# AGENDA

**A meeting of the Trust Boards-in-Common (meeting held in Public)**
**to be held on Thursday, 13 June 2024 at 9.00 am to 1.00 pm**
**in the Boardroom, Hull Royal Infirmary**

**For the purpose of transacting the business set out below:**

| No. | Agenda Item | Format | Purpose | Time |
|---|---|---|---|---|
| **1.** | **CORE / STANDING BUSINESS ITEