of the following:
			   o Contents
			   o Glossary
			   o Document control
			   o How to feedback and other formats
			• Changes throughout to meets information accessibility standards

QUALITY COMMITTEE SUMMARY

REFERENCES

Only PDFs are attached

Quality Committee Summary June 2023.pdf

Item: Tissue Viability – Deep Dive	**Level of assurance gained: Limited**

The committee received an update on progress in reducing hospital acquired pressure ulcers in the Trust. The team have made changes to the validation process within Datix which will ensure that the data is reflecting the reduction.

The task and finish group has now been incorporated into the Safer Skin Committee and any outstanding actions have been picked up by the committee.

A video has been developed to share with staff from July with actions to be implemented.

There is now a standard escalation report that each Health Group submits to Safer Skin Committee, matrons in areas of concern are also expected to feedback.

The compliance with the mattress audit has significantly increased, teams have been given training how to complete and there is also a QR code on the mattress to support completion of the audits.

The increased use of the digital photography is supporting the team for validation and safeguarding.

A discussion was also held around needing to support the community to improve skills and knowledge in the care sector, especially in relation to end of life patients and deteriorating skin.

The matron from ICU presented the work done by the team to reduce the number of deep tissue injuries from devices, which will now be rolled out.

The committee acknowledged there was a downward trajectory but were not yet assured the improvements were sustained.

Item: Digital – Deep Dive	**Level of assurance gained: Limited**

The committee received a presentation covering the digital work since the CQC inspections in ED and Maternity.

The work within ED had provided an oversight and assurance that the fundamental care had improved within the ED. There are revision being made to improve the functionality of the Digital Sepsis Screening Tool, the new modules scheduled for September 2023 will also bring additional functions.

The Digital Maternity Antenatal Assessment Task and Finish Group had been established and had were tasked with;
- Establishment of a Digital Antenatal Assessment System including:
  - Online Telephone triage form
  - Online Assessment form
  - Dashboard and reporting
  - Hunt Group and Recording of calls.
- Telephone Hunt Group
- Telephone Call Recording
- Revise existing Lorenzo EPR Assessment Form
- Create new telephone Triage Form

There was a significant risk identified in relation to the implementation of BSOTS and Badgernet which had been delayed until February 2024, meetings were being held to establish if BSOTS could be implemented paper based in the interim, assurance that women would not be a risk with interim work around was requested.

It was also raised that the Section 31 conditions would not be lifted until there was evidence of sustained improvement which would be impacted by the delay of the implementation of Badgernet.

The chair of the committee agreed to escalate this risk to the Chief Executive and Chief Information Officer directly and raise at the July board.

Item: Learning from Deaths	Level of assurance gained: Reasonable

The quarter four report was shared with the committee with highlights that the Trust's SHMI remained on a downwards trajectory, although the trust remained being identified as higher than expected for Septicaemia and Urinary tract infections.

The Trusts compliance with structured judgement reviews remained very good and continued to remain above mandatory levels.

The internal audit provided reasonable assurance and there were two actions recommended.

There were examples of learning shared within the report and an update for the Medical Examiners Service.

Item: Effectiveness Review	Level of assurance gained: Reasonable

As requested by the committee a review was undertaken on the assurance provided to the committee over the past twelve months and also included what was received at the non-executives directors meeting and the Trust board. Key aspects were pulled from this information which including what we knew about ED, Maternity and Surgery.

The annual effectiveness review was presented with recommendation on to improve effectiveness shared with the committee.

Item: CQC Report	Level of assurance gained: Limited

The committee received the summary paper and supporting papers.

The monitoring arrangements are in place with Maternity and ED having monthly Safety Champion meetings and weekly check and challenges. Surgery and Medicine have monthly check and challenge meetings.

The Trust provide presentations for the HUTH Quality Improvement Group (QIG) and it is proposed that those presenting first attend Quality Committee.

The Mental Health Assessment area had now opened to patients and the action was closed.

Badgernet delay had already been escalated, the training and competency had been agreed to start in ADU and then be rolled out.

The committee were advised of the additional support that had been requested to support the Trust and the exit criteria for the HUTH QIG was also shared.

A discussion was held over understanding the measures of success and the impact and effectiveness of the actions and agreed that ED would attend the next committee.

Item: Patient Safety	Level of assurance gained: Reasonable

The Trust began the transition to PSIRF on the 1st April, the Trust share its PSIRF journey with ICB partners as a regional 'early adopter'; to support other organisations with the learning from the transition period and of any amendments to the PSIRP we make along the way.

As we come to the end of quarter one of the PSIRF transition the Trust has declared three Patient Safety Incident Investigations (PSIIs) which will focus on the 'work systems' and human factors which led to the events occurring. Two incidents were in relation to patient deaths and the third was a wrong site nerve block and was initially declared a Never Event but is expected to be de-logged.

A thematic review was undertaken following the two deaths of patient on the TAVI waiting list, alongside two ongoing serious incidents. The 10 actions that have been recommended have timescales no longer than within 6months. Looking to process map the full pathways to see where the squeeze points are. It was discussed that the pathways needs be delivered in the same manner at the cancer pathways.

There have been 12 After Action Reviews (AARs) have been supported by the Patient Safety Team in the reporting period in line with PSIRF. The learning from AARs are also presented by Health Groups to Patient Safety and Clinical Effectiveness Committee, via a monthly email from the Governance Team and learning is showcased at the quarterly Learning Forum.

There have been six serious incidents declared, these have been declared during the PSIRF transition as the incidents occurred prior to the go live date on 01 April 2023. There are currently 18 serious incident investigations were ongoing; 13 of the investigations were declared prior to the transition to PSIRF. The trajectory is to have all 13 investigations declared prior to PSIRF closed by August 2023.

There has been a reduction in the number of overall incidents reported over the last 12 months however there has been an increase in the number p1000bd resulting in moderate and above harm to a patient. Pressure ulcers and falls remain the highest reported harms

Three Patient Safety Alerts were issued in the reporting period April – June 2023, two of which are now closed following action and one is on track to be compliant by the end of October 2023.

Item: IPC	Level of assurance gained: Reasonable

The annual report provides an overview of the work done in accordance with the Infection Prevention and Control Board Assurance Framework (IPC BAF) during the financial year 2022-23. The report highlighted changes underpinning the IPC team and the meeting structures to gain traction on the issues has been key.

Within 2022-23 the region are a regional outlier for bloodstream infections which will be our focus this year and will encourage the ICB to do the same.

CDIFF we are now a positive outlier following driving improvement early on and supporting staff to understand the process.

There has been a significant improvement in Antimicrobial with the introduction of the MicroGuide and the Guardianship.

It was also flagged that the team needed the digital system IC Net to enable the team to be digitally agile.

Item: Patient Experience Update	Level of assurance gained: Reasonable

The committee received the quarter four report and the appendix showing the improvement work.

The nurse directors and teams have completed a great piece of work to reduce the backlog of complaints, Surgery had 57 open complaints and now have 10, Medicine had 42 and now have 2, so they can begin to focus on the learning.

There is now an established group NHS Model Complaints Steering Group to implement the standards. Examples of changes include continuing to offer face to face meetings as the first option, keeping complainants informed throughout the process, the reflective practice sessions

Item: Safeguarding	Level of assurance gained: Reasonable

A Learning Group has been established within Education and Development and all required training is under review. From a MCA perspective, the proposed plan is to revise our current training in line with the feedback from staff who attended the bespoke MCA training delivered January to March 2023. We will be combining a revised concise MCA training with Mental Health basic understanding and detainments as this is a key gap in our mandatory training. This will allow the Trust to provide assurance that MH is delivered to all staff as part of Level 1 training under the Safeguarding umbrella.

The team are also involved in the Consent Workstream.

Item: Board Assurance Framework	Level of assurance gained: Reasonable

The BAF was shared with the committee it was initially proposed that the risk ratings remained the same for quarter one but following discussion it was agreed that the following recommendations should be made.

BAF Quality 3.1, it was agreed to change the wording from Outstanding to Good, and to change risk appetite to Low.

BAF Patient Harm 3.2 it was agreed that the current risk from 16 to 25 due to the risk on Corporate Risk Register in ED for crowing and the target risk to increase to 16.

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

The committee received the following updates for assurance, there were no escalations raised;
- Operational Update
- Safety Oversight Group
- Non-Clinical Quality
- Quality Indicator Report
- Quality Accounts – Approved as delegated by Trust Board

REFERENCES

📕 Trust Board - Our People 11.07.23.pdf

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item		**Meeting**	Trust Board		**Meeting Date**	11.07.23
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

11th July, 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

The Trusts key challenge remains the number of 'No Criteria to Reside' patients in a hospital bed which is currently 154 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 2022-23 was 4.4%. The total absence including sickness and Covid-19 for 2022-23 was 4.8%. 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 4.5%. This is an increase from 4.4% as at the last Board meeting in May 2023.

4. Staff Vacancies

The Trusts overall vacancy position as at 31st May 2023 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1491.5	1380.8	48.5	62.2	4.2%
Add Prof Scientific and Technical	373.4	338.7	2.2	32.5	8.7%
Administrative and Clerical Staff	1631.6	1663.2	10.7	0.0	0.0%
Allied Health Professionals	524.5	505.7	3.6	15.2	2.9%
Estates and Ancillary	615.6	544.8	14.6	56.2	9.1%
Healthcare Scientists	177.2	158.8	0.6	17.8	10.0%
Medical & Dental - Consultant	524.4	485.4	14.8	24.2	4.6%
Medical & Dental - SAS	77.6	58.9	0.2	18.5	23.8%
Medical & Dental – Trainee Grades	723.2	693.0	26.4	3.8	0.5%
Nursing and Midwifery Registered	2516.1	2503.5	30.6	0.0	0.0%

Trust Total	8655.1	8332.8	152.2	170.1	2.0%

Overall the Trust vacancy position is 2.0%. The Consultant vacancy rate has increased to 4.6%. 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. Please note that the vacancies for Registered Nursing and Midwifery is excluding ODPs and Nurse Associates.

6. Communications and engagement
Staff Survey Actions
Following discussions with Health Groups and at the Workforce Transformation Committee a draft Culture Transformation plan has been developed. This sets out some key actions as follows:

- Create clear narrative and communicate strategy (NCTR ward, Day surgery, ICP, group structure, Zero30, RDI, EDI, people first approach)
- Embed the Just Culture approach in all staff learning and development, communications and engagement
- Relaunch staff charter and mandate PACT training for all staff and run a series of Civility sessions with all managers during July/August
- Hold a series of winter leadership briefings to all 700 B7+ (Oct-Dec)
- Review content of and widely promote all leadership programmes
- Change management process to be reviewed and formalised
- Appraisal review and wellbeing conversations
- Actively promote and support home working, for better recruitment and retention
- Shift the mind-set around breaks and leave - we frown when people don't take breaks NOT when they do
- Develop 'golden rules' around communication/flexible working/change management and staff wellbeing (it's everyone's responsibility to make decisions in accordance with our vision and values)

The staff charter has been revised in preparation for the civility sessions with managers and will form the basis for the Professionalism and Civility training that will be held for managers, prior to further roll-out. This has been ratified at Workforce Transformation Committee.

Work is ongoing to develop a key narrative for the Trust and will progress further once the new Chief Executive is in post. This will form the basis of the winter leadership briefings.

In addition, it is the ambition of the Trust to achieve a 60% return rate in the 2023 National Staff Survey. All managers of teams where there are 10+ staff will be asked to support their teams to complete the survey to ensure they receive a staff engagement score for their areas.

Standardised wording has been drafted to go into line manager job descriptions around creating the right culture in teams. This includes the 60% staff survey return requirement. It is hope that by engaging more staff with the survey we will receive a more accurate picture of how staff are feeling at HUTH.

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
- Staff Support Psychology continue to provide online webinars on Stress and Sleep Well. Sessions are bookable via HEY 24/7
- The Staff support inbox remains open and active with 1-2 emails a week requesting support from staff support psychologists
- The OD team provide resilience and well-being training for HCSW induction on a monthly basis.

Occupational Health

The Occupational Health Service (OHS) underwent an assessment by 2 external assessors on the 9th May as part of the Safe Effective Quality Occupational Health Services (SEQOHS) accreditation scheme. SEQOHS standards have been set by the Faculty of Occupational Medicine (FOM) following extensive consultation, they are reviewed 5yearly incorporating any legislative changes, ethical considerations and evidenced based best practice guidelines.

SEQOHS accreditation provides independent and impartial recognition that the service provider, having been independently assessed against the SEQOHS standards, has objectively demonstrated their competence.

It represents a quality mark demonstrating that accredited OHS's provide a safe, effective, quality service.

The service was congratulated for the robust underpinning Clinical Governance - showing good evidence of continued support and development of the whole team and providing excellent evidence of comprehensive health needs assessments, of which they are to be congratulated.

8. Learning and Organisational Development
Organisational Development Update (Bespoke Work)
- Cardiology Team Support continues with focus on improving civility in the workplace and new incivility reporting tool due to launch July 2023.
- Providing ongoing leadership development support for Band 6/7s in ICU including Clinical/Leadership supervision.
- Provision of support for leadership team within NICU. Leadership supervision for senior leadership team and 2 development days for Band 6s.
- Systemic team coaching session booked with the Infectious diseases service in July
- Team development and priority setting time out for Pharmacy operational managers booked in July.
- Insights session for ED administrative team

New OD interventions
- Insights and mission statement development day booked in September for CNE team
- Insights and team development session for corporate nursing team booked in July

- Insights and team development session for ED band 7s including clinical supervision booked in July.

Focus on Maternity Services
- Ongoing delivery of culture workshops on 'Kindness, Professionalism and Compassion within Maternity Services' from January 2023 – January 2024 for midwives and midwifery assistants. Workshops will expand in July 2023 to invite all staff within Maternity Services
- Incivility Reporting tool has been launched enabling any staff member to report negative behaviours using a QR code which will trigger support from an independent Circle Group (Representatives from Human Resources, Freedom to Speak Up Guardian, Organisational Development)
- 1-2-1 Listening Sessions being held in July inviting any staff from Maternity Services to share their experiences and improvement ideas
- Regular tea trolley visits planned within Maternity Services to promote the listening sessions and Incivility Reporting tool along with promotion flyers/business cards.
- [Online support booklet on how to manage your behaviours including how to report.](#)

Apprenticeship update
During the first quarter of 2023/24, the Trust experienced a fall in apprenticeship starts compared to previous years. However, this was anticipated following difficulties to recruit to posts and is reflective of regional reports of a drop in apprenticeship uptake averaging around 40% (Source HEY LEP).

However, the first quarter is typically the slowest recruitment time for the Trust, both for existing staff commencing on apprenticeships (CPD) and recruitment to new posts. It also follows a flurry of activity in the prior month (March) where the Trust had 17 apprenticeship starts, specifically in Team Leadership and Supervision.

The Widening Participation Team are working closely with departments across the Trust to increase uptake in apprenticeships in the further quarters of the year. Current plans are to commission over £1.6m in apprenticeship activity in the coming financial year. Key opportunities being explored include partnership working with colleagues at NLAG to offer cross-Trust apprenticeship cohorts in leadership and management, and levy transfers to smaller health and/or social care partners across the patch.

Discussions are also commencing around further cohorts of customer service/administration apprentices for the autumn and options for more bespoke options for existing staff including bereavement services. All activity is dependent upon funding for recruitment and/or options to release staff to complete the required 6 hours minimum per week off the job learning.

Work Experience Update
Placements have increased significantly this year with close to 100 work experience opportunities booked between September 2022 and November 2023. We have currently closed requests for placements for this academic year (which ends on Friday 21st July for Hull Schools), due to capacity and time required to complete all required checks, however we aim to reopen requests for the academic year 2023-24 in August.

Currently there are 37 different areas across the Trust open to hosting work experiences for those in Years 10, 11, and 12 of full time education. It is hoped to expand opportunities with a review of the current work experience policy, aiming to open up additional areas for young people in these year groups from September.

The WP team are also exploring options with the Trusts' EDI leads to link with local charities to explore options to offer increased access to work experience, and apprenticeships, for talented young people with physical disabilities and/or neurodiversity.

Career Engagement

The team, along with a cohort of 107 career ambassadors, continue to support a scope of career activities across the Hull, East Riding and North Lincs areas (in partnership with colleagues at both NLAG and York Trusts). May and June has seen a steep increase in requests to attend career fairs across the patch, often with the team attempting to accommodate last minute requests from schools and colleges. Moving forward, the team is looking at ways to widening career engagement and knowledge, including a potential project with the ICB/HEY LEP to offer experience days to local teachers to help cascade knowledge and embed health careers within local curriculum delivery.

Learning Steering Groups

The Required Learning TNA Steering Group and Learning Needs Analysis Groups were launched in April 2023, to begin a review of the Trusts current offering and to identify gaps in programmes and skills of our workforce. The groups meet on a monthly basis with involvement from a wide range of subject and departmental leads to ensure that we are able to provide the correct level of training and to explore new avenues, this is done in line with the NHSE learning needs.

New Courses

A new course 'Focusing on People - Understanding Customer Care' was launched in June and is available in both face to face and webinar formats. Major Incident Level 1 training, has also been re-instated in face to face format.

The team continues to play a key role in developing the rollout plan for the Oliver McGowan Mandatory Training on Learning Disability and Autism through our membership of the Humber and North Yorkshire Mandatory Training Project Group.

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 focusing on sustainable simulation – back to basics. Places can be booked on Eventbrite.

Human Tissues Licence Granted to HUTH Surgical Skills Centre, Suite 22, CHH

The Surgical Skills Centre have now been granted a Human Tissue Licence for the use of cadavers within our surgical training. 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 and the team have now started taking bookings.

Voice Recognition

HILS have secured an Innovate UK grant of £25k as part of a recent bid application to develop a voice recognition device in partnership with the University of Hull. The device would be used in Theatre and clinical settings, it will respond to an individual's voice command to display clinical guidelines. The project is currently in its infancy and recruitment at the University will commence shortly.

Associate Simulation Fellows

HILS currently have voluntary vacancies available for Associate Simulation Fellows to join the team to help facilitate simulation teaching on behalf of the Trust. The role is voluntary alongside clinical roles with the approval of their educational supervisors. There is an expectation that the fellow would help teach on 10 dates whether half day or full within a 12 month period, in return HILS will develop the individual as a simulation facilitator and provide them with certificates in facilitating, human factors and debriefing as well as hands on and shadowing opportunities. The fellows may also be supported to attend relevant educational conferences.

9. Equality, Diversity & Inclusion (EDI)
LGBTQ+ Staff Network Conference
The inaugural LGBTQ+ Staff Network Conference was held on the afternoon Friday 23rd June 2023, at the Mercure Hotel. The focus of Conference was to highlight the work, in the last 18 months, led by the Network and championed by the Trust on the subject of Trans and non-binary inclusion, both as a workplace and a healthcare provider. The keynote speaker, Ugla Stefanía Kristjönudóttir Jónsdóttir (Owl Fisher) delivered their keynote address (Trans Awareness with My Genderation). A table top discussion took place on the importance of Psychological Safety, with the surrounding context that mental health disproportionately affects LGBTQ+ people. The chair of the LGBTQ+ network gave a presentation on the successes and achievements of the Network in the last 18 months, including pronouns now being displayed on name badges and signatures, the positive responses to the HUTH Rainbow Badge Pledge, the growing number of Network membership and the launching of a new Allyship Network. Members of the LGBTQ+ Staff Network Leadership Team took part in an open discussion Q&A. The conference was filled to capacity with Network Members and their Allies of all levels up to and including Board Members.

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

7

TRADE UNION FACILITY TIME REPORTING REQUIREMENT REGULATIONS

2023 REPORT

REFERENCES

📕 9.2 - TU Facility Time Reporting 010422 to 310323 Board 150623.pdf

Hull University Teaching Hospitals NHS Trust

Agenda Item		Meeting	Trust Board	Meeting Date	11/07/23
Title	Trade Union Facility Time Publication Requirements				
Lead Director	Simon Nearney, Director of Workforce and OD				
Author(s)	Louise Whiting, Employment Policy and Resourcing Manager and Sarah Dolby, Senior HR Advisor Employment Policy and Resourcing				
Report previously considered by (date)	This report was tabled at the Workforce Education and Culture Committee on 12 June 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:
Under the Trade Union (Facility Time Publications Requirements) Regulations 2017, all public sector organisations that employ over 49 full time employees are required to publish annually certain data relating to facility time usage within their annual reports, on their organisation website and also through the Governments reporting service. This year reporting needs to be complete by 31 July 2023.
The Facility Time Regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.
The Trust Board is requested to note and approve the content of this report which was previously tabled and agreed at the Workforce Education and Culture Committee on 12 June 2023.
Once approved by the Board, the report will be published on the Trust and Gov.UK websites. It is also referenced in the Trust Annual Report.

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Hull University Teaching Hospitals NHS Trust

Trust Board
Trade Union Facility Time Publication Requirements

1   **Purpose of this Report**
The purpose of this report is to explain the background to the Trust's reporting requirements in relation to Trade Union Facility Time, provide an overview of the specific annual reporting requirements, together with Trust data for the 2022/23 reporting period.

2   **Background**
The Trade Union (Facility Time Publications Requirements) Regulations 2017, which came into force on 1st April 2017, implemented the requirement introduced by the Trade Union Act 2016 for specified public-sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time.

The Facility Time Regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.

It is not however expected that it will result in a significant impact on trade union representatives carrying out their trade union duties for which there is a legal entitlement to reasonable paid time off work.

The Government will assess the information published by public sector employers on facility time before deciding whether regulations to introduce limits on the level of facility time that public sector employers provide, in proportion to their total pay bill, are appropriate.

3   **Annual Reporting Requirements**
The report (covering the period 1 April 2022 to 31 March 2023) must be published by 31 July 2023 on the Trust's website and referenced in the Trust Annual Report. The information must also be reported via the government portal to the same timescales so that it can be placed on the Gov.UK website.

The reporting requirement applies only where an employer has at least one trade union representative and 50 or more employees for seven months during the reporting period, which is the period of 12 months beginning 1 April each year. As such the Regulations apply to the Trust.

The duty to report covers specific information (set out in detail in Schedule 2 of the Regulations) relating to time off taken for trade union duties, for example negotiations with employers, representing members in the workplace, or the duties of a learning representative and activities, or to carry out duties and receive training under the relevant safety legislation. The Trust's proposed report also contains brief narrative to contextualise the required data (Appendix 1).

Trade union representatives can get paid time off to carry out 'duties' which is set out in legislation. Employers may also grant paid time off for trade union activities for which there is no statutory right to paid time off.

4   Trust Data 2022 – 2023

The Trust's mandatory data for the reporting period 1 April 2022 to 31 March 2023 (detailed in Appendix 2) highlights that the Trust percentage of the total pay bill spent on facility time is 0.01%.

The figures have been calculated using the standard methodologies used in the Trade Union (Facility Time Publication Requirements) Regulations 2017, utilising data submitted from staff side representatives (taken from national NHS Electronic Staff Record, HealthRoster, Job Planning systems or paper returns).

Whether in providing support to individual staff members at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas (e.g. Job Matching Panels, Joint Negotiating and Consultative Committee (JNCC), Local Negotiating Committee (LNC), Collective Agreements, Policy Sub Group, Junior Doctor's Forum, Health and Safety and Staff Surveys) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

Whilst not included in the return, as they are not Trust employees, the Trust also benefits from the input of fulltime trade union officers supporting the employee relations agenda, as appropriate, and also in the case of Unison caseworkers for occasions no local staff side representative is available.

Many of the Trust's local staff side representatives occupy clinical roles. The Trust's ongoing post-pandemic recovery period has resulted in these representative's focus continuing to be on their clinical work. It is therefore not surprising that the Trust's percentage of pay bill spend on facility time remains at 0.01%, for the third consecutive year.

5   Comparative Data – Using Data from the Previous Reporting Period

The reforms encourage public sector employers, including the Trust, to monitor and, where appropriate, evaluate the amount of money spent on facility time, in the interests of transparency and accountability.

As part of this assessment the Trust has used the retrospective 2021 – 2022 data published on the Cabinet Office website to compare the percentage of the pay bill it spent on facility time in 2021 – 2022 (0.01%) with comparable NHS organisations both nationally and more geographically based (i.e. with a headcount of 5001 to 9999), as well as with local (non-comparable sized) Trusts.

Analysis of the data of the 73 Trusts nationally (with 5001 to 9999 employees) who formally reported via the national reporting tool by the July 2022 deadline shows:
- the percentage of the pay bill spent on facility time ranged from 0% to 0.18%
- the mode was 0.01% (the percentage value that appears most often, accounting for 23 of the 73 Trusts),
- the median was 0.03% (the middle value in the list of numbers),
- data for Trusts more geographically based are shown in Table 1 below.

Table 1: Comparable Sized NHS Trusts (headcount 5001 to 9999) Data 2021 – 2022

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Trust Name	% of Pay Bill Spent on Facility Time	Higher/ Lower % than the Trust (0.01%)
Bradford Teaching Hospitals NHS Foundation Trust	0.01%	Same
County Durham and Darlington NHS Foundation Trust	0.01%	Same
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	0.03%	↑
Northern Lincolnshire and Goole NHS Foundation Trust*	0.03%	↑
The Mid Yorkshire Hospitals NHS Trust	0.01%	Same
York Teaching Hospital NHS Foundation Trust	0.02%	↑

no record of formally reporting, details taken from Annual report

A further comparison was also undertaken against other (non-comparable sized) local Trusts.

Table 2: Non-Comparable Local NHS Trusts Data 2021 – 2022

Trust Name	% of Pay Bill Spent on Facility Time	Higher/ Lower % than the Trust (0.01%)
Harrogate District Foundation Trust	0.01%	Same
Humber Teaching NHS Foundation Trust	0.04%	↑
Rotherham, Doncaster and South Humber Foundation Trust	0.05%	↑
Leeds Teaching Hospitals NHS Trust	0.01%	Same

The analysis provides assurance that, based on the figures for the last reporting year (2021 – 2022), the data for the Hull University Teaching Hospitals NHS Trust was within reasonable limits.

The Trust will again compare the percentage of pay it has spent on facility time for 2022 – 2023 with other similar sized and local NHS Trusts, once they have submitted their data for this reporting period deadline.

6   The Proposed Report for 2022 – 2023
Attached for the Trust Board approval (as Appendix 1 and 2), is the proposed report to meet the Trade Union Facility Time Publication Requirements for the reporting period 1 April 2022 to 31 March 2023.

7   Recommendation.
The Trust Board is requested to note and approve the content of this report, which was previously tabled and agreed at the Workforce Education and Culture Committee on 12 June 2023.

Once approved by the Board, the report will be published on the Trust website, prior to the 31 July 2023. It will also be placed on the Government portal.

4

Helen Knowles
Head of HR Services
July 2023

Appendix 1

Hull University Teaching Hospitals NHS Trust

Trade Union Facility Time Publication Requirements
Reporting Period; 1 April 2022 to 31 March 2023 Inclusive

1   Introduction

The Trade Union (Facility Time Publications Requirements) Regulations 2017, which came into force on 1st April 2017, implemented the requirement introduced by the Trade Union Act 2016 for specified public sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time.

2   Background to the Reporting Requirements

The Facility Time Regulations are intended to ensure transparency of facility time and the associated costs to the taxpayer. Organisations should ensure the costs to the taxpayer of facility time are proportionate to the benefits in the delivery of public services.

3   Annual Reporting Requirements

The duty to report covers specific information (set out in detail in Schedule 2 of the regulations) relating to time off taken for trade union duties, for example negotiations with employers, representing members in the workplace, or the duties of a learning representative and activities, or to carry out duties and receive training under the relevant safety legislation.

Trade union representatives can get paid time off to carry out 'duties' which is set out in legislation. Employers may also grant paid time off for trade union activities for which there is no statutory right to paid time off.

4   Trust Data 2022 – 2023

The Trust's data for the reporting period 1 April 2022 to 31 March 2023 is attached as Appendix 2.

Whether in providing support to individual members of Trust staff at a departmental level, or by playing a valuable role in contributing to Trust-wide agendas (for example: Joint Negotiating and Consultative Committees, Job Matching Panels, Collective Agreements, Policy Sub-Group, Junior Doctor's Forum, Health and Safety and Staff Surveys) the Trust recognises that the participation of trade union representatives supports the partnership process and contributes to delivering improved services to patients and users.

Whilst not included in the return, as they are not Trust employees, the Trust also benefits from the helpful input of fulltime trade union officers, as appropriate, and also for one union, caseworkers for occasions where no local staff side representative is available.

The Trust will continue to monitor and evaluate the amount of money spent on facility time, in the interests of transparency and accountability.

Appendix 2

Hull University Teaching Hospitals NHS Trust

**The Trade Union (Facility Time Publication Requirements) Regulations 2017
Reporting Period; 1 April 2022 to 31 March 2023 Inclusive**

Table 1: Relevant union officials
Total number of Trust employees who were relevant union officials during the relevant period, 1 April 2022 to 31 March 2023:

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number (of trade union representatives)
57	49.80

Table 2: Percentage of time spent on facility time
Hull University Teaching Hospitals NHS Trust's employees, who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	37
1%-50%	20
51%-99%	0
100%	0

Table 3: Percentage of pay bill spent on facility time
The percentage of the Trust's total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period:

	Figures
Total cost of facility time	£62,164.61
Total pay bill	£479,524,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.01%

Table 4: Paid trade union activities
As a percentage of total paid facility time hours, the number of staff hours spent by employees who were relevant union officials during the relevant period on paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	0%

The figures have been calculated using the standard methodologies used in the Trade Union (Facility Time Publication Requirements) Regulations 2017.

REFERENCES

📄 FTSUG report Q4 and annual 2022 - 2023 Trust Board July 2023.pdf

Agenda Item		Meeting	Trust Board	Meeting Date	11th July 2023
Title		Freedom to Speak Up Guardian report – Quarter 4 and annual report 2022/2023			
Lead Director		Suzanne Rostron, Director of Quality Governance			
Author		Head of Freedom to Speak Up			
Report previously considered by (date)		N/A			

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

Key Recommendations to be considered:
• The Trust Board are asked to receive and accept this Quarter 4 and annual report of the work and activities of the Trust's Freedom to Speak Up Guardian.
• The Trust Board are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Quarter 4 and Annual Report 2022/2023

1.   Purpose of the paper

The National Guardian's Office requires Freedom to Speak Up Guardians (FTSUG) in NHS Trusts to report directly to their Trust Board.

This report provides an update on the concerns raised by staff, students, trainees and/or volunteers through HUTH's FTSUG during Quarter 4 and annually during 2022/2023, including an overview of themes and the activities undertaken by the Trust's FTSUG. Furthermore, the report aims to provide assurance to the Board on promoting a 'speaking up' culture at the Trust for staff and complying with Key Line of Enquiry 3 as part of the CQC Well-Led domain.

2.   Introduction

Following the Francis Review, all Trusts are required to have a FTSUG in place. There are a number of processes at HUTH in place that allow staff to raise concerns. These include:
- Formal Raising Concerns and Whistleblowing Policy
- Anti-fraud service
- Through their line manager
- Through the Staff Conflict Resolution and Professionalism in the Workplace Policy or the Grievance Policy
- Freedom to Speak Up Guardian

There are other routes as ways in which staff can receive support if they are experiencing difficulties at work, for example Occupational Health and other staff support services.

In addition, professional organisations such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) also issue guidance which sets out the GMC's expectations that all doctors will, whatever their role, take appropriate action to raise can act on concerns about patient care, dignity and safety.

3.   FTSUG Activities during 2022 to 2023

A summary of the activities of the FTSUG during April 2022 to March 2023 are detailed below:
Raising awareness:
- Coordinated and provided a training and awareness session at the request of the Paediatric International Medical Graduates across Yorkshire and the Humber. Worked in partnership with the FTSUGs at Sheffield Children's Hospital NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust to deliver the event and received excellent feedback.
- Delivered induction presentations to ensure new starters to the Trust are aware of the FTSUG role, remit and key contact details. Presentations have been provided to the newly qualified midwives, Let's Get Started nursing induction programme, for newly qualified nurses and those returning to practice and Doctors in Training induction days. The FTSUG also provided the annual teaching session to FY1 Doctors in August 2022.
- The FTSUG was invited to present at the Executive Nursing and Midwifery Committee, Occupational Health Nurses team time out and to the CHH surgical Ward Managers, to explain and further reinforce the Guardian role and speaking up across the Trust.

Speak Up Champions Network:
- October 2022 was the national awareness month for Freedom to Speak Up. The FTSUG concentrated on the theme 'FTSU for Everyone' through the start of the implementation of the Trust's Speak Up Champion Network.
- The recruitment to 'Speak Up Champions' was launched to establish a network of colleagues across the Trust who raise awareness and signpost others to speaking up services. The principles and the role description of the Speak Up Champions has been closely developed in line with the National Guardian Office guidance 'Developing Freedom to Speak Up Champion and Ambassador Networks' and advice from the Information Governance Team.

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- Staff members were invited to submit an expression of interest to become a 'Speak Up Champion'.
- The FTSUG developed a bespoke training package including videos of the conversations champions could expect to be having with staff, kindly filmed by members of the Trust drama group. 17 Champions are trained, with a further 10 to be trained during 2023/2024.
- Support to the Champions was established through bimonthly peer support and development sessions; the first session was held in December 2022.
- Regular communications to the Champions including a newsletter was developed.
- The Digital Communications team developed branding and logos for the Speak Up Champion Network to promote awareness and identify Champions across the Trust.

Partnership working (internal):
- Linked in with the Chaplain responsible for Staff Support to discuss the FTSUG role and promote mutual referrals.
- Met with the new Staff Support Psychologist to discuss each other's roles and promote mutual referrals and joint working.
- Attended the HR Business Partner, HR Manager and HR Advisor meeting to present key learning and promote partnership working.
- Met the Named Nurse for Safeguarding Adults jointly with the Staff Psychology Team to discuss working together, and key safeguarding requirements.
- Commenced regular 121s with the Chief Nurse.

Partnership working (external):
- The FTSUG was invited to participate in a focus group with Lord Jonathan Evans, the Chair of the Independent Committee on Standards in Public Life, who advises the Prime Minister on arrangements for upholding ethical standards of conduct across public life in England. The discussions held in the focus group forms part of a national review examining the role of leadership in embedding the Principals of Public Life.
- Continued 'buddy' 121s with FTSUGs from Northern Lincolnshire and Goole NHS Foundation Trust, York and Scarborough Teaching Hospitals NHS Trust and Rotherham Doncaster and South Humber NHS Trust.

National work:
- NHS England and Improvement national requirements – please see section 5 of this report.

Internal audit:
- The FTSUG worked with the RSM team in providing information for an internal audit of the FTSU service.
- The audit concluded that the Board can take <u>substantial assurance</u> that the controls upon which the organisation replies to manage this risk, are suitably designed, and consistently applied and effective. Four low level actions were identified; which the FTSUG was already progressing as business as usual.

Staff Networks:
- The FTSUG continues to work as an ally of each of the staff networks. As part of this the FTSUG participated in 'Bridging the Gap' disability awareness training to further support the role and staff raising disability related concerns.
- Involved as a member of the 'Circle Group' to support the Zero Tolerance to Racism Framework task and finish group and with the launch of the new reporting tool and attendance at Circle Group meetings. This involvement has been within the national guidance of the FTSUG role e.g. impartiality.
- The FTSUG had a market stall at the HUTH Staff Disability conference and was one of the key note speakers and spoke about speaking up and the importance of psychological safety.

Ad hoc:
- Successfully completed the new mandatory training modules required by the National Guardian Office to continue as a FTSUG.
- As part of the Well Led inspection, the FTSUG was interviewed by the CQC and discussed the arrangements for speaking up at HUTH and the initiatives including the Speak Up Champion Network.
- Following a query at the previous Public Trust Board, the FTSUG has commenced a comparison of the number of individual concerns raised at similar sized Acute Trusts.

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4.   Trust contacts

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

4.1   Contacts during 1st January 2023 to 31st March 2023 (Q4)

During Q4 22 further individual contacts were received by the FTSUG. Graph 1 provides the main theme of the concerns during Q4 and Graph 2 the professional group of staff making contact with the FTSUG during Q4.

Graph 1: Themes of concerns raised during Q4 2022/2023

Graph 7: Concerns raised by professional group during 2022/2023

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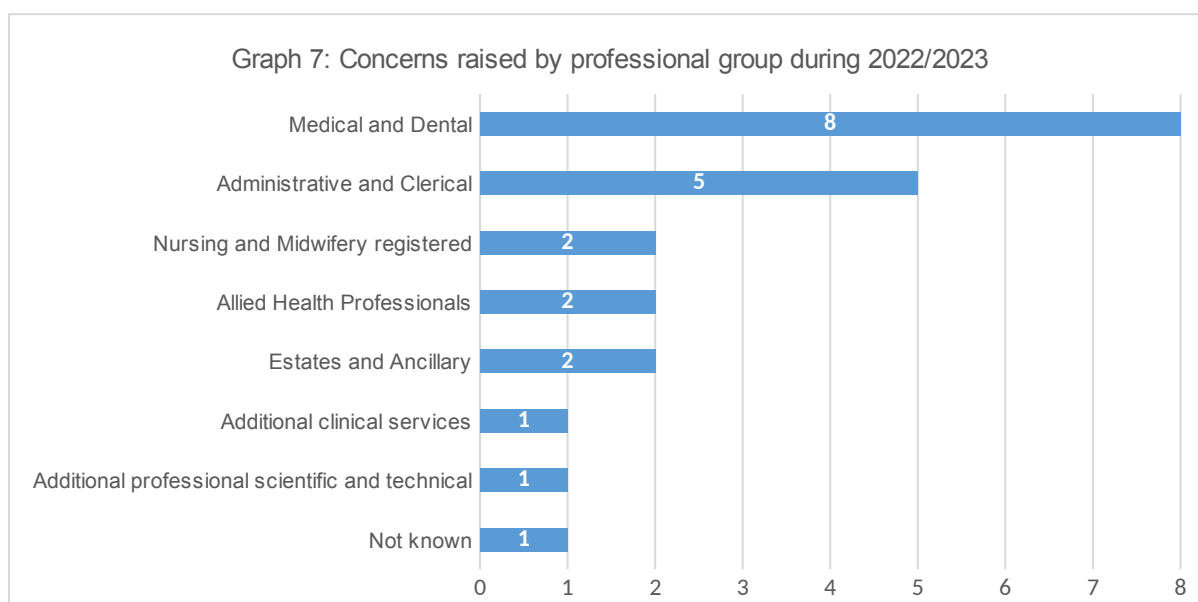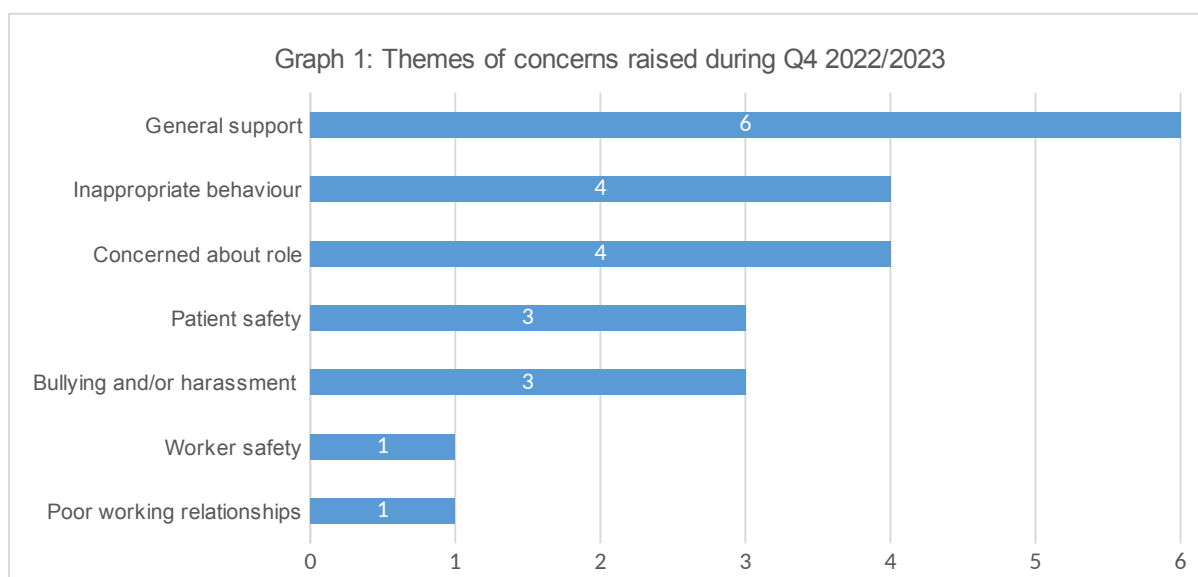
4.2   Contacts during 1ˢᵗ April 2022 to 31ˢᵗ March 2023 (Q1, Q2, Q3, Q4)

Graph 3 summaries the total numbers of open and closed cases (data extracted at 04.07.2023):

Graph 3: Open and closed cases 2022/2023
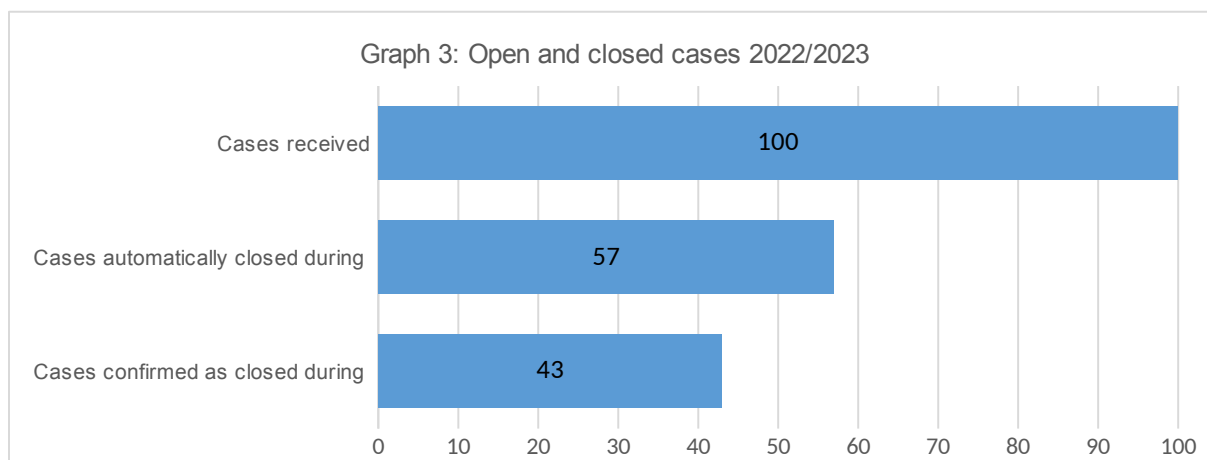
For the data during Q1, Q2, Q3 and Q4 - Graph 4 shows a comparison of the number of individual contacts received, on comparison with the annual data since 2017. Graph 5 provides the main theme of the concerns and Graph 6 the professional group of staff making contact with the FTSUG:

Graph 4: Individual contacts to FTSUG during 2022/2023

Graph 5: Themes of concerns raised during 2022/2023

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Graph 6: Concerns raised by professional group during 2022/2023

Professional group	Q1	Q2	Q3	Q4
Medical and Dental	7	7	4	5
Administrative and Clerical	4	6	11	2
Nursing and Midwifery registered	5	4	3	8
Allied Health Professionals	3	4	8	1
Estates and Ancillary	2	3	2	
Additional clinical services			5	1
Additional professional scientific and technical		2		
Not known		1		1

Comments and observations:

- The annual number of concerns raised to the FTSUG has further increased – from 71 (2021/2022) to 100 (2022/2023). Of the 100, this reflected 96 standalone concerns. NB – the national guidance requires Trusts to report on numbers of *individuals* approaching the Guardian.
- This increase may further reflect the renewed communications and reminders of the FTSUG role and offering varying ways of accessibility.
- The most common reasons for concern raised has changed since 2021/2022. The most common being general support (21), inappropriate behaviour (20) and concerns about role (16). During 2021/2022 the most common reasons for concerns were inappropriate behaviour (13), bullying behaviour (11) and HR processes with concerns about unfairness (11).
- The concerns regarding general support mainly concerned specific queries about an individual's employment, improvement ideas or where an individual had concerns about a different department or area of the Trust.
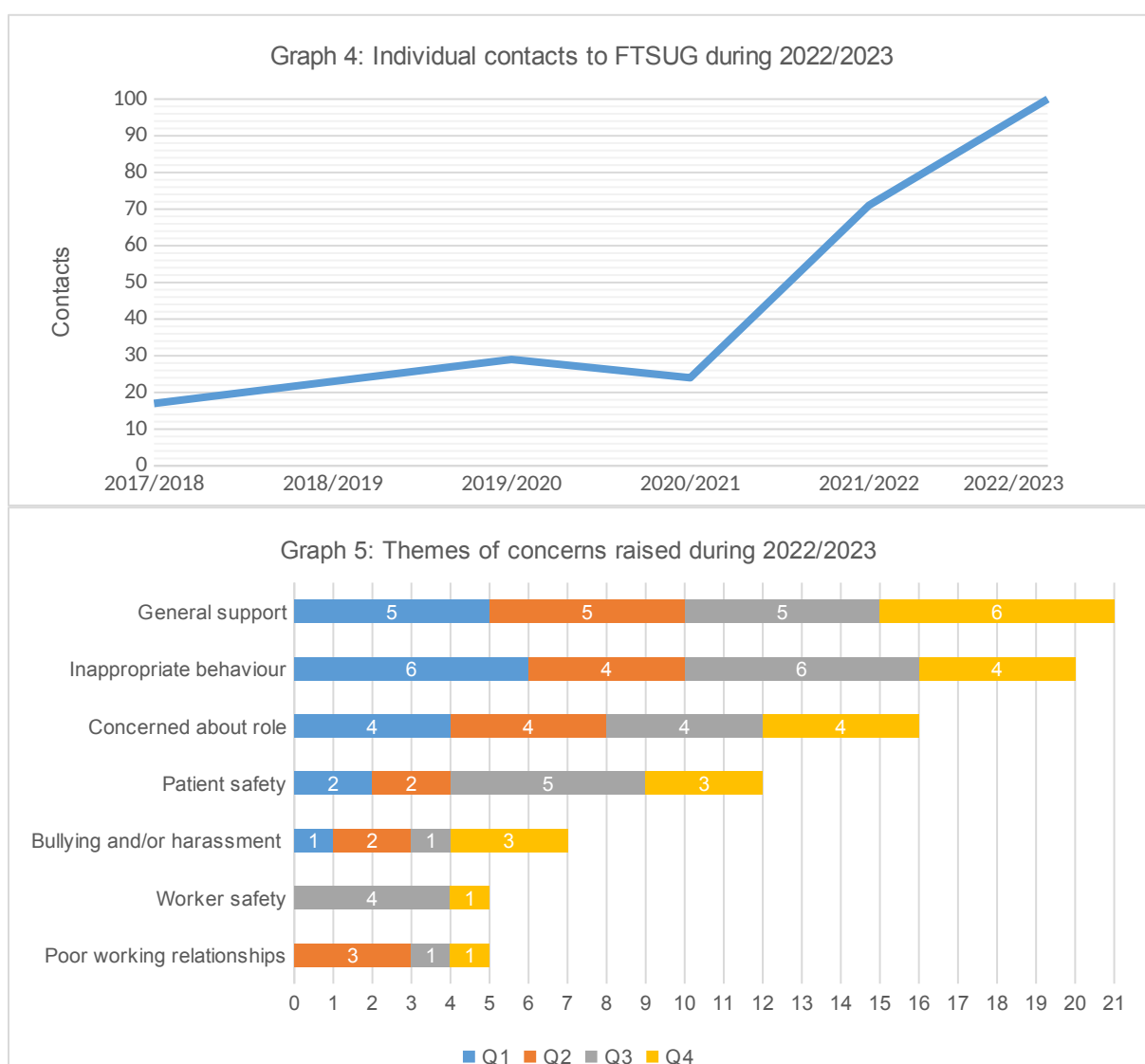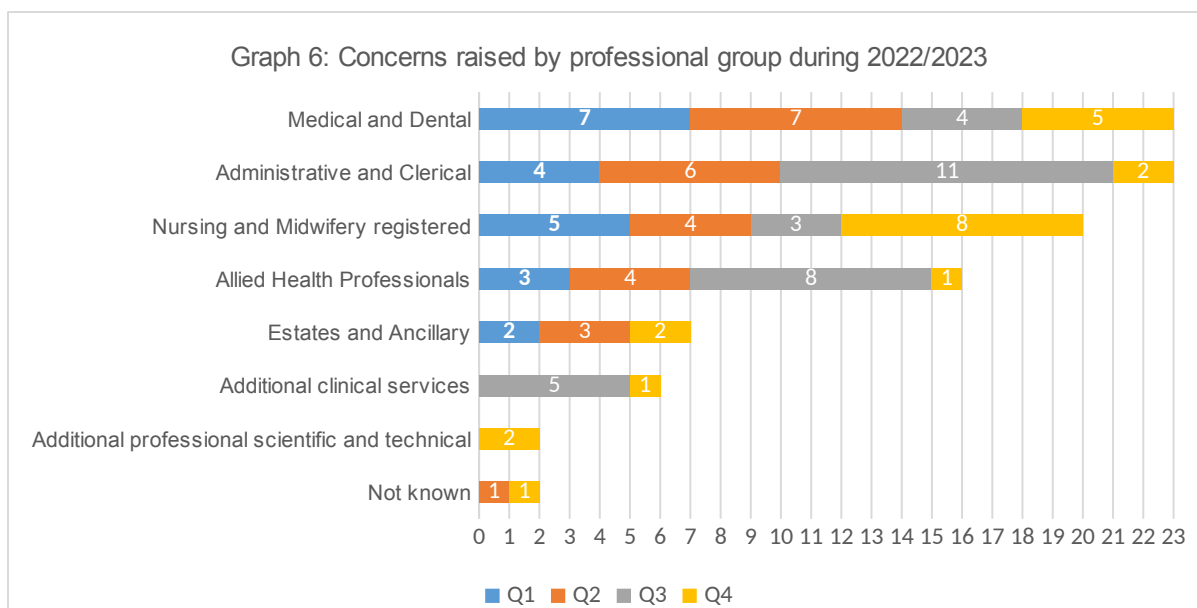- Administrative and Clerical and Nursing and Midwifery roles equally were the most common staff group to raise concerns. The NGO staff group's guidance has changed during 2022/2023 and therefore the FTSUG will monitor in the coming year a comparison of staff approaching the FTSUG.
- 3 out of 100 concerns were reported to the FTSUG anonymously, and the FTSUG did not know the identity of the individual. Support was provided where possible in these cases.
- In the event an individual has consented for the FTSUG to assist in escalating concerns; the FTSUG has been received positively with managers wanting to assist the individual in resolving the concerns.

5. NHS England and Improvement national requirements

NHS England have published a new national Freedom to Speak Up policy and in conjunction with the National Guardian Office, a revised self-reflection and planning tool for Boards.

NHSEI are asking all Trust Boards to be able to evidence by the end of January 2024:
- An update to their local Freedom to Speak Up policy to reflect the new national policy template.
- Results of their organisation's assessment of its Freedom to Speak Up arrangements against the revised guidance and;
- Assurance that it is on track implementing its latest Freedom to Speak Up improvement plan.

5.1 New Board Self-Reflection

On 8th February 2023 Trust Board held a Board development session to discuss the self-reflection and planning tool and resulting improvement plan and identification of strengths in the speaking up arrangements. This document was approved at Trust Board on 14th March 2023 and progress reports

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will be received at future meetings. The first progress report on the plan is detailed in Appendix 1 of this report.

5.2   New national speak up policy

The FTSUG has commenced an initial review of the new national policy, including commencing discussions with the HR Team. The national policy has been converted into the HUTH policy template and circulated to internal stakeholders in preparation for ratification at the Workforce Transformation Committee on 20th July 2023.

6.   Conclusions

The Trust continues to support the FTSUG role and it is positive that the number of individuals approaching the FTSUG has increased further. The FTSUG continues to work to build networking and relationships with key individuals and teams across the Trust, and referrals between the FTSUG and other staff support services have been positive.

7.   Recommendations

The Trust Board is asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

Freedom to Speak Up Guardian
July 2023

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Appendix 1:
Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner	Progress update
1. Scheduled assessments and review of associated improvement programmes of speaking up arrangements.	30/06/23	Executive Lead	**Action completed** Repeat self-assessment of the Board Self-Reflection will be scheduled no longer than two years from the previous assessment (February 2023). Executive Lead committed to ensuring this has been completed.
2. Continue to grow contacts via the champions and promotion to identify themes for learning and improvement programmes.	31/03/24	FTSUG	**Action in progress** 5 further Speak Up Champions recruited and trained during March, April, May and June 2023.
3. Continually review the speak up champion network, to promote champions within different staffing groups and at different levels across the Trust.	31/03/24	FTSUG	**Action in progress** Bimonthly training dates booked until end of 2023.
4. Update the 2023 speaking up communications plan. To include: • Clear messages that detriment will not be accepted or tolerated at HUTH. • Communication of the new national speak up policy once ratified. • Further reminders about the availability of the e-learning modules as self-managed learning. • Incorporate, where possible, positive stories of speaking up.	31/12/23	FTSUG Request communications from senior leaders.	**Action in progress** • New national Speak Up policy has been circulated to stakeholders and will be provided for ratification at the Workforce Transformation Committee on 20th July 2023. • Joint drop in session with the York and Scarborough NHS Teaching Hospitals NHS Trust held for SHYPS staff 27th July 2023. • Joint drop in session with the Chief Nurse scheduled for August 2023.
5. Launch the feedback survey for staff who have spoken up to the FTSUG. To include: • Consideration will be given to including a question regarding whether they experienced positives behaviours that	31/03/23	FTSUG	**Action in progress** • Question about whether the individual had experienced positive behaviours when speaking up considered and included in the

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			feedback survey.
encouraged them to speak up. • Include in the feedback survey for staff members approaching the FTSUG, a question asking how the staff member knew about the FTSUG role. Review this data and identify any improvements to widen the awareness of the role and speaking up. • Monitor the feedback survey responses for information on staff subject to detriment and where possible, to understand the circumstances. • A free text box if respondents are comfortable feeding back their experiences. Review the answers from the feedback survey, and include any appropriate case studies (with consent of the staff member) in future Board reports.			• Question about referral route and awareness of the FTSUG role included in the feedback survey. • Free text box included in the survey to include permission to share stories of speaking up.
6. Review our programmes of delivery to ensure that the FTSUG process and person is clear/explicit. This would be done with better involvement of FTSUG operationally in content creation. This is alongside being explicit how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbiotic way as a leader.	31/03/24	Head of Organisational Development	
7. Bring clear speak up processes into our bespoke cultural transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an "internal consultant" to bring expertise into bespoke work design.	31/03/24	Head of Organisational Development	**Action in progress** FTSUG invited to join the new Circle Group for Maternity and Cardiology and to be involved in the ongoing concerns that are raised. Maternity reporting concerns tool now live.
8. Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators.	31/03/24	Head of Organisational Development	
9. Development of a Trust wide Professionalism and Kindness programme that supports just and speaking up culture.	31/03/24	Head of Organisational Development	**Action in progress** Work completed on initial programme, to be trialled in Maternity.
10. Implementation of the new NHS England speaking up policy. To include: • Implement the new NHS England speaking-up policy before January 2024. This is also an action recorded from an audit	31/12/23	FTSUG	**Action in progress** • National policy transferred into HUTH template and personalised. • Due to be presented for ratification at the

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of the speaking up service conducted during December 2022. • Review the new national speak up policy template and include reference to the processes if a staff member feels subject to detriment.			Workforce Transformation Committee on 20th July 2023.
11. Involve key stakeholders (e.g. Staff Support Networks) in the consultation process of the policy.	31/03/23	FTSUG	**Action completed** Draft policy sent to internal stakeholders for information/comment. Including Executive Lead, Director of Workforce, Head of Workforce, Head of HR, Disability Staff Network Chair, BAME Staff Network Chair, LGBTQ+ Staff Network Chair, JNCC Chair, LNC Chair, Equality Diversity & Inclusion Trust Lead.
12. Review with the Organisational Development Team whether it is appropriate for speak up training to be incorporated into any of the programmes of delivery.	31/05/23	FTSUG	**Action completed** Discussed with Head of Organisational Development the inclusion of the speak up e-learning into existing leadership development courses and future line manager training.
13. Review what triangulation of data is possible including what data can be obtained e.g. patient safety, staff survey. Link with action 8 above.	31/03/24	FTSUG	**Action in progress** FTSUG conducted a breakdown per Health Group of the staff survey 2022 results. Presented information within the Health Group Governance briefing reports.
14. Review the self-reflection and planning tool outputs from at least two other Trusts. Identify any best practice applicable to HUTH and incorporate into the Freedom to Speak Up improvement plan.	31/12/23	FTSUG	**Action in progress** • Reviewed and shared with Northern Lincolnshire and Goole NHS Foundation Trust. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber.
15. Implement requesting for feedback from senior nursing staff when concerns are escalated directly by the FTSUG, as per	31/03/23	FTSUG	**Action completed** Ongoing progress as appropriate

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the request of the Chief Nurse.			
16. Create a freedom to speak up strategy. To include: • Inclusion of this improvement plan created by the Board self-reflection and planning tool. • Regularly review the freedom to speak up strategy and improvement plan and report on progress updates to the Trust Board on a regular basis.	31/03/24	FTSUG	

Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner	Progress update
1. Share speak up arrangements with other Trusts. To include: recruitment and ring fenced time for the role, locally agreed absence arrangements, creation of the speak up champions network, involvement with other services across the Trust and being an ally of each staff network.	30/09/23	FTSUG	**Action in progress** • Reviewed and shared with Northern Lincolnshire and Goole NHS Foundation Trust. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber.

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REFERENCES

📄 9.4 - GOSW Annual Board Report.pdf

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING 2022-2023

Agenda Item		Meeting	Trust Board June 2023	Meeting Date	
Title		Annual report on rota gaps and vacancies: doctors and dentists in training 2022-2023.			
Lead Director		Makani Purva – Chief Medical Officer			
Author		Mahmoud Loubani – Guardian of Safe Working			
Report previously considered by (date)		Annual report on rota gaps and vacancies: doctors and dentists in training 2020-2021.			

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	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	
Assurance	Y	Staff Confidentiality		Caring	Y	High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive	Y	Great Clinical Services	
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
The Board is asked:
• to note the findings of this report, which should be regarded as a baseline for future reports
• to support the development of a coherent strategy for the medical workforce and its support by non-medical practitioners and other staff.

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Executive summary

This paper provides an annual summary of gaps and exception reports received by the department for each quarter from April 2022 to March 2023 at Hull University Teaching Hospitals NHS Trust, together with a plan to improve these gaps.

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Professor Mahmoud Loubani started in the role as Guardian of Safe Working from September 2020 and is responsible for monitoring the safe working of junior doctors within the Trust. This relates to their working hours, service support available and education/training opportunities.

From April 2022 to March 2023 exception reports submitted included a wide range of themes. Many offline rotas were discovered due to the e-Roster roll out, as medical staffing were able to have an enhanced line of communication with the trainees they were able to encourage exception reporting for any variance against their work schedule. There has been an increase in educational exception reports due to a greater interest in SDT hours taken by foundation and GP trainees. Other reports were received for many isolated incidents requiring trainees to work additional hours to maintain patient safety.

Introduction

This report provides a summary of information from April 2022 – March 2023.

High level data (As of 31 March 2023)

Number of doctors / dentists in training (total):   574.4 (April 22 – March 23)

Number of doctors / dentists in training on 2016 TCS (total):574.4 (April 22 – March 23)

Annual average fill rate among this staff group: 89.3% (April 22 – March 23)

Annual data summary

The following table shows the rota establishment rate in comparison to how many trainees are in post from April 2022 to March 2023. This is a combined summary of the data from the previous four quarterly reports.

Summary of Rota gaps and vacancies.

The board has received quarterly updates throughout the year on the gaps across the different specialties and grades.

There are consistent gaps in the following departments:

- Breast Surgery (65.00% Fill Rate) – There have been a number of trainee vacancies across the year at Core Trainee (CT) and Speciality Trainee (ST) level. The CT vacancies have been consistently filled with Locally Employed Doctors. There is an agreement that the ST vacancies caused by NHSE can be filled by Acute/General Surgery as they contribute the this rota out of hours and these have again been filled using Locally Employed Doctors.
- OMFS (54.15% Fill Rate) – This department has consistent and long standing trainee vacancies at CT level. The department does try to fill these by recruiting locally but has small numbers of suitable candidates so often doesn't fill all the vacancies that they have in their establishment.
- Paediatric Surgery (37.50% Fill Rate) – There have been a number of trainee vacancies across the year at CT Level. These vacancies have been consistently filled with Locally Employed Doctors.
- Histopathology (81.25% Fill Rate) – This department has a small number of Specialty Trainee and often has a vacancy. The department doesn't advertise to recruit to any of their vacancies locally.

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Department	Quarter 1		Quarter 2		Quarter 3		Quarter 4		
	Rota Establishment	In Post	Rota Establishment	In Post	Rota Establishment	In Post	Rota Establishment	In Post	Average
Academic, GP, Psych & Community	125	119.5	143	127.3	149	132.3	137	123.3	90.85%
Acute Medicine	23	21	27	20.8	27	21.8	26	21.6	85.26%
Anaesthetics	57	57.1	56	51.4	56	51.4	58	52.6	93.63%
Breast Surgery	5	4	5	3	5	3	5	3	65%
Cardiology	16	15	17	14	17	14	17	14	85.25%
Cardiothoracic Surgery	6	6	7	6	7	6	7	6	89.28%
Chemical Pathology	1	1	1	1	1	1	1	1	100%
Colorectal Surgery	11	10.8	12	10.8	12	10.5	12	10.5	93.92%
Dermatology	2	2	2	2	2	2	2	2	100%
Elderly Medicine	27	24.2	27	21.4	27	22.4	27	23.8	87.83%
Emergency Medicine	47	41.6	46	43.4	46	43.4	46	44.7	93.58%
Endocrinology	11	11	9	7	9	8	9	8	88.9%
ENT	11	9.3	12	9.6	13	11.6	13	12.6	87.65%
Gastroenterology	12	13.4	11	11	11	7.8	11	7.8	88.38%
General Surgery	1	1	1	1	1	1	1	1	100%
Haematology	10	9.8	10	8.2	9	8.2	9	8.2	90.55%
Histopathology	4	3	4	3	4	3	4	4	81.25%
Immunology	2	2	1	0	1	0	1	0	87.5%
Infectious Diseases	9	8	10	8	10	9	13	11.3	86.45%

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Neurology	12	10.6	13	12.8	12	12	12	12	96.7%
Neurosurgery	8	6	8	7	8	7	8	7	84.38%
Obstetrics & Gynaecology	26	23.8	24	23.8	24	23.8	24	23.6	97.05%
Oncology	12	11.4	17	14.2	17	15.2	15	13.6	89.65%
Ophthalmology	8	7	8	8	8	8	8	8	96.88%
Oral & Maxillofacial Surgery	12	5	12	7	12	7	12	7	54.15%
Paediatric Neonatal Medicine	14	14.4	14	14.4	14	14.4	14	14.1	102.35%
Paediatric Surgery	2	1	2	1	2	1	2	0	37.5%
Palliative Care	2	2	2	1.8	2	1.8	2	2.4	100%
Plastic Surgery	10	9.6	9	8.2	9	8.4	9	8.8	94.55%
Paediatrics	24	23.3	21	18.6	21	17.6	21	14.9	85.12%
Radiology	42	38.9	29	28.4	29	27.4	29	27.4	94.88%
Renal Medicine	10	9	12	10	12	11	12	11	89.175%
Respiratory Medicine	20	18	20	16	20	17	20	19	87.5%
Rheumatology	6	5.8	6	6	6	6	6	6	99.18%
Stroke Medicine	1	1	1	2	1	2	1	2	175%
Trauma & Orthopaedics	17	17	17	14.8	17	14	17	16	90.9%
Upper GI	14	12	14	14.6	14	13	14	12	92.15%
Urology	9	8	9	9	9	8.2	9	7.2	90%
Vascular Surgery	9	6.8	9	8.8	9	8	9	7	85.03%
Total	**638**	**590.3**	**648**	**575.3**	**653**	**579.2**	**643**	**574.4**	**86.82%**

4

Summary of exception reports.

There have been a total of 697 exception reports submitted between April 2022 and March 2023.

Exception reports submitted per month
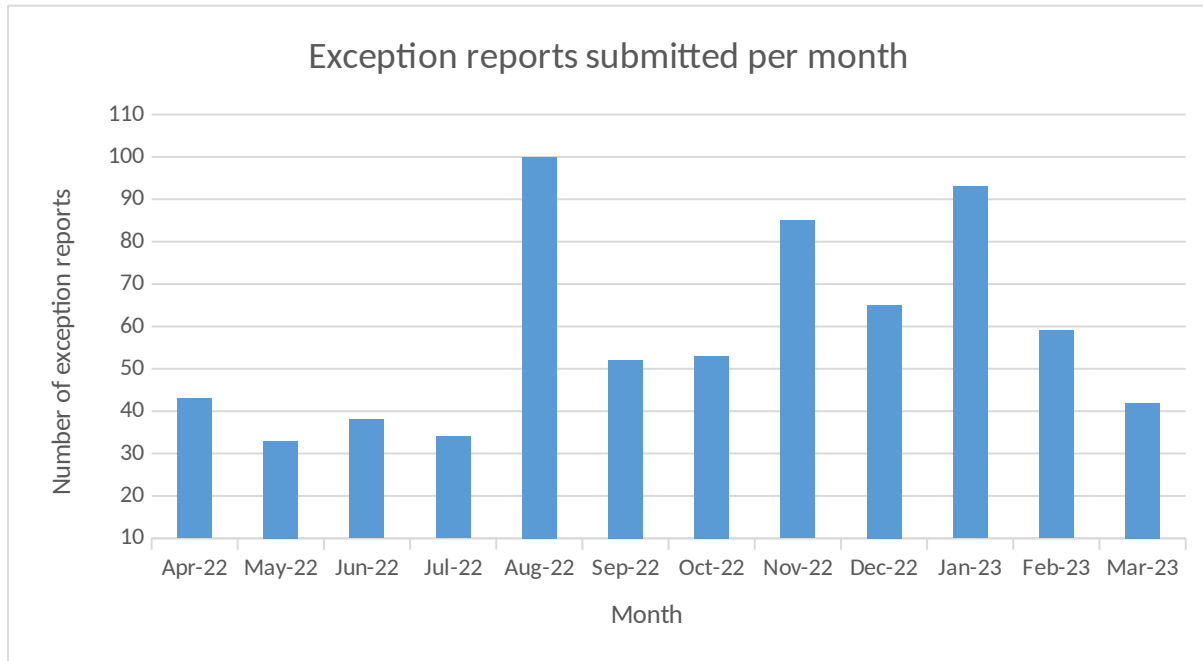
As it takes time to settle into a new Trust with a change in systems a spike in exception reports can be seen, this is experienced each year during rotation dates. In the summer of 2022 the e-Roster roll out began, this project works to upload all rotas to the online rostering system and have the majority of rotas managed centrally by the Medical Staffing team. As shown above there is an increase in exception reports received after the project began. This is due to having access to offline rotas which are a most frequently a varied version of the working pattern previously issued by medical staffing. As there is now an enhanced line of communication between trainees and medical staffing exception reporting is further encouraged. Other contributing factors highlighted in this report identify why the latter end of the year receive increased number of exception reports.

5

Number of exception reports sumbitted in Q1 April - June 2022
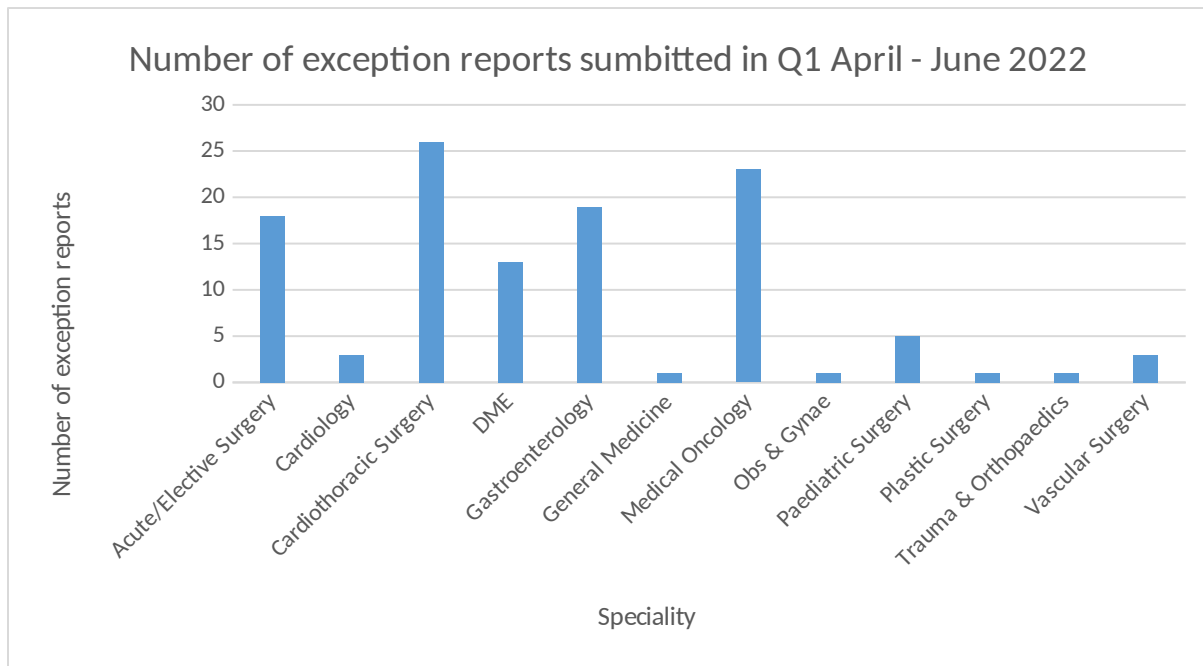
Within the first quarter Cardiothoracic Surgery received the highest number of exception reports submitted from trainees within the department. A particular trainee working in Cardiothoracic Surgery submitted 19 exception reports relating to a four month period of working additional hours beyond their contracted duty, they were used for data collection purposed due to being submitted outside of the contractual time frame. Similarly in Oncology a small number of trainees submitted a high quantity of exception reports highlighting the requirement to redesign the rota. In all other specialties usual numbers of reports were received due to service demand, low staffing meaning trainees more frequently worked additional hours to maintain patient safety and complete jobs such as IDL's.

6

Number of exception reports submitted in Q2 July - September 2022
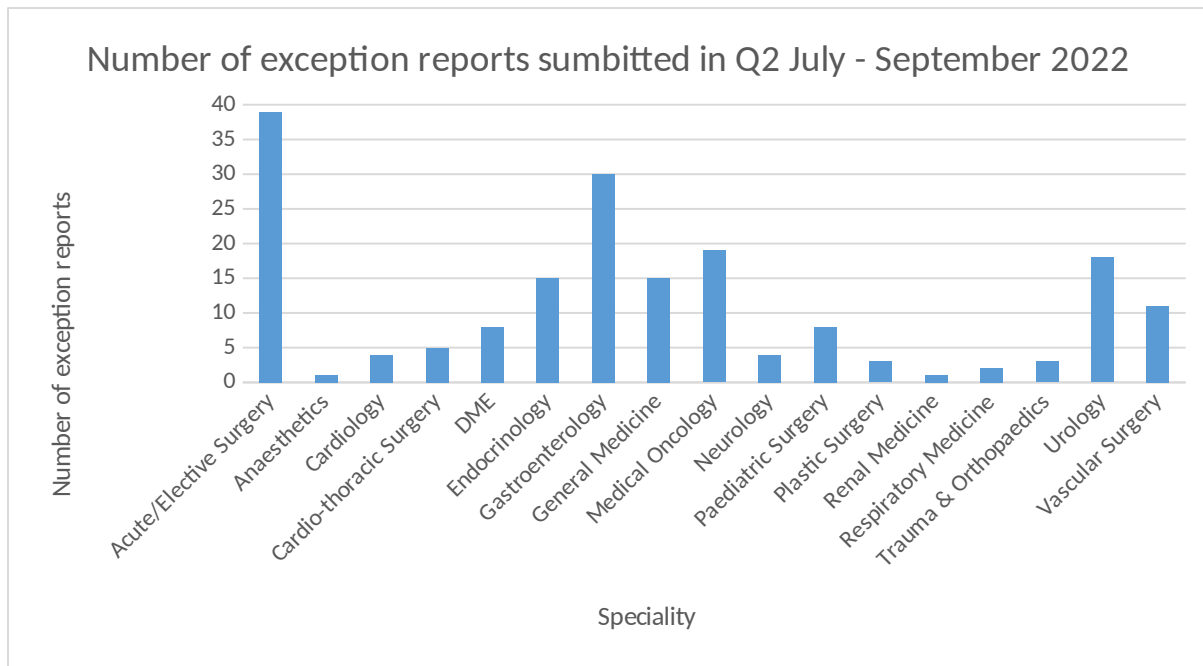
Within the second quarter the August rotation takes place which always shows a rise in submission of exception reports. Specifically within Acute and Elective majority of these were submitted by foundation trainees as there is a high number allocated to the departments. Across all specialty's above trainees reported longer clerking time as they familiarised themselves with departmental workings and new systems.

7

Number of exception reports sumbitted in Q3 October - December 2022
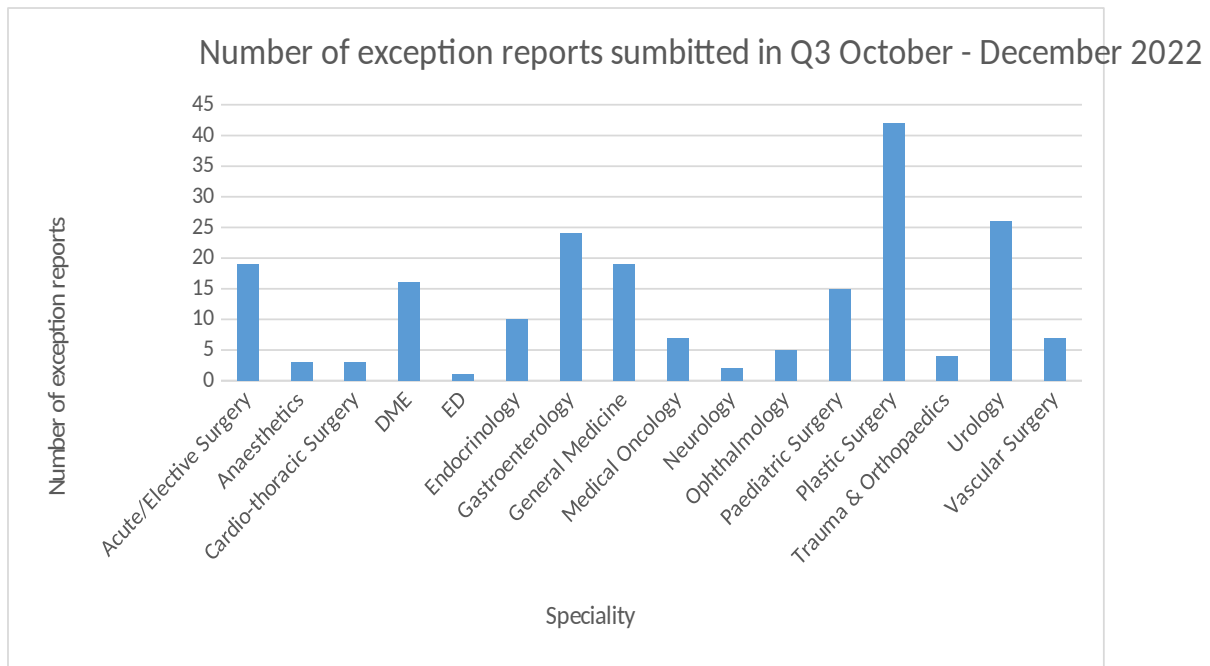
During this quarter Plastic Surgery were recognised as working an offline rota although it was compliant the service demand had changed significantly from when the rota was initially built. This meant they were being called out more than what was detailed in the working pattern. To update their work schedules the rota was taken through the organisational change policy process which requires notices periods to be met this means the full resolution was across two quarters as seen in the below graph. Urology also experienced similar issues with an offline rota managed within the department, this demonstrates the importance of the e-Roster roll out project allowing for greater sight over the rota.

8

Number of exception reports sumbitted in Q4 January - March 2023

In the fourth quarter which saw the first period of ongoing junior doctor industrial action, as a result there was an increase in submission of exception reports across many specialities. No exception reports were received over the industrial action period however a number were received afterwards due to increased workloads. As previously mentioned a significant amount were received form Oncology and Plastic Surgery to gather data allowing the rota to be redesigned to a more accurate working pattern.

Amount Paid in Fines

A bar chart titled "Amount Paid in Fines" with the y-axis labelled "Amount charged to departments from Fines (£)" ranging from 0 to 50000, and the x-axis labelled "Axis Title" with categories: Surgery, Clinical Support, Family & Womens, and Medicine.

- Surgery: 23
- Clinical Support: 2
- Family & Womens: 56 (approximately £44,500)
- Medicine: 1

Summary of Fines

The Trust has incurred 69 fines from April 2022 to March 2023 which totals to the amount of £46, 532.18. This includes £17451 which was paid to the trainees and £2545.75 to the Guardian of Safe Working funds.

During the JDF the Guardian of Safe Working budget is discussed and decisions are agreed on how it should be spent.

Below are examples of some of the fines issued (April 22 – March 23):

- An ST5 in Paediatric Surgery was required to remain onsite for their NROC shift from 08:00 – 08:00 after working the resident proportion of their shift until 5pm the workload remaining mean they continued on site, then attended two surgeries overnight and a further patient who required senior review, this incurred several fines for multiple rule breaks.
- An ST1 in Orthopaedics was required to carry a bleep and cover additional wards and duties due to vacancies and sickness meaning there was reduced staffing. This meant that their shift was over 13 hours and consequently meant they worked more than 72 hours in a week, breaching two rules.

As the family and women's health group began in the first phase of the e-Roster roll out, a detailed investigation was done into each rota to ensure it was uploaded to e-Roster correctly. This meant that for rotas such Plastic Surgery where they were being called out multiple times through NROC shifts adequate rest was not received. As the other health groups have further investigations similar circumstances may arise.

10

Junior Doctors Forum (JDF)

The Junior Doctors Forum takes place on the second Friday of each month. Representatives for each grade attend as well as any other trainees that want to attend. There are different members of staff from all across the Trust that attend the JDF to provide support for the trainees. The purpose of the meeting is to allow junior doctors to raise and highlight any concerns or issues that they have experienced in addition to this the Guardian of Safe Working is able to provide feedback on trends that have been recognised through exception reporting. Since Covid the JDF has been held virtually and increased attendance has been recorded, the JDF group has agreed for the meetings to continue virtually in the near future. All monthly papers are uploaded to the staff intranet after approval from the Chair and JDF Group ensuring there are an accurate depiction.

Actions taken to resolve issues

One of the current actions being taken, to ensure that the Trust is compliant with the Junior Doctors Terms and Conditions, is working to ensure all departments are using the E-Roster system fully. This allows the Guardian of Safe Working to monitor the working hours of trainees, it will automatically flag an issue if a rule has been broken and it is no longer practicing safe working. When an exception report is submitted in relation to a difference in hours worked, E-Roster is able to be updated with the hours actually worked and it will highlight if any rules have been breached. Medical Staffing are continuing the roll out of e-Roster the benefits of this system supporting our junior doctors are already evident.

Detailed in last years annual board report were the issues surrounding Phlebotomy and the necessity for juniors to complete the role of phlebotomists. As a result a business case was built include evidence from exception reporting, after approval 9 phlebotomists were employed and no further exception reports have been received since. On the other hand the similar issue with ECG's have been reoccurring. The Guardian has met with departments to reach a resolution with nursing staff who will be upskilled and later able to complete ECG's without having to ask trainees.

From April 2022 to March 2023, 65 exception reports were submitted in relation to missed education or training opportunities. This continues to be an issue as trainees workloads in combination with staffing problems meaning that they are unable to take their rostered self-development time within the working week to complete their ARCP. There are ongoing discussions regarding SDT which also remains a standard JDF agenda item, the possibility of having SDT rostered is likely to be explored as the e-Roster roll out continues.

The 2016 doctors and dentists in training terms and conditions has been updated to allow the Guardian of Safe Working to intervene on review of exception report to reach a conclusion should one not have been reached within the time frames detailed in the contract. We continue to work with the software provider on updates to improve user experience.

Questions for consideration

The Workforce, Education and Culture meeting has requested to receive this report and decide if the report provides sufficient information and assurance and decide if any further information / actions are required.

REFERENCES

📕 9.5 - WECC Summary Jun 23.pdf

Item: Staff Support Services Update	Level of assurance gained: Reasonable

A Trust Health and Wellbeing Lead has been appointed on a 12-month secondment, currently there is no funding for this role after 12 months which is a risk for the Trust.

The staff psychology support has been in place for 2 years and has expanded to support both individuals and teams. Permanent space for staff wanting to be seen for 121 psychological support on HRI site is a challenge.

REACT training will soon be launched, which is similar to mental health first aid to provide staff with the skills to provide peer to peer support.

Item: Talent Management	Level of assurance gained: Limited

The talent management team have redeveloped appraisals to include toolkits and conversation guides, supported career progression within nursing and commissioned positive action programmes for BAME and Disability leadership programmes.

The OD team are under significant pressure and do not currently have the capacity to progress new developments and run structured talent management programmes.

Item: Medical Undergraduate Progress Report	Level of assurance gained: Reasonable

The Trust performance for Year 1-3 teaching has improved over the last two years. One of the challenges is the delivery of Year 4 teaching, particularly in Women's Health (WH). Two new consultants have been appointed with 1 PA in their job plans to deliver teaching. An ST6 trainee from WH has taken 12 months out of training to work as a CTF to support students with teaching.

Physical space is a challenge for teaching due to the increase in student numbers additional to the loss of dedicated teaching rooms. An audit will be completed to identify what teaching rooms are available across the site. A joint piece of work will be undertaken by the Clinical Dean, Interim Chief Nurse and Head of Learning & OD to assess training space within the Trust.

Item: Guardian of Safe Working Q4 & Annual Report	Level of assurance gained: Reasonable

The Trust is having discussions with the JDF and BMA regarding junior doctor additional pay rates. Multiple exception reports have been received regarding foundation doctors and GP trainees being unable to use their self-development time. The roll-out of eRoster is progressing. The issue of trainee's having to complete ECGs that was thought to be resolved still remains an issue

The new Junior Doctors Mess has opened in HRI and has been well received by the junior doctors.

Item: Staff Survey Update	Level of assurance gained: Limited

The Director of Communications presented the progress to date of the actions from the staff survey and a number of actions taken by the Health Groups.

Item: Employee Relations Progress Report	Level of assurance gained: Substantial

The average length of cases has increased due to a number of cases that have time constraints that are not within the Trust's control, a stop the clock will be implemented going forwards.

The data shows that male colleagues are more likely to be included in employee relations cases. The data shows that BAME colleagues are no more likely to be involved in a disciplinary process than white colleagues. EF&D have more employee relations cases than they have staff in the Trust proportionately.

Item: Trade Union Facility Time Requirements	Level of assurance gained: Substantial

No issues were raised regarding the Trade Union Facility Time Requirements report.

Item: Nursing and Midwifery Staffing Report	Level of assurance gained: Substantial

The Interim Chief Nurse advised the number of CHPPD significantly increased in April 2023, there was a reduction in patients but the reduction was not proportionate to the increase.

The nursing workforce has the potential to be over-established by September 2023, which will provide resilience for winter.

Item: People Strategy Performance Report	Level of assurance gained: Substantial

The Director of Workforce and OD advised that an action plan is in place to improve statutory / mandatory training and appraisal levels.

REFERENCES   Only PDFs are attached

📄 10 - PAF_PerformanceReport_June23_Final.pdf

Agenda Item		Meeting	Performance and Finance Committee	Meeting Date	26th June 2023
Title		Performance Report			
Lead Director		Ellen Ryabov – Chief Operating Officer			
Author		Louise Topliss – Assistant Director of Operations (Operational Performance)			
Report previously considered by (date)					

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 Performance and Finance Committee is asked to receive, discuss and accept this update on key performance issues.

Performance and Activity Report
May 2023 Performance

April 2023 for Cancer data

Produced June 2023

Table of Contents

1. Executive Summary

Areas requiring improvement	
Urgent Care performance – ED and Ambulance handovers	• For May 2023, the Ambulance handover position deteriorated slightly against the April position and was just under the Improvement trajectory. Delivering 62.8% of Handovers within 30mins (target 63.6%). The average time for Handover was 38 minutes. • ED missed the improvement trajectory for the 4hr Quality Standard in May 2023 (55%) delivering 49.3% for Type 1 activity. • The number of patients in May 2023 with No Criteria to Reside continues to be the single largest factor affecting performance (although beginning to see a slight decrease) with a daily average of 197 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. Year to date there has been a 12% increase in 2WW referrals received. • In April 2023, the Trust failed to achieve the cancer waiting times' national standards. The combined Faster Diagnosis Standard (FDS) performance was just below target at 73.8%. In performance terms, long wait backlogs (+63 and +104 days) and FDS are the core metrics. • The number of patients on the 62-day Cancer PTL is beginning to reduce again to ~1,500 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. The new recovery trajectory to be achieved

	by 31 March 2024 is no more than 148 patients waiting 63 days or more.
	• The Trust has been formally advised that due recent deterioration (following the steady progress of the +63 day backlog), we continue to be monitored through the Tier 1 process. Whilst this is disappointing, services and all concerned will strive to recover the position following industrial action and Bank Holidays which have negatively impacted on the number of patients in the backlog. The impact being loss of tracking days, loss of theatre and OPA sessions, surgical capacity in urology and Gynae-oncology, and ongoing capacity issues in oncology & radiotherapy are contributing factors to the current backlog position.
	• 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, with MDT leads attending some meetings to consider further opportunities for improvement.
	• 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.
	• The NHSE Improvement Support Team (IST) have been invited to review our systems and processes by comparison to the national Cancer Waiting Times rules, and good practice from other organisations.

Recovery of elective activity	• Recovery of elective activity in May 2023 against the operational plan:
	   ○ New Activity 106%
	   ○ Follow up Activity 109%
	   ○ Day Case Activity 97%
	   ○ Ordinary Elective Activity 90%
	
	• The 23/24 operational plan has a requirement to reduce outpatient follow ups without a procedure by 25% of the 19/20 baseline. In May 2023, follow up activity was 109% of the plan and 103% of baseline. There is on-going analysis and improvement projects linked to outpatient pathways to support this operational requirement, and a range of

	• performance discussions at Health Group 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. Additionally, many OP follow up activities are actually a procedure, albeit not attracting an HRG and work is underway to quantify this activity and address any data quality issues. • Ward C9a opened as a 7-day ward from 15 May 2023 to support the recovery for orthopaedics and neurosurgery, however in an attempt to create a firebreak for VRE on the 12th floor, the staffing resource has been moved to H1 and C9A is currently closed. • Mutual aid (largely 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	• The Trust was stepped down to a Tier 2 trust for long waits from November 2022 (regional oversight & assurance). • At the end of May 2023, the Trust reported zero x 104 week waits and 53 x 78 week wait breaches, a reduction from the position at April 2023. The Trust is forecasting zero breaches for the end of June 2023. • 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. • 3,654 patients have waited more than one year for their appointment/procedure, this is below the trajectory of 5,328.
Reducing the delays in people leaving acute setting	• In May 2023, there were 197 (average) patients per day with NCTR. This is 18% of the total general and acute beds and 28% of beds at HRI (total G&A 698 HRI/398 CHH). • NCTR patients who should be receiving appropriate care elsewhere with the support of other partner organisations or settings.

2. Emergency Care Standards – 4 hour Performance

ED: Standard Performance Type 1 & 3

	Variation		Assurance	
	Common Cause		F.	Not capable
	Value	62.3%	UCL	72.56
	Target	95.0%	Mean	65.18
			LCL	57.80

Description
The percentage of patients that are discharged, admitted or transferred within four hours of arrival (Type01 and 03).
Numerator: The number of patients that are discharged, admitted or transferred within four hours of arrival at A&E.
Denominator: The number of patients that are discharged, admitted or transferred from A&E.

Percent — Target — LCL — Mean — UCL ● Common Cause ● Concern ● Improvement ● Neither
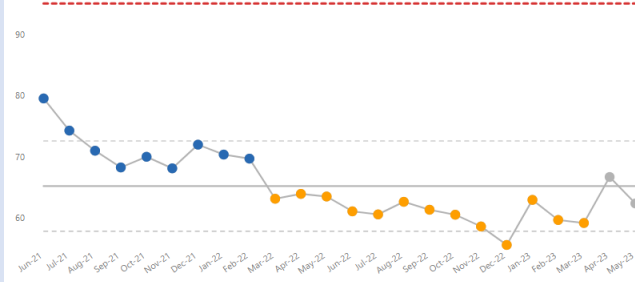
ED: Attendances Type 1 & 3

	Variation		Assurance	
	Common Cause		N/A	N/A
	Value	17,893	UCL	19.02K
			Mean	16.85K
	Baseline		LCL	14.69K

Description
The number of ED attendances (Type01 and 03)

Numeric — Target — LCL — Mean — UCL ● Common Cause ● Concern ● Improvement ● Neither
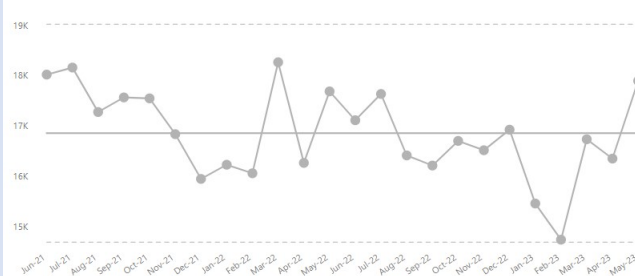
What the chart tells us
The 4-hour performance delivery remains fairly static, although is significantly below the required standard. In May 2023, performance was 62.3% for all attendance types and above the improvement trajectory.

Intervention and Planned Impact
- CDU for Nurse Led pathways to be implemented from 22nd May 2023. These pathways historically breach in ECA as awaiting timed treatment/results.

- 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. This was delayed due to states work until W/C 19th June.

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.

- New NCTR build is going to accommodate existing patients from Rossmore and therefore will only create 18 additional spaces not the 60 originally planned.

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
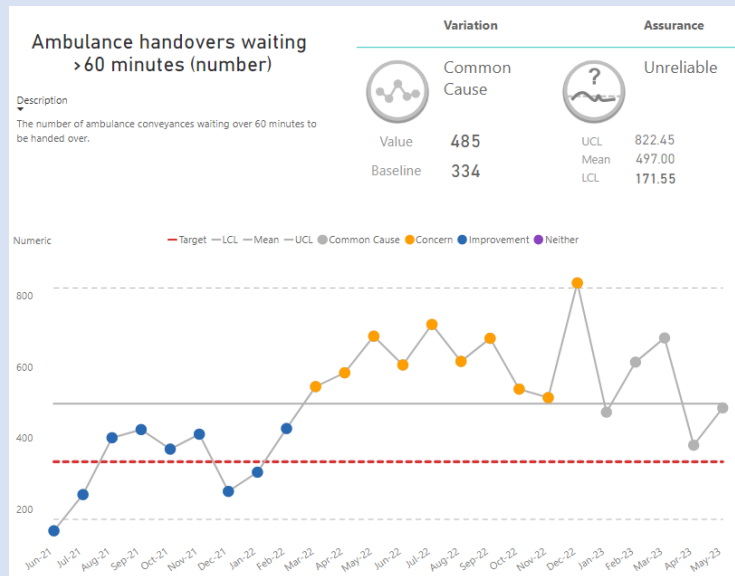
What the chart tells us
There were 485 waits over 60 minutes reported in May 2023, which equated to 16% which is an improved position.

Intervention and Planned Impact

- From the 19th June Co-horting by HUTH will be available 24hrs

- 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. This has been delayed YAS have a number of improvement programmes to be prioritised.

- In May 2023 the Trust delivered 62.8% of Ambulances against a trajectory of 63.6%. The average handover time was 38 minutes.

Risks / Mitigations

- Flow remains challenged as the number of patients with No Criteria to Reside, who are unable to be discharged, are occupying over 18% of the overall bed base.

- YAS are unable to use the EPR to capture the early handover of Resus Patients. This is currently being tested.

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

ED: 12 hour trolley waits

	Variation	Assurance
	Common Cause	Not capable
Value	**300**	UCL 440.98
Target	0	Mean 252.00
		LCL 63.02

Description
Number of Patients who have attended ED and had a trolley wait of over 12 hours
Numerator: Number of patients who attended ED with and spent 12 hours on a trolley

Numeric

Legend: —Target —LCL —Mean —UCL ● Common Cause ● Concern ● Improvement ● Neither

Day of Week Number	1	2	3	4	5	6	7	Total
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	
ED Departures (Type 01)	1,831	1,851	1,738	1,455	1,408	1,305	1,327	10,915
ED 12 Hour Trolley Breaches	37	65	68	41	26	25	32	294
ED 4 Hour Standard Performance (Type 01)	48.4%	49.6%	48.3%	53.3%	48.2%	47.0%	50.2%	49.3%

ED 12 Hour Trolley Breaches by Date

What the chart tells us

There were 300 x12 hour trolley wait breaches in May 2023 with the longest wait from Decision to Admission (DTA) of 27 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 May 2023 was that 10.2% of patients (1,110 patients) waited over 12 hours against a national tolerance of 2%.

Intervention and Planned

- There has been sustain improvement in the number of lodged patients moved by 10am and starting to see an increase in the number moved by 14:00

- Mental Health Streaming facility was delayed from end of May 2023 due to be operational from 19th June 2023.

Risks / Mitigations

- High numbers of No Criteria to Reside patients, outside of the NCTR bed base are occupying acute beds reducing for acute work.

- Further strike action in June may impact on timely flow of patients.

5. No Criteria to Reside

No Criteria To Reside (c-chart)
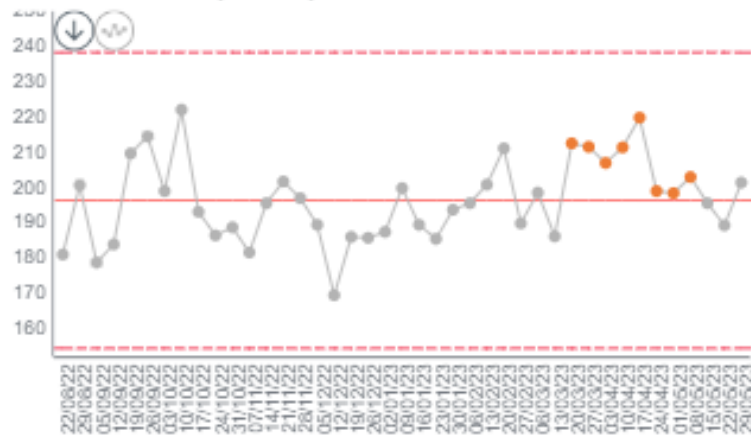
What the chart tells us

On average, there were 197 patients per day with No Criteria to Reside in May 2023. There was an average impact of 4 days increase on Length of Stay due to the NCTR.

The NCTR accounted for 4,163 lost bed days in May 2023.

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.

- The new process for the 13th Floor is due to commence 26th June with the new build for NCTR patients opening W/C 3rd July 2023.

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

- New build will replace some existing capacity rather than be all new capacity

6. Referral to Treatment – Total Waiting List Volume

RTT Total Waiting List

Description

Waiting list volume as at the end of the month
Numerator: Total waiting list volume size snapshot taken at the end of the month

	Variation		Assurance	
	Concern (High)		Unreliable	
Value	68,016	UCL	68.27K	
Trajectory	64,972	Mean	65.26K	
		LCL	62.26K	

Target — LCL — Mean — UCL ● Common Cause ● Concern ● Improvement ● Neither
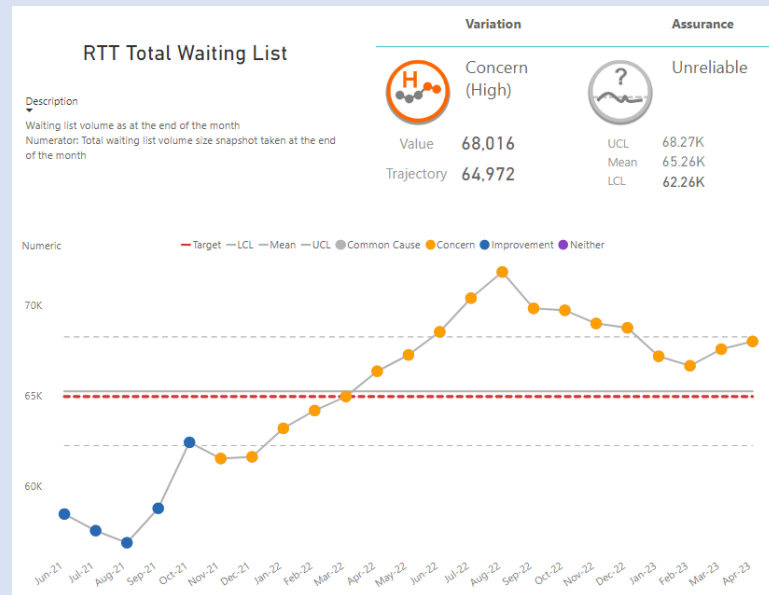
What the chart tells us

The Trust's total waiting list volume (WLV) has increased marginally, impacted by bank holidays and industrial action during 2023/34 Q1. At the end of May 2023, the current un-validated position is 68,746, this has been reducing since August 2022. The total WLV is below the trajectory.

Overall, referrals in are 3.8% down on the previous year.

Intervention and Planned Impact
- Targeted HG & speciality meetings continue to reduce waiting
- Internal milestones set to reduce maximum waits
- 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 and continuing in May, into June 2023. This will be required into Q2.
- 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 to support firebreak for VRE from beginning of June 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
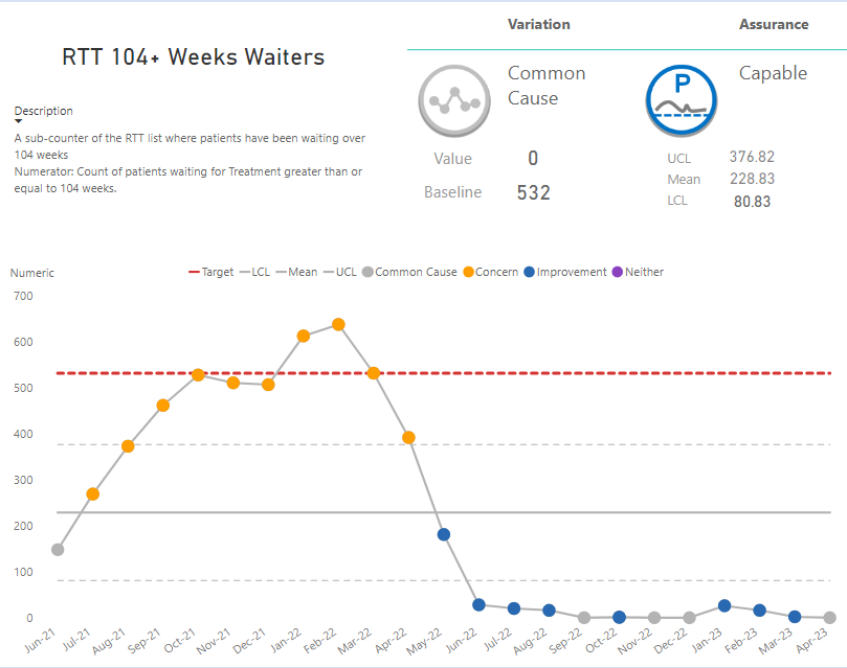
What the chart tells us
At the end of May 2023, the Trust reported 0 x 104-week waits.

Intervention and Planned Impact
- 104-week patient – zero tolerance approach adopted

Risks / Mitigations
- BI reports and governance processes detect and manage any "pop-ups"

8. 78 Week Waits & Planned Trajectory

RTT 78+ Weeks Waiters

Description
A sub-counter of the RTT list where patients have been waiting over 78 weeks.
Numerator: Count of patients waiting for Treatment greater than or equal to 78 weeks.

	Variation		Assurance	
	Improvement (Low)		Unreliable	
Value	**77**		UCL	1.99K
			Mean	1.40K
Baseline	**1,491**		LCL	820.70

Numeric

Legend: —Target —LCL —Mean —UCL ●Common Cause ●Concern ●Improvement ●Neither
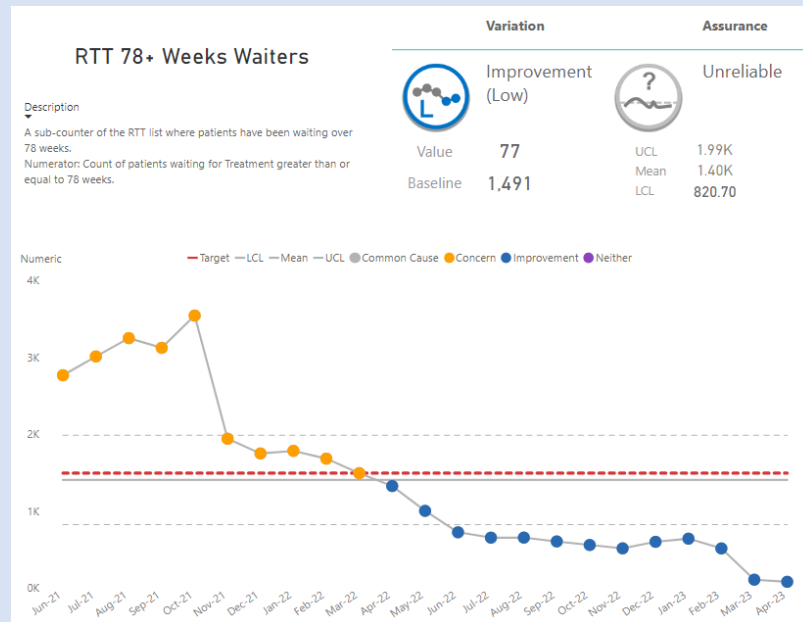
What the chart tells us

At the end of May 2023, the Trust reported 53 x breaches of the 78-week target, against a forecast position 77, with the majority of the breaches (37) in gynaecology.

The current position (at 13.6.23) is 149 total 78 week patients to treat by the end of June 2023. 68% of these have an appointment/TCI date booked before the end of June 2023; progress has been impeded by the Easter weekend followed by industrial action in June 2023.

The current risk assessment is 9 patients that will breach but have dates in July 2023.

Intervention and Planned Impact

- Continued focus at speciality level of patients dated and/or risks now focussed to achieve zero 78-week waits by the end of June 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, now amended to RTT ticking pathways as mandated 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
- Speciality capacity risks:
  - Gynaecology (capacity and obstetric clinical prioritisation)
  - Plastic Surgery (immediate DIEP demand)
  - Breast (gender reassignment – clinical capacity)
  - Ophthalmology (corneal transplant donor material)

9. Capped Theatre Utilisation

Capped Theatre Utilisation %: Touch time within planned session vs planned session time, National Distribution ≡ Download

In order of Capped Theatre Utilisation %: Touch time within planned session vs planned session time (n=120)

■ My Provider
— Peers (My Region) Median (78%)

■ My Peers
— Top/Best Decile (83%)

■ Non-Peer Providers
— Provider Median (77%)
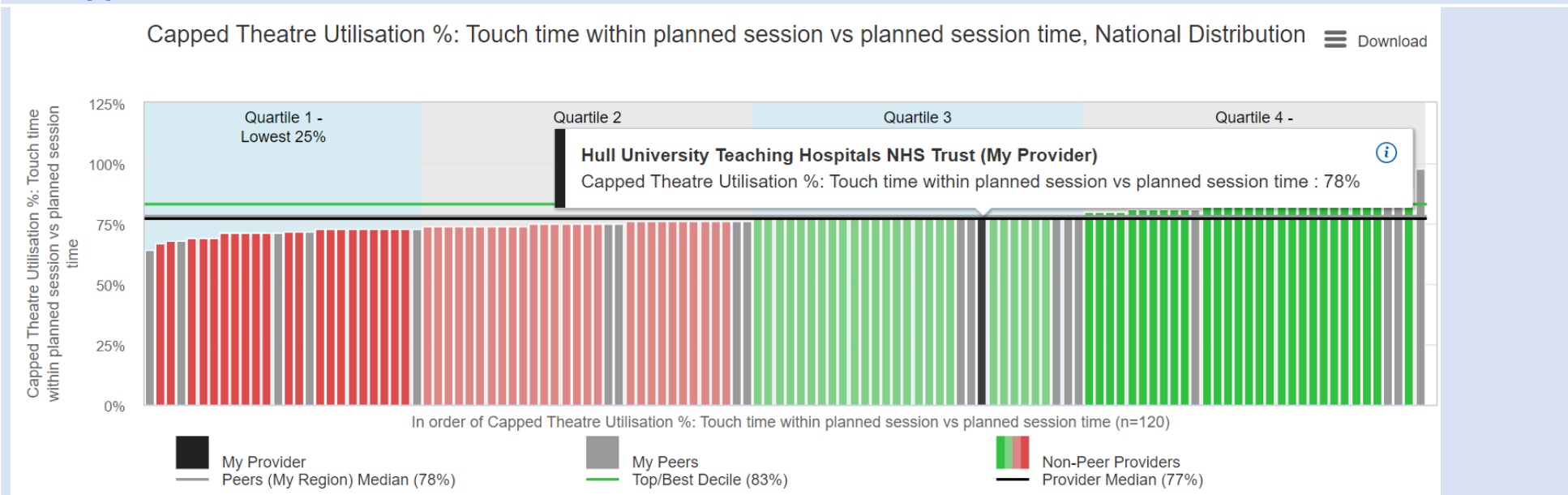
What the chart tells us

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 21.5.23) shows capped theatre utilisation at 78% and in Quartile 3 nationally.

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.
- 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.
- Surgery HG to implement a Theatre Productivity Meeting from July 2023.

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
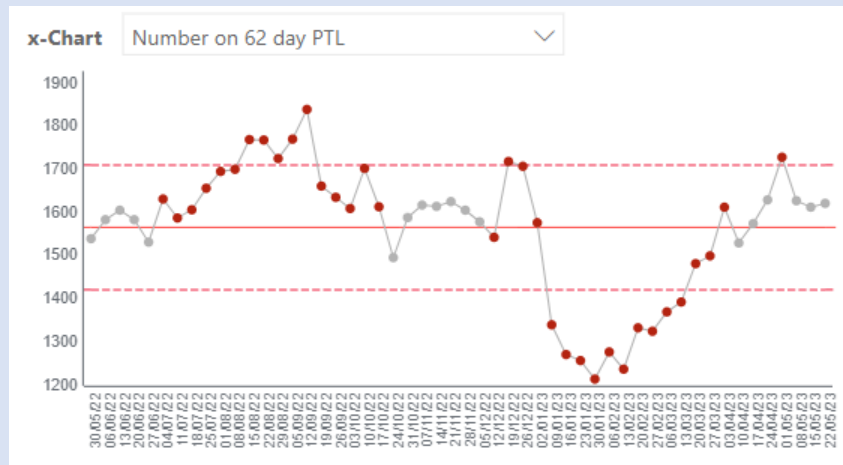
What the chart tells us

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. There was a small increase that recorded in January (1,256).

At week commencing 12 June 2023, the PTL size was ~**1,500**, this a reduction from the previous month. The volume in the PTL remains as a result of a significant spike in referrals in March 2023 across all tumour sites but, more markedly in Colorectal. A large number of these patients are still in the system and delayed at the diagnostic stage (e.g. colonoscopy/endoscopy). Referral rates have returned to normal however the Trust receives ~2,500 per month.

At the beginning of May 2023 the number of patients 63 days and over was **348** compared to 302 at the beginning of April 2023. This reflects the issues described above.

Colorectal has increased in volume which is attributed to high referral numbers with an increase of 29% in March, many patients will remain on the PTL until diagnostic tests confirm benign disease and will be removed or cancer when the patients will progress through the pathway.   Recruitment to the triage nursing has been completed with start dates agree for the beginning of August then, following a short period of training a nurse led triage service will be implemented. It should be noted that improvements are not expected until Q3 2023/24 (including FDS performance).

The Urology remains static, similarly, a significant increase in referrals through March 2023 (60%) has impacted on the volume. Long lead times for surgery (6-8 weeks) continue to cause delays from decision to treat to treatment. In addition, from mid-June 2023 the service will be carrying a consultant surgeon vacancy therefore reducing robotic surgical capacity further.

Gynae-oncology – ongoing review, revision and implementation of pathways, which are consultant led, continues Q1 2023/24; additionally, surgical capacity remains a tangible risk however, the service are making strides to secure additional capacity by accessing IS providers.
Lung continues to see a steady reduction in the backlog and is on track to meet the

trajectories for May 2023.   Capacity for access to navigational bronchoscopy is a concern, as is timely oncology out-patient appointments to discuss treatment options.

Late IPTs continue to be a factor in regards to the HUTH +63 day backlog, mainly urology, lung and Gynae-oncology. An ICS wide improvement project led by the Cancer Alliance is being developed.

The Subsequent Radiotherapy 31-day target of 94% has not been achieved since May 2022; a dip in achievement for the first time in the life of the Cancer Waiting Times targets. Performance in April was 40.7% which is a 10% drop since March (50.5%)

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 supported initial improvement in Faster Diagnosis Standard in the colorectal pathway (January 2023 31.9% & February 2023 51.6%). However, in April performance deteriorated to 22% (March was 33.2%)
- Colonoscopy capacity has been hampered recently resulting in longer waiting times which are also affecting FDS performance.

Histology capacity/delays – focus on histology turn-around times remains with good working relationships with the SHYPS team. More recently prostate biopsies have been outsourced by SHYPS to another provider due to capacity constraints in house. This has led to turn-around delays for urology.

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
- 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 commenced 12 December 2022 with metrics developed to monitor improvement. Further funding from the HNY 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 completed. When the department is fully staffed (no vacancies) the post has provided the cover required for staff absences.
- A review of the tracking/MDT staff working schedules have been reviewed and new processes have been introduced to avoid variation due to public holidays which affect tracking capacity.

Radiotherapy capacity/delays
- Radiotherapy - on-going radiotherapy workforce constrains, with prioritisation process in place.   Approval for rolling advert to recruit to Band 5 & 6 vacancies as appropriate
- Physics – the role of 'Duty Physicist' has been introduced in an attempt to improve efficiency
- Mutual aid arrangements with United Lincoln Hospitals that were stalling progress have now been resolved with a plan in place to progress with mutual aid
- Linac capacity has been compromised in the last month with unplanned downtime affecting capacity however, the department's capacity has returned to full Linac capacity

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 agreed by the Cancer Alliance. Planned improvements at the front end of the pathway are expected in Q3 23/24

- when recruitment and training of triage nurses is complete.
- Increasing numbers of 2WW referrals received with a FIT test result remain static at 72% in April 2023.
- Recent upgrade to the Endoweb system included a mandatory field for clinicians to determine whether patients on a fast track pathway can be removed where cancer is not indicated. This will facilitate the tracking team to remove patients from the PTL at an earlier stage which in turn should support the volume of patients in the PTL.
- Gynae-oncology – the improved PMB pathway has been approved and ready for implementation. Further discussions to implement the pathway continue within the service (Consultant led).
- Urology action plan developed and agreed with the service and was gaining traction; progress had stalled but a recent update and engagement meeting took place in early May 2023 to expedite actions. Surgical capacity has been affected with the departure of one of the robotic pelvic surgeons however, there is a plan to replace as soon as possible.
- Upper GI – the number of patients on the PTL has reduced and being well managed. Constraints remain in the staging and treatment parts of the pathway; these include timely access to oncology OPA and treatment.
- 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 rates since April have remained constant ~2500 patients per month
- High profile patients and national cancer awareness media coverage result in an influx of referrals - recent Bowel Screening TV campaign has coincided with a spike in colorectal 2WW referrals and the increase continues with the highest number seen in March 2023 (550 referrals); many of these were still in the system in April and May 2023
- Histology tracking systems implemented locally to prioritise long-wait patients – skin and Gynae continue to receive reasonable turnaround times
- Radiotherapy delivery continues to be a considerable challenge
- Improvement plans fail to impact on performance metrics
- Mutual aid for radiotherapy has been a challenge; plans to work with ULHs in in progress
- The required additional haematuria clinics have not been fully implemented

	due to lack of sufficient staff to support them • Cancer Transformation programme • Review of late IPT referrals by the Cancer Alliance to increase the number received by Day 38

11. Cancer 62 day Performance

Cancer 62 Day Waits for first treatment (from urgent GP referr...

	Variation		Assurance	
	Common Cause		Not capable	
Value	58.7%	UCL	68.82	
Target	85.0%	Mean	56.73	
		LCL	44.65	

Description

Patients referred for cancer treatment by their GP, screening or consultant upgrade waiting less than 62 days for treatment to start. Numerator: The number of patients referred for cancer treatment by their GP, screening or consultant upgrade who waited for less than 62 days for treatment to start.

Percent

Target · LCL — Mean — UCL ● Common Cause ● Concern ● Improvement ● Neither

Cancer 28 Day Wait - Faster Diagnosis Standard

	Variation		Assurance	
	Common Cause		Unreliable	
Value	73.8%	UCL	83.70	
Target	75.0%	Mean	74.64	
		LCL	65.57	

Description

The percentage of people told cancer diagnosis outcome within 28 days of referral. Numerator: Number of people told cancer diagnosis outcome within 28 days of referral. Denominator: Total number of people told cancer diagnosis outcome.

Percent

Target · LCL — Mean — UCL ● Common Cause ● Concern ● Improvement ● Neither

What the chart tells us

Performance for April 2023 was **55.1%** a reduction of 4% since March; performance has not been achieved for some time. The Faster Diagnosis Standard (combined) April 2023 failed to achieve the 75% target at 73.8%.

Intervention and Planned Impact

Largely the same as Section 8. Above.

- Administration processes continue to be reviewed and actions implemented as appropriate with the IST invited to review during July 2023
- Improvements in the process to despatch times of bowel preparation for CTC slots utilisation, leading to improved access to CT Colon should have a direct impact on FDS performance for colorectal.
- Timely access to colonoscopy is also required and is being addressed by the surgery health group
- 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; further pathway analysis to be undertaken to tackle constraints to treatment by day 62
- Gynae-oncology – pathway review, revisions and implementation. FDS performance made good progress in March 2023 – 49.7%, (February 2023 – 43.9%), however, April's performance dipped to 42.9% which was due to the increase in referrals in March 2023
- FDS for tumour sites not achieving the target under review and process improvements being considered for implementation. Lung met the standard in April with performance reaching 81%

Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times; referrals continue to be high in certain tumour sites
- Loss of OPA capacity (treatment option discussions and results clinics) as well as reduced number of patients being discussed at MDT meetings due to junior doctor strike reducing activity
- Colorectal referral increase is sustained due to Bowel Screening Campaign (PTL volume increase; further demand/pressure on CTC/colonoscopy) continues to

	impact on the number of patients on the PTL
	• 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
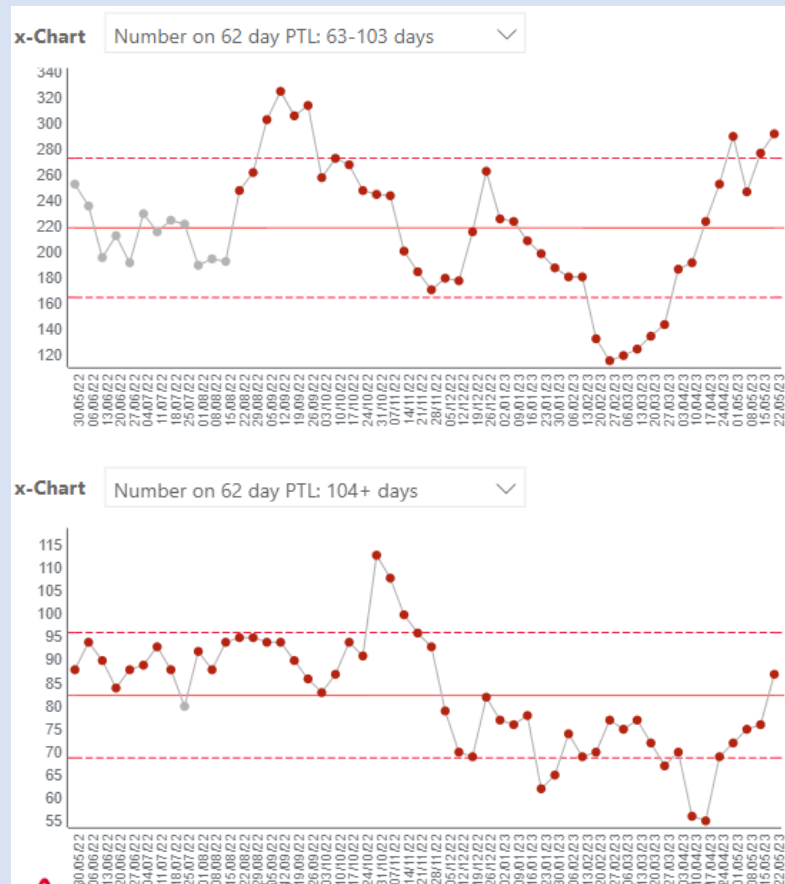
What the chart tells us

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 63+ and 104+ day backlog and achievement of FDS each month. 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 and the Hull and East Riding Place teams 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 has been reinvigorated at a meeting in early May 2023.

Colorectal – 2WW referrals with a FIT test/result remains at a regular 72%; there is work for the Cancer Alliance to support to increase the rate to a target of 80%. A meeting with primary care cancer lead managers and clinicians and the cancer alliance convened in early June to begin a joint plan of action to improve the compliance for GPs to ensure a FIT result is available at the time of 2WW referral.

- 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). Two nurses have been recruited with start date of early August; a period of training will ensue with a view to a fully nurse led triage service up and running in Q3 2023/24.

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 148 by 31 March 2024. Colorectal contribution is no more than 45 by the end of 2023/24 (currently at 170 over 63 days)
- 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 scheduled in April and May has proven difficult to provide due to lack of sufficient trained staff to support them

13.   Elective Recovery Fund

Activity data up to	06/06/2023		Apr	May
			*Actual activity for current mon	
			Plan activity is from health grou	
Indicative Activity Requirement (% of baseline):			104%	104%
Ceiling target for follow up activity (% of baseline):			75%	75%
TRUST TOTAL	New	Baseline	17,637	17,096
		Plan	13,078	14,532
		Actual*	13,379	15,390
		Plan %	102%	106%
		19/20 Baseline %	76%	90%
	Follow Up	Baseline	33,158	37,048
		Plan	31,562	35,069
		Actual*	33,172	38,140
	(minimise)	Plan %	105%	109%
	(minimise)	19/20 Baseline %	100%	103%
	Day Case	Baseline	6,080	6,198
		Plan	6,121	6,801
		Actual*	5,616	6,615
		Plan %	92%	97%
		19/20 Baseline %	92%	107%
	Ord Elect	Baseline	1,203	1,276
		Plan	1,079	1,199
		Actual*	1,016	1,074
		Plan %	94%	90%
		19/20 Baseline %	84%	84%

What the chart tells us

Recovery of elective activity in May 2023 against the operational plan delivered:

➢   New Activity 106%
➢   Follow up Activity 109%
➢   Day Case Activity 97%
➢   Ordinary Elective Activity 90%

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 – which was briefly opened to orthopaedics and neurosurgery during April and May 2023, now supporting the HRI 12th floor firebreak for VRE management.

Additional funding to support HOB expansion at HRI however, physical space and workforce is limiting the delivery respectively.

The on-going Junior Doctor Industrial Action impacted during 2023/24 Q1 – cancer performance, OPA and elective activity.

Day case delivered 97% of plan (activity) in May 2023 (107% of 19/20).

OP 1st attendances (activity) achieved 106% of the plan in May 2023 and 90% of 19/20 baseline.

OPFU (activity) continue to over-perform at 109% of the plan and 103% 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

14. Non-Elective Activity

Activity data up to	06/06/2023		Apr	May
			*Actual activity for current mon	
			100%	100%
TRUST TOTAL	Non-elective	Baseline	4,735	4,952
		Plan	4,928	5,093
		Actual*	4,848	5,146
		Plan %	98%	101%
		19/20 Baseline %	102%	104%

What the chart tells us

Non-elective activity in May 2023 was higher than the baseline of 19/20.

Intervention and Planned Impact
-

Risks / Mitigations
-

REFERENCES

📕 10.1 - Elective Care Priorities 202324 Front Sheet.pdf

📕 10.1.1 - PRN00496_Elective care 2023-24 priorities letter_230523.pdf

📗 10.1.2 - ElectiveCarePriorities_2324_BoardChecklist 14062023 FINAL.xlsx

Agenda Item		Meeting	Trust Board	Meeting Date	11.07.23
Title		Elective Care 2023/24 Priorities			
Lead Director		Ellen Ryabov, Chief Operating Officer			
Author		Julia Mizon, Deputy Chief Operating Officer			
Report previously considered by (date)		The report was previously considered at the Performance and Finance Committee in June 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 requested to: • Review the Board checklist prepared by the Deputy Chief Operating Officer and approve the content.

NHS

England

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS regional directors
- Cancer alliance managing directors
- ICB chief executives

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

23 May 2023

Dear Colleagues,

Elective care 2023/24 priorities

Thanks to your continued focus and effort on elective care and cancer recovery we have managed, through the exceptional efforts of your teams, to drive a significant reduction in the number of long waiting patients over recent months.

Despite a very challenging environment, where ongoing industrial action has seen planned care particularly hard hit, the number of patients waiting over 78 weeks has decreased from 124,911 in September 2021 to 10,737 at the end of March 2023, and the number of patients with urgent suspected cancer waiting longer than 62 days has decreased from a peak of 33,950 last summer to 19,023 at the end of March 2023.

We now look ahead to further reduction in 78 week waits, following the disruption from industrial action and delivering our next ambitions, as set out in Operational Planning Guidance, of virtually eliminating 65 week waits, reducing the 62-day backlog further, and meeting the Faster Diagnosis Standard, by March 2024. This letter sets out our priorities, oversight and support for the year ahead as well as including a checklist for trust boards to assure themselves across the key priorities (annex 1).

First, we should acknowledge the progress made over the last year or so:

- Since the beginning of February 2022, the NHS has treated more than 2m people who would otherwise have been waiting 78 weeks by the end of March 2023 (ie: the "cohort").

- The number of patients waiting 65 weeks has reduced from 165,885 in September 2021 to 95,001 in March 2023.

- The cancer 62 day backlog has reduced year-on-year for the first time since 2017.
- The NHS has seen a record 2.8 million referrals for urgent suspected cancer, with the early diagnosis rate now higher than before the pandemic.
- In February 2023, the NHS achieved the faster diagnosis standard (FDS) for the first time since it was created.

Your leadership, collaboration with colleagues and across providers, innovation and tenacity has led to these improvements for patients and should give confidence for the future, despite the continued complexity of the environment that we are all working in.

Recognising the challenges and the complexity you are all dealing with, we thought it would help to set out the key priorities for the year ahead:

1. **Excellence in basics**
   - Maintaining a strong focus on data quality, validation, clinical prioritisation and maximising booking rates have contributed massively to our progress. We need to retain a clear focus on these things.

2. **Performance and long waits**
   - Continue to reduce waits of over 78 weeks and those waiting over 65 weeks.
   - Make further progress on the 62-day backlog where this is still required in individual providers, whilst pivoting towards a primary focus on achieving the Faster Diagnosis Standard.
   - To support this, we have reviewed and refreshed our tiering approach to oversight, so that we can be sure that we are focusing on those providers most in need of support. This refresh has been communicated to tiered providers.

3. **Outpatients (productivity actions annex 2)**
   - We know there is massive potential in our outpatient system to adjust the approach, engage patients more actively and significantly re-focus capacity towards new patients.

4. **Cancer pathway redesign**
   - In 2023/24 Cancer Alliances have received a funding increase to support implementation of priority changes for lower GI, skin and prostate pathways (included in annex 1). All trusts should now have clear, funded plans in place with their Alliance for implementation.

2

5. **Activity**

- Ensure that the increasing volume of diagnostic capacity now coming online is supporting your most pressured cancer pathways. ICBs have been asked to prioritise CDC and acute diagnostic capacity to reduce cancer backlogs and improve the FDS standard, as set out in the [letter](#) from Dame Cally Palmer and Dr Vin Diwakar.

- Generally, we all need to see a step up in activity over the coming months, as we recover from the ongoing impact of industrial action.

6. **Choice**

- A major contributor to our collective progress over this last year has been the way organisations and systems have worked together to accelerate treatment for long waiting patients. This includes work with the Independent Sector (IS) who have stepped up to help in this endeavour. We know this will continue to be important this year and we encourage all systems and providers to crystalise their plans to work together (including IS) early in the financial year to give us the best chance of success.

- We expect that patient choice will be an increasingly important factor this year, as set out in the Elective Recovery Plan, with some technological advances to support this. We will communicate this more fully when plans have been finalised.

Moreover, it is crucial that we continue to recover elective services inclusively and equitably.
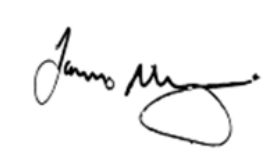
- Systems are expected to outline health inequality actions put in place and the evidence and impact of the interventions as part of their planning returns. Disaggregated elective recovery data should support the development of these plans.

- A collective effort is needed to continue to address the recovery of paediatric services. Provider, system, and regional-level elective recovery plans should set out actions that will be put in place to accelerate CYP recovery and ensure that elective activity gap between CYP and adults is reduced, a [best practice toolkit](#) has now been published to help achieve this.

- Systems are expected to continue to recover specialised service activity at an equitable rate to that of less complex procedures, ensuring a balance between high volume and complex patient care requirements.

3

Included with this letter is the board checklist (annex 1). This tool has been designed to be the practical guide for boards to ensure they are delivering against the ambitious objectives set out in the letter above.

Thank you again for all your efforts since the Elective Recovery Plan was published. Together, we have made laudable progress in reducing long waits and transforming services, as set out in the plan. We can all take confidence in this as we move on to the next stages of the recovery plan and continue to improve care for patients. If any support is required with these actions, please let us know.

Yours sincerely,

Sir James Mackey
National Director of Elective Recovery
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
NHS England

Chair
Getting It Right First Time (GIRFT)
programme

4

Annex 1: Board checklist

We ask that boards review the checklist below to assure plans to deliver our elective and cancer recovery objectives over the coming year. There is national support available in each of these areas, please contact england.electiverecoverypmo@nhs.net to discuss any support needs.

The three key performance deliverables and metrics we need to focus on are:

- Virtually eliminate waits of >65w by March 2024
- Continue to reduce the number of cancer patients waiting over 62d
- Meet the 75% cancer FDS ambition by March 2024

	Assurance statement	Support/materials
1	**Excellence in basics**	
	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	
	Are referrals for any Evidence Based Interventions still being made to the waiting list?	Release 3 will be published on 28 May. It focuses on the following specialties: breast surgery, ophthalmology, vascular, upper gastrointestinal surgery, cardiology, urology, and paediatric urology
2	**Performance and long waits**	
	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	
3	**Outpatients**	
	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	NHSE GIRFT guidance

5

	Assurance statement	Support/materials
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	Validation toolkit and guidance [NHS England » Validation toolkit and guidance](#) published on 1st December 2022
4	**Cancer pathway re-design**	
	Where is the trust against full implementation of FIT testing in primary care in line with [BSG/ACPGBI guidance](#), and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	[Using FIT in the Lower GI pathway published on 7th October 2022](#) [BSG/ACPGBI FIT guideline and supporting webinar](#)
	Where is the trust against full roll-out of teledermatology?	[Suspected skin cancer two week wait pathway optimisation guidance](#)
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	[Best Practice Timed Pathway for Prostate Cancer](#)
5	**Activity**	
	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	[Letter from Dame Cally Palmer and Dr Vin Diwakar dated 26 April 23.](#)
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?	
	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?	

6

Assurance statement	Support/materials
Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery? Are patients supported to optimise their health where they are not yet fit for surgery? Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations.	NHS England » 2023/24 priorities and operational planning guidance NHS England » Revenue finance and contracting guidance for 2023/24 Perioperative care pathways guidance
Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	
Is full use being made of protected capacity in Elective Surgical Hubs?	
Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	https://future.nhs.uk/NationalCommunityDiagnostics/groupHome
Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients??	

7

	Assurance statement	Support/materials
6	**Choice**	
	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	www.dmas.nhs.uk
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	
7	**Inclusive recovery**	
	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	
	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	
	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	CYP elective recovery toolkit

Supporting guidance and materials are available on the Elective Recovery Futures site: https://future.nhs.uk/ElectiveRecovery

Annex 2: Outpatients (OP) productivity action

As set out in the [2023/24 Priorities and Operational Planning Guidance](#), systems are expected to deliver in line with the national ambition to reduce follow-ups by 25% against the 2019/20 baseline by March 2024. To note this excludes appointments where a procedure takes place. Further technical guidance (that covers other exclusions) is [here](#).

Expected actions

In order to work towards achieving the 25% follow-up reduction target, trusts are expected to focus on the following within the first quarter of the year:

- Embed OP follow-up reduction in trust governance mechanisms
- Engage with clinical leads for specialties about the significance of the 25% follow-up reduction target, building on [GIRFT guidance](#)
- Review clinic templates to ensure they are set up to enable a 25% reduction in follow-up appointments
- Validate patients waiting for follow-ups to identify any who do not need to be seen
- Ensure continued and expanded delivery of patient initiated follow up (PIFU) in all major OP specialties, particularly accelerating uptake in specialties with the longest waits (ENT, gynaecology, gastroenterology and dermatology)
- Ensure patients who no longer need to be seen in secondary care are appropriately discharged, in line with clinical guidelines
- Work to reduce appointments that are missed by patients (DNAs), in line with [NHS England guidance](#), including by:
  - Understanding the most common reasons why patients miss appointments, building on available [national support](#)
  - Making it easier for patients to cancel or reschedule appointments they don't need eg through [sending a response to an appointment reminder](#)
- Local analysis of patients on multiple pathways or those with multiple follow-ups.
- Consider conducting a retrospective clinical review of a sample of OP follow-up activity in at least two specialties with the longest waits, to identify where an alternative pathway of care could have been used (eg discharge, PIFU, appointment met through alternate means).

Payment

Reducing OP follow-ups is incentivised by the [NHS payment scheme](#), where follow-up appointments are covered by a fixed payment element, and first appointments are covered by a variable element.

Support available

Competing priorities will always make it difficult to focus on making these changes. Continued support will be available through:

- Data packs for each tiered trust, and top ten other trusts with high OP follow up reduction opportunity
- Clinically-led conversations with tiered trusts from National Clinical Directors, GIRFT clinical leads, and OP clinical leads
- Operational support to amend clinic templates
- Support to improve equity of access through the national Action on Outpatients programme.

10

REFERENCES

📄 10.2 - Performance and Finance Committee Report Month 2.pdf

Agenda Item	7.1	**Meeting**	Performance and Finance Committee	**Meeting Date**	26.6.23
Title	Finance Report – 2023/24 - Month 2				
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 Performance and Finance Committee is asked to note the following:

a) The reported position at Month 2 showing a deficit of £2.5m, £1.8m above plan. The deficit is driven by shortfall on CRES and the cost of covering the junior doctor strike.

b) The need to focus on identification and delivery of CRES targets by Health Groups and Corporate areas

c) The potential shortfall of £1m on funding for the agenda for change pay award.

d) The high level of agency spend in the first two months.

e) .The risk to income due to lost activity during the Junior Doctors strike.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

PERFORMANCE AND FINANCE COMMITTEE: MONDAY 26th JUNE 2023

FINANCIAL UPDATE 2023/24 – MONTH 2

1.   **Purpose of Paper**

To update the Performance and Finance Committee on the financial position at month 2.

2.   **Background**

The Trust has submitted a deficit financial plan of £7.2m for 2023/24, which fits within an overall HNY ICS deficit of £30.0m. The overall ICB position has been signed off by NHSE with the caveat that the ICB and all its providers continue to work to improve the financial position and move closer towards balance. The letter from NHSE (Appendix 1) details the actions that all parties are expected to put in place. The Trust is reviewing the action list to ensure it meets all the criteria.

The Trust position will be very challenging to achieve and includes a high level of savings to be actioned. This includes £18.0m of Health Group & corporate CRES targets, which is equivalent to 2.8% of budgets. The Trust has also agreed a stretch target of £10m, which has yet to be identified. Further reductions are built into the plan including moving the running of the Paragon facility to CHCP, closing Ward H1 and limiting the amount available to invest in the Independent sector. There is also some expected 'technical' release from the balance sheet to support the position non-recurrently.

Some of these additional actions are likely to only be delivered non-recurrently and the Trust will start the year with an underlying deficit position of £42m. A plan to address this underlying position will need to be developed in year.
.
3.   **Month 2**

The table in appendix 2 shows the month 2 reported position against the NHSI plan, at health group level. The Trust is reporting a deficit of £2.46m, which is £1.8m worse than the plan. This is £0.4m deterioration from month 1.

Income
Income is broadly in line with plan at month 2 with a slight over achievement on injury recovery income.

The income plan will be updated at Month 3 to reflect the agreed pay award for agenda for change staff. The Trust has received additional funding to cover the pay award but there is the possibility that the funding will not be sufficient to cover the full costs. This is currently estimated as a risk of £1.0m.

The position does not include any adjustment for variable activity in the first 2 months. The Trust expects to be below plan in Month 1 given the days lost to strike action. The Trust is awaiting information from NHSE on how the Elective Recovery Fund is to be implemented and there remains a risk that income will be reduced due to activity being below contract.

Expenditure

Health groups and corporate areas are reporting that they have a deficit of £3.6m at month 2. This is £0.5m higher than month 1 and reflects that agreed additional budgets have been issued to Health Groups and Corporate departments. Cardiology is now shown as a separate Division, separate to the Medicine Health Group.

The two biggest elements of the deficit are unidentified CRES at £1.3m and the cost of covering the industrial action in April of £0.5m.

The CRES position is £1.3m short of plan at month 2, an increase of £0.3m in month. Only Estates, Facilities and Development is showing as fully achieved. Delivery ranges from 0% within Cardiology to 71% in Clinical Support Services so all areas need to step up identification and delivery. The Cardiology shortfall is expected to be a timing issue with a large element to be achieved following successful completion of a tender for clinical supplies. All Health Groups have been tasked to step up CRES identification and provide a year-end forecast for month 3. The breakdown by Health Group is as per the following table:

Month 2 Performance	Annual Plan £'k	YTD CRES Plan £'k	YTD CRES Actual £'k	YTD CRES Variance £'k	% Achieved YTD
Medicine	2,572	450	89	-361	20%
Emergency Medicine	579	103	42	-61	41%
Surgery	3,731	535	285	-250	53%
Family & Womens Health	2,705	420	99	-321	24%
Clinical Support Services	3,074	511	361	-150	71%
Cardiology	360	59	0	-59	0%
Corporate	1,983	364	252	-112	69%
Estates, Facilities & Development	1,999	301	301	0	100%
Central inc MEC	992	165	156	-9	95%
TOTAL	**17,995**	**2,908**	**1,585**	**-1,323**	**55%**

Excluding CRES the overall HG position deteriorated by £0.2m. This partly reflects the issuing of agreed budgets to positions.

Surgery Health Group overspent by £0.4m in month, excluding CRES. The main pressures are in Anaesthetic Consultants, junior doctors and non-pay. The junior doctor's element may relate to the strike action and this is being investigated.

Clinical Support Health Group deficit increased by £0.2m driven by non-pay costs related to activity.

Emergency Health Group overspent by £0.1m driven by additional band 2 support workers put in place over winter to support patient flow that are expected to be moved to vacant posts across the Trust.

Medicine Health Group (£0.2m) and Family & Women's Health Group (£0.2m) both underspent in month due to lower levels of activity.

Corporate Departments overspent by £0.1m with pressure on the clinical admin service to support the strikes and elective recovery.

Estates, Facilities & Development underspent by £0.2m in month following funding issued for the new building developments.

4. **Agency Spend**

NHSEI have re-established controls on Trust agency expenditure. They have set targets with the aim of reducing overall NHS spend on agency to less than 3.7% of the total pay bill. As HUTH is already below the 3.7% target, its control total is based on not increasing usage from 2022/23 (based on month 7 forecast outturn). This sets the limit at £10.4m. The Trust plan was set at £9.7m recognising the need to improve the Trust underlying position.

Expenditure to Month 2 was £2.2m, above the plan of £1.6m. The overspend was all on Consultants. Some of the cost may relate to covering strike action. If it continues at the current rate, the Trust would be £2.8m above the 2022/23 baseline.

5. **Forecast**

A full forecast by Health Group will be provided from month 3 onwards. At this stage, the Trust is reporting that it will deliver its plan but there is a high risk of non-delivery. This will be increased if the strike actions continue indefinitely.

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

The SOFP and SOCF for month 2 are reported in appendices 3 and 4.

Capital

The reported capital position at month 2 shows gross capital expenditure of £1.98m against a plan of £4.1m. The main areas of expenditure relate to the PFI lifecycle costs; backlog maintenance and Theatres. The slippage relates to the day surgery unit and is a profile issue. There is also some slippage on IFRS16 leases, for example the cyclotron.

The planned capital expenditure for 2023/24 (incl PFI/IFRIC12 impact) is £50.1m. This includes assumptions on receiving PDC relating to Day Surgery (£20.7m); Digital Diagnostics (£0.4m) and EPR (£1.7m).

The Trust is also expecting PDC allocations for CDC and Urgent Treatment Centres These are not included within the Month 2 position until formal notification is received.

Cash

The Trust's liquidity position remains healthy with a cash balance of £60.8m at the end of month 2. The forecast cash balance by the end of March 24 remains as per the plan at £33.4m. This will depend on the timings of payments in relation to the capital programme, the success of the CRES delivery and income relating to Elective Recovery.

To date the Trust has paid 96.3% by volume and 86.3% by value of non-NHS invoices within best practice terms. In May, the figures were 95.9% and 85.2% respectively

Debtors

The Trust currently has £2.9m of debt that is over 90 days, a reduction of £0.1m from month 1 and £0.4m in last 2 months. The main debtors are as follows:

Debtors Over 90 Days	April 23	May 23	Change
	£	£	£
Northern Lincolnshire And Goole Nhs Ft	193,495	90,630	-102,865
Nhs Humber And North Yorkshire Icb	69,448	74,664	5,216
Fresenius Medical Care Renal Services Ltd	114,340	71,741	-42,599
Humber Teaching Nhs Foundation Trust	72,330	71,163	-1,167
East Riding Fertility Services Ltd	67,860	69,286	1,426
Alliance Medical Ltd	93,101	65,925	-27,176
Crawford & Company Adjusters (Uk) Ltd	60,720	60,720	0
Nhs England	57,050	57,050	0
Ge Healthcare	51,962	51,962	0
Other	2,242,306	2,253,460	11,154
Total	3,022,809	2,866,599	-156,210

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.

Debtors over £50k are being chased. The other debtors are being reviewed, with a proposal to write off the older debt. A provision against the potential write-off was included in the year-end position.

Stocks

Stock levels are at £17.0m, an increase of £0.4m from year-end with small increases in Clinical support and Surgery.

Health Group	Mar 23 £000	Apr 23 £000	May 23 £000	Change from March 23 £000
Clinical Support	7,725	7,871	7,913	188
Surgery	4,894	4,905	5,069	175
Medicine	1,842	1,842	1,842	0
F & WH	1,174	1,174	1,182	8
Other	642	642	644	2
PPE Stock	335	335	335	0
Total	16,613	16,770	16,986	373

7. **Recommendations**

The Performance and Finance Committee is asked to note the following:

f) The reported position at Month 2 showing a deficit of £2.5m, £1.8m above plan. The deficit is driven by shortfall on CRES and the cost of covering the junior doctor strike.

g) The need to focus on identification and delivery of CRES targets by Health Groups and Corporate areas

h) The potential shortfall of £1m on funding for the agenda for change pay award.

i) The high level of agency spend in the first two months. Some of this may relate to covering the junior doctors strike.

j) .The risk to income due to lost activity during the Junior Doctors strike.

Stephen Evans
Operational Finance Director
June 2023

Financial Year 2023/24 Month 2

	Annual Budget £000	Budget £000	Actual £000	Variance £000	Month 1 £000	Change In Month £000
Nhs Contract Income	707,224	117,870	117,898	28	5	23
Nhs Other Clinical Income	112	19	37	18	9	9
Education + Training Income	23,518	3,920	3,920	0	0	(0)
Other Income	5,799	967	1,010	43	50	(7)
Donated/Grant Income	2,380	0	0	0	0	0
Total Income	**739,033**	**122,776**	**122,865**	**89**	**64**	**25**
Surgery	(147,507)	(24,523)	(25,769)	(1,246)	(928)	(318)
Medicine	(80,943)	(13,623)	(13,782)	(159)	(83)	(76)
Cardiology	(17,469)	(2,911)	(2,997)	(86)	(83)	(3)
Clinical Support Services	(111,009)	(18,677)	(19,185)	(508)	(554)	46
Pass through drugs	(72,699)	(12,117)	(12,122)	(5)	4	(9)
Family + Womens Health	(92,380)	(15,508)	(16,202)	(694)	(811)	117
Corporate Directorates	(82,309)	(13,762)	(14,293)	(531)	(379)	(152)
Reserves	(20,477)	(2,786)	(1,205)	1,581	1,774	(193)
Other Operating Expenditure	(6,358)	(1,056)	(1,067)	(11)	(20)	9
Emergency Care Health Group	(18,231)	(2,909)	(3,158)	(249)	(148)	(101)
Estates Facilities & Developmt	(56,868)	(9,324)	(9,459)	(135)	(350)	215
Unaddressed Risk	0	0	0	0	0	0
Total Operating Expenditure	**(706,250)**	**(117,196)**	**(119,239)**	**(2,043)**	**(1,578)**	**(465)**
Donated Asset Income	(2,380)	0	0	0	0	0
EBITDA	**30,403**	**5,580**	**3,626**	**(1,954)**	**(1,106)**	**(440)**
Depreciation	(24,017)	(4,003)	(4,003)	0	0	0
Interest Payable	(6,839)	(1,134)	(1,265)	(131)	(70)	(61)
Interest Receivable	1,350	300	540	240	138	102
Pdc Dividends	(9,532)	(1,589)	(1,589)	0	0	0
Profit / Loss On Disposal	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Total Non Operating Expenditure	**(39,038)**	**(6,426)**	**(6,317)**	**109**	**68**	**41**
Net Surplus/Deficit	**(6,255)**	**(846)**	**(2,691)**	**(1,845)**	**(1,445)**	**(400)**
Donated Asset Adjustment (NEW)	(976)	234	234	0	0	0
Adjusted Financial Performance before Profit/Loss Adjustment	**(7,231)**	**(612)**	**(2,457)**	**(1,845)**	**(1,445)**	**(400)**
Profit/Loss Disposal Assets Adjustment	0	0	0	0	0	0
Adjusted Financial Performance Surplus/Deficit	**(7,231)**	**(612)**	**(2,457)**	**(1,845)**	**(1,445)**	**(400)**

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF FINANCIAL POSITION

	2022/23 Accounts 31/03/2023 £000	2023/24 Actual 31/05/2023 £000	2023/24 Movement from 31/03/23 £000	2023/24 Forecast 31/03/2024 £000
Non-current assets				
Intangible assets	8,459	8,055	(404)	8,707
Property, plant and equipment: on-SoFP IFRIC 12	68,065	67,798	(267)	67,729
Property, plant and equipment: other	353,725	352,620	(1,105)	377,568
Right of use assets - leased assets for lessee (excl	13,344	12,959	(385)	13,198
Investment property	100	100	0	100
Investments in joint ventures and associates	0	0	0	0
Other investments / financial assets	549	549	0	549
Receivables: due from NHS and DHSC group bodie	1,261	1,337	76	1,261
Receivables: due from non-NHS/DHSC group bod	2,557	2,497	(60)	1,698
Other assets	(859)	(859)	0	(859)
Total non-current assets	**447,201**	**445,056**	**(2,145)**	**469,951**
Current assets				
Inventories	16,612	16,986	374	15,412
Receivables: due from NHS and DHSC group bodie	23,256	22,395	(861)	5,756
Receivables: due from non-NHS/DHSC group bod	18,170	16,407	(1,763)	14,415
Credit Loss Allowances	(3,155)	(3,155)	0	(3,155)
Other investments / financial assets	0	0	0	0
Other assets	0	0	0	0
Non-current assets for sale and assets in disposal	0	0	0	0
Cash and cash equivalents: GBS/NLF	53,742	60,844	7,102	33,383
Cash and cash equivalents: commercial / in hand	7	5	(2)	7
Total current assets	**108,632**	**113,482**	**4,850**	**65,818**
Current liabilities				
Trade and other payables: capital	(13,420)	(3,367)	10,053	(9,760)
Trade and other payables: non-capital	(121,828)	(137,294)	(15,466)	(93,334)
Borrowings	(4,946)	(5,028)	(82)	(5,170)
Other financial liabilities	0	0	0	0
Provisions	(589)	(542)	47	(589)
Other liabilities: deferred income including contr	(2,265)	(2,646)	(381)	(2,265)
Liabilities in disposal groups	0	0	0	0
Total current liabilities	**(143,048)**	**(148,877)**	**(5,829)**	**(111,118)**
Total assets less current liabilities	**412,785**	**409,661**	**(3,124)**	**424,651**
Non-current liabilities				
Trade and other payables	0	0	0	0
Borrowings	(51,898)	(51,448)	450	(47,694)
Other financial liabilities	0		0	
Provisions	(2,576)	(2,592)	(16)	(2,088)
Other liabilities	0	0	0	0
Total non-current liabilities	**(54,474)**	**(54,040)**	**434**	**(49,782)**
Total assets employed	**358,311**	**355,621**	**(2,690)**	**374,869**
Financed by				
Taxpayers' equity				
Public dividend capital	350,700	350,700	0	373,513
Revaluation reserve	51,751	51,751	0	51,751
Financial assets at FV through OCI reserve	549	549	0	549
Other reserves	0	0	0	0
Merger reserve	0	0	0	0
Income and expenditure reserve	(44,689)	(47,379)	(2,690)	(50,944)
Others' equity				
Non-controlling Interest	0	0	0	0
Charitable fund reserves	0	0	0	0
Total taxpayers' and others' equity	**358,311**	**355,621**	**(2,690)**	**374,869**

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF CASH FLOWS

	Accounts 31/03/2023 £000	Actual 31/05/2023 YTD £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	5,950	(372)
Operating surplus/(deficit) of discontinued operations		
Operating surplus/(deficit)	**5,950**	**(372)**
Non-cash or non-operating income and expense:		
Depreciation and amortisation	22,155	4,002
Impairments and reversals	6,399	0
Income recognised in respect of capital donations (cash and non-cash)	(520)	0
Amortisation of PFI deferred income / credit	0	0
On SoFP pension liability - employer contributions paid less net charge to the SOCI	0	
(Increase)/decrease in receivables	(6,946)	2,608
(Increase)/decrease in other assets	0	0
(Increase)/decrease in inventories	(745)	(374)
Increase/(decrease) in trade and other payables	13,319	15,460
Increase/(decrease) in other liabilities	(1,012)	381
Increase/(decrease) in provisions	(3,762)	(31)
Corporation tax (paid) / received		
Movements in operating cash flows of discontinued operations		
Other movements in operating cash flows	(1)	
Net cash generated from / (used in) operations	**34,837**	**21,674**
Cash flows from investing activities		
Interest received	1,485	540
Purchase of financial assets / investments		
Proceeds from sales / settlements of financial assets / investments		
Purchase of intangible assets	(932)	0
Proceeds from sales of intangible assets		
Purchase of property, plant and equipment and investment property	(63,491)	(13,173)
Proceeds from sales of property, plant and equipment and investment property	39	0
Initial direct costs, up-front payments and (lease incentives) in respect o	(76)	0
Receipt of cash donations to purchase capital assets	1,956	0
Prepayment of PFI capital contributions (cash payments)		
Cash flows attributable to investing activities of discontinued operations		
Cash movement from acquisitions of business units and subsidiaries (not absorption transfers)		
Cash movement from disposals of business units and subsidiaries (not absorption transfers)		
Net cash generated from/(used in) investing activities	**(61,019)**	**(12,633)**
Cash flows from financing activities		
Public dividend capital received	19,837	0
Public dividend capital repaid	0	0
Movement in loans from the Department of Health and Social Care	(1,260)	0
Movement in other loans	0	0
Other capital receipts		0
Capital element of finance lease rental payments	(2,129)	(388)
Capital element of PFI, LIFT and other service concession payments	(1,657)	(338)
Interest on DHSC loans	(347)	0
Interest on other loans		
Other interest (e.g. overdrafts)		
Interest element of finance lease	(63)	(13)
Interest element of PFI, LIFT and other service concession obligations	(5,986)	(1,201)
PDC dividend (paid)/refunded	(7,892)	0
Cash flows attributable to financing activities of discontinued operations		
Cash flows from (used in) other financing activities		
Net cash generated from/(used in) financing activities	**503**	**(1,940)**
Increase/(decrease) in cash and cash equivalents	**(25,679)**	**7,101**
Cash and cash equivalents at 1 April - brought forward	79,427	53,748
Prior period adjustments		
Cash and cash equivalents at 1 April - restated	**79,427**	**53,748**
Cash and cash equivalents at start of period for new FTs	0	
Cash and cash equivalents transferred by absorption	0	
Unrealised gains/(losses) on foreign exchange		
Cash transferred to NHS foundation trust upon authorisation as FT	0	0
Cash and cash equivalents at Month (Year) End	**53,748**	**60,849**

Verbal

REFERENCES Only PDFs are attached

📕 10.2 - PAM Report to Trust Board July 2023.pdf

📗 10.2.1 - Appendix 2 Trust Board July 2023.xlsx

Agenda Item		Meeting	Trust Board Committee	Meeting Date	11th July 2023
Title		Premises Assurance Model (PAM)			
Lead Director		Director of Estates, Facilities & Development			
Author		Director of Estates, Facilities & Development			
Report previously considered by (date)		Estates, Facilities & Development Management Committee 24th May 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 to be considered:

NHS Standard Contract 2023/24 (Service Condition 17.9) states that:

'The Provider (if it is an NHS Trust or an NHS Foundation Trust) must complete the NHS Premises Assurance Model (PAM) and submit a report to its Governing Body in accordance with the requirements and timescales set out in the NHS Premises Assurance Model, and make a copy available to the Co-ordinating Commissioner on request'.

There is also a requirement to upload the individual self-assessment ratings to the NHS England / NHS Improvement (NHSE/I) PAM portal.

The Trust Board are requested to:

1. Receive the report,
2. Note the internal NHS PAM self-assessment outcomes for information and assurance,
3. Approve the submission of the PAM self-assessment ratings to the NHS England / NHS Improvement (NHSE/I) PAM portal.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD COMMITTEE

PREMISES ASSURANCE MODEL (PAM) REPORT

1. PURPOSE OF THE PAPER

The purpose of the paper is to inform the Trust Board of the outcome of the self-assessments allied to the Premises Assurance Model (PAM) annual assessment and the outcome ratings for each self-assessment question (SAQ), undertaken in 2022/23. It further seeks approval to submit the PAM self-assessment ratings to the NHS England / NHS Improvement (NHSE/I) PAM portal.

2. BACKGROUND

The Trust estate and its related services are integral to the delivery of high-quality clinical care. Therefore, it is essential that the Trust provide a safe, high quality, efficient and effective estate. The NHS Premises Assurance Model (PAM) is a national Estates and Facilities benchmarking tool designed to be used by NHS organisations for Board reporting, and externally to provide assurance to Regulators and Commissioners. Completion of NHS PAM was made mandatory for all NHS Trusts from April 2020.

The objectives of NHS PAM is to support the NHS constitution pledge:

"To provide services from a clean and safe environment that is fit for purpose based on national best practice" and the current regulatory requirements to ensure that "service users are protected against risks associated with unsafe and unsuitable premises".

NHS PAM is a self-assessment management tool, designed to provide a nationally consistent approach to evaluate NHS premises performance against a set of common indicators. NHS PAM has seven domains:

- Safety (Hard),
- Safety (Soft),
- Patient Experience,
- Efficiency,
- Effectiveness,
- Governance.
- Helipad

The PAM has 49 Self-Assessment Questions (SAQ's) with a range of sub questions (prompts) for each SAQ. The SAQ's are listed in Appendix 1. The response to the prompt questions are scored/rated with due regard to the evidence gathered in relation to the following requirements:

- **Relevant guidance and legislation**: Policies, procedures, working practises etc. should comply with any relevant guidance and legislation,
- **Evidence should demonstrate**: The approach (policies, procedures etc.) is understood, operationally applied, embedded, adequately recorded, reported on, audited and reviewed.

Once the evidence available is considered a self –assessment rating is determined for that prompt question. Ratings are awarded as follows:

- Blue – Outstanding
- Green Good
- Yellow – Minor Improvement Required
- Amber – Moderate Improvement Required
- Red – Inadequate
- Grey – Not Applicable

3. CURRENT POSITION

3.1 PROCESS

The process applied within the EF&D directorate is that each SAQ is assigned a 'Professional Lead'. The 'Professional Lead' will determine which officers will be members of the 'Expert Group'; this will obviously depend on the discipline of the SAQ.

The 'Professional Lead' will then discuss the evidence and views gathered from the 'Expert Group' to the EF&D PAM Facilitator and propose a self-assessment rating.

The most recently issued PAM self-assessment guidance contains more comprehensive information and guidance as to what evidence might be required for each sub-question for the SAQ's. This has resulted in some of the previous self-assessment ratings decreasing. Where this is the case, actions to strengthen compliance have been identified. One of the pre-requisites of the PAM is that in order to be rated 'Good or Outstanding' there should be no actions identified for improvement.

The catering Services SAQ (SS1) and the Cleanliness and Infection Control SAQ (SS4) have prompts from the recently publications NHS National Standards of Healthcare Cleanliness 2021 and the National Standards for Healthcare Food and Drink respectively

The action plan progress will be monitored at the Non-Clinical Quality Committee.

3.2 SUMMARY OF ASSESSMENT OUTCOME 2022/2023

When comparing the year on year level of assurance the last three years has seen a decrease in the level of assurance.

2018-19	2019-20	2020-21	2021-22	2022-23
67.47	69.28	66.08	64.79	56.09
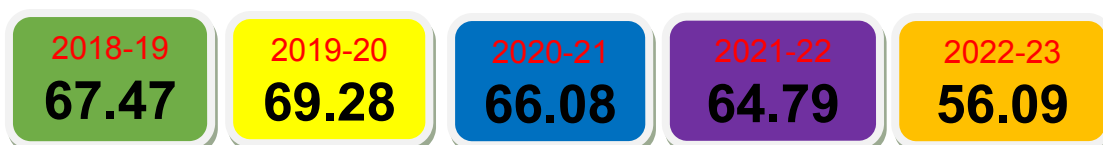
The PAM for 2022/23 was undertaken whilst the directorate was still restructuring with new senior and middle managers being appointed to key posts. This could have affected the continuity of some of the actions previously identified and brought in new oversight and opinions of assurance and performance.

In addition, the PAM facilitators were more informed on what does 'good look like' and therefore the challenges were more rigorous and robust. These may be considered as potential contributory factors to new PAM ratings for 2022/23.

4. OVERSIGHT

1. A review of the overall SAQ ratings identifies that:
   - 4 have improved when compared to the previous year's PAM
   - 10 have remained the same compared to the previous year's PAM
   - 32 have decreased when compared to the previous year's PAM
   - 3 are new for 2022/23

2. There are no SAQ's rated overall as Outstanding

3. There are three SAQ's rated overall as Good
   - Healthcare Safety Investigation Branch (HSIB)
   - Town Planning
   - Land and Property Management

4. There are twenty SAQ's with an overall rating of Requires Moderate Improvement an increase of seven from the previous year.

5. There are four SAQ's with one or more rating of Inadequate:
   - SH18 Safety in Other Premises (7)
   - SS7 Transport Services and Access Arrangements (1)
   - G1 Governance Process (1)
   - Leadership and Culture (1)

6. There is only one SAQ with an overall rating of Inadequate
   - SH18 Safety in Other Premises

The detailed SAQ ratings are included in Appendix 2

The SAQ rated as inadequate overall, is SH18 – Safety in Other Premises. This is when HUTH operates out of premises not owned by the Trust and is typical of 'outreach clinical services'. The weakness in assurance is considered an organisational issue and not solely isolated to EF&D. It has been self-assessed as part of the PAM as the Property Manager resides within the EF&D directorate. The root cause is due mainly to Health Groups occupying facilities in other 'landlord's premises', in order to deliver services close to the patient. However, this is invariably undertaken without any Heads of Terms, lease or rental agreement being put in place. This has the potential to put HUTH staff at risk, as they may be unaware of local procedures and arrangements, e.g. fire alarms and evacuation, health and safety arrangements, lone working, key handling, etc.

The assurance in the Safety Hard and Safety Soft domains can be strengthened by the development and approval of discipline specific policies and procedures. Improvement in the management of risk assessments will also serve to underpin the level of assurance, this is illustrated in Table 1.

Table 1: Further scrutiny of the Safety Domains (Soft & Hard)

	Numbers of Prompts self-assessed as being					Numbers of prompts identified as Not Applicable
	Outstanding	Good	Requires Minimal Improvement	Significant Improvement	Inadequate	
Policy & Procedures	0	5	12	11	2	0
Roles & Responsibilities	0	7	12	10	1	0
Risk Assessment	0	8	14	7	1	0
Maintenance	0	9	12	4	1	4
Training & Development	0	5	16	5	1	3
Emergency & Business Continuity Planning	0	10	14	2	1	3
Review Process	0	10	13	5	1	1

The table above clearly demonstrates that all the domains require strengthening in order to improve on the level of assurance offered to the Board.

- Policies and Procedures – in many areas we tend to rely on the fact that we have an umbrella policy e.g. Estates Operations Policy. At a recent PAM National Workshop it was strongly recommended that local policies are required as part of a HTM requirement or industry good practice should be compiled, approved and published locally. This was for the majority of the Safety Hard SAQ's and all the Safety Soft SAQ's. Failure to have such local documentation was seen as a significant risk.
- Roles and Responsibilities – These would be detailed in local policies and procedures in order that there is a Trust wide understanding of roles and responsibilities.
- Risk Assessments - following the re-structuring of the directorate some key personnel have expressed their concern regarding the quality and robustness of current risk assessments and are intending to revise all current risk assessments.
- Maintenance – this appears to stem from the lack of confidence in the PPM schedule on the current Estates CAFM system and the failure to receive formal handover documentation as part of the commissioning and hand over of new facilities. As a consequence of the replacement of the current Estates CAFM significant attention is being paid to the robustness of the PPM programme and is also including a complete technical asset re-survey.
- Training and Development – this is predominantly a consequence of the cancellation of face to face training for key Estates Authorised and Competent Persons. Whilst the Trust was not exposed to any significant risk and the Authorising Engineers extended technical appointments quite readily, due to the nature of the cancellation. In Facilities the newly launched National Standards for Healthcare Food and Drink, is very prescriptive regarding food hygiene training requirements for levels within both the Catering hierarchy and nursing and other supporting roles.
- Review Process - it was identified that some key professions and services have no external or independent review processes. This could be improved by the

implementation of an internal auditing programme for an independent team within the directorate.

In the Governance domain, there are two key drivers required to strengthen assurance; they are the implementation of a governance framework and strengthen the leadership and culture within the directorate.

The governance arrangements are essential to strong assurance, the old adage 'from Ward to Board' the 'Golden Thread'. Clear lines of escalation with opportunities and accountabilities at different levels to resolve and manage issues. Strong and impactful lines of communication are evident leading to positive two-way communications. Accountability and responsibility will be set at the appropriate level, trusting staff to make the decisions and allowing learning when things do not go as planned.

The Leadership & Culture domain is also an area requiring attention. The Staff Survey has been an indicator of concern for the EF&D directorate, with only the Emergency Care Health Group scoring less overall. There is clear evidence of the need to listen, trust and respect our staff and look to develop an improvement plan that will strengthen staff morale and improve productivity and culture. It is the responsibility of all managers and staff in the directorate to work towards improving the staff survey results.

In the Performance Management / Improved Efficiency / Continuous Improvement domains assurance was reduced due to the lack of a committee structure that would receive such reports from the services. This is a direct correlation to the need to review and strengthen the governance arrangements in the directorate. As we transition into the 'living with COVID-19' stage, this is the ideal opportunity for the senior management team to consider what governance arrangements are required in order to strengthen overall assurance for the directorate.

In order to ensure that the assurance is strengthened overall action plans have been established. The progress against these actions will be monitored at the Non-Clinical Quality Committee.

5. COSTS

As a consequence of assessing the level of assurance, SAQ Leads have been asked where there is a weakness to develop an action plan to strengthen assurance. Some of these actions may incur a cost additional to that which is available within the directorate's revenue allocation.

Table 2: Identifies costs identified by SAQ Leads in order to strengthen assurance

Ref	NHS Premises Assurance Model - Self Assessment Questions	Costs to achieve compliance 2022		
		Capital	Revenue	
SH3	Document Management	£0	£30,000	Technical Asset Officer (B3)
SH5	Asbestos Management	£0	£6,000	Asbestos Archive
SH6	Medical Gas Systems	£0	£20,000	Schematic drawings.(HTM requirement)
SH8	Water Safety Systems	£0	£50,000	Schematic drawings.(HTM requirement)
SH18	Safety in Other Premises	£0	£80,000	Appoint a junior surveyor (B7).
	Overall Costs for Hard FM Domain	£0	£186,000	

SS1	Catering Services	£0	£6,000	Food Hygiene training (New Healthcare Standards for Food and Drink) requirements
SS8	Pest Control	£0	£2,000	Estates Officers training in basic pest control.
	Overall Costs for Soft FM Domain	£0	£8,000	
P4	Access and car parking	£150,000	£5,000	Site wayfinding maps. Correction of BPA audit actions. Equality & Access improvements
P6	Catering Services	£0	£45,000	Recruitment of Catering Dietician
	Overall Costs for Patient Experience Domain	£150,000	£55,000	
E4	Suitable Sustainable Approach	0	£5,000	CHP certification. Dangerous Goods transportation training.
	Overall Costs for Effectiveness Domain	£0	£5,000	
F3	Improved Efficiencies in Capital Procurement	0	£50,000	Space Manager recruitment
	Overall Costs for Efficiency Domain	£0	£50,000	
G1	Governance Framework	0	£5,000	PAM Software solution
	Overall Costs for Governance Domain	£0	£5,000	

Overall Total Costs		**£150,000**	**£304,000**

6. RISK

The outcome of the 2022/23 self-assessment does highlight some risks to the organisation with regards to the management of the estate and provision of Hard and Soft FM services. The domains rated below 50% assurance and requiring immediate attention are as follows:

- Asbestos Management
- Safety in other Premises
- Fire Safety
- Engagement and Involvement
- Condition, appearance, maintenance and privacy and dignity perception
- Governance process
- Leadership and Culture

7. BENCHMARKING

It is possible to compare our level of assurance against that of other Trusts, once the PAM ratings are published. The benchmarking data is usually published towards the end of the calendar year. Fundamentally, they do not form part of the Model Hospital information dataset at present.

8. RECOMMENDATIONS

The Trust Board is asked to:
- Receive the report,
- Note the internal NHS PAM self-assessment outcomes for information and assurance,
- Approve the submission of the PAM self-assessment ratings to the NHS England / NHS Improvement (NHSE/I) PAM portal.

Lee Bond
Chief Finance Officer
June 2023

Appendix 1

Safety Hard: (Reportable)

SH1 – Estates and Facilities Operational Management
SH2 – Design, Layout & Use of Premises
SH3 – Document Management
SH4 - Health & Safety at Work
SH5 – Asbestos Management
SH6 – Medical Gas Systems
SH7 – Natural Gas & Specialist Piped Systems
SH8 – Water Safety Systems
SH9 – Electrical Systems
SH10 – Mechanical Systems e.g. lifting equipment
SH11 – Ventilation, Air Conditioning and Refrigeration Systems
SH12 – Lifts, Hoists & Conveyancing Systems
SH13 – Pressure Systems
SH14 – Fire Safety
SH15 – Medical Devices and Equipment
SH16 – Resilience, Emergency and Business Continuity Planning
SH17 – Safety Related Systems
SH18 – Safety in Other Premises
SH19 – Contractor Management
SH20 – Healthcare Safety Investigation Branch (HSIB) (new for 2022/23)

Safety Soft: (Reportable)

SS1 – Catering Services
SS2 – Decontamination Services
SS3 – Waste Management
SS4 – Cleaning & Infection Control
SS5 – Laundry & Linen Services
SS6 – Security Management
SS7 – Transport Services
SS8 – Pest Control
SS9 – Portering Services
SS10 – Estates IT and Building Information (BIM) Systems (change for 2022/23)

Patient Experience: (Reportable)

P1 – Service User Involvement
P2 – Condition, Appearance & Maintenance
P3 – Cleanliness
P4 – Access & Car Parking
P5 – Grounds & Gardens
P6 – Catering Services

Effectiveness:

E1 – Clear, Vision & Strategy
E2 – Town Planning
E3 – Management of Land and Property
E4 – Suitable Sustainable Approach

Efficiency:

F1 – Performance Management

F2 – Improved Efficiency in Operational Services

F3 – Improved Efficiencies in Capital; Procurement

F4 – Robust Financial Management

F5 – Continuous Improvement & Sustainability Ensured

Governance:

G1 – Governance Framework

G2 – Leadership, Culture & Vision

G3 – Professional Advice

Helipad

H1 – Helipad (new for 2022/23)

PERFORMANCE AND FINANCE SUMMARY

Verbal

REFERENCES

📄 10.4 - PAF Summary June 2023.pdf

Item: Performance	Level of assurance gained: Reasonable

Ambulance turnover times had improved but the Trust had marginally missed its trajectory in May 2023.

ED performance was also improving slowly but it was likely that the Trust would not achieve its June trajectory.

The daily average for patients with no criteria to reside was 187. Rosmore 2 will open on 24 July 2023.

The Mental Health patient hub had opened.

Cancer performance had deteriorated in May/June and the Intensive Support Team had been invited to review the issues from an administration point of view.

The Day Surgery Unit at Castle Hill Hospital had opened and theatres were being opened in a controlled way.

Item: Financial Report Month 2	Level of assurance gained: Reasonable

At month 2 the Trust was reporting a deficit of £2.4m which was £1.8m worse than plan.

Key issues: The CRES plan and the cost of the Junior Doctor strike in April 2023.

The underlying financial position was £42m. The plan to address this was being developed.

Item: Capital Plan 2023/24	Level of assurance gained: Reasonable

The reported capital position at month 2 shows gross capital expenditure of £1.98m against a plan of £4.1m. The main areas of expenditure relate to the PFI lifecycle costs; backlog maintenance and Theatres. The slippage relates to the day surgery unit and is a profile issue. There is also some slippage on IFRS16 leases, for example the cyclotron.

The following reports were also shared:
- Board Assurance Framework – Q1 2023/24
- Screening Programme Update
- Elective Care Priorities 2023/24
- Committee Effectiveness Review

The following contracts were received:
- 6 month extension for the supply of mini cardiopulmonary bypass equipment and adult membrane oxygenators/reservoirs for extracorporeal – The Committee asked for more background information relating to this contract.
- Independent sector contract requirements for 2023/24 – Approved subject to full Committee approval

DATE AND TIME OF THE NEXT MEETING

Tuesday 12 September 2023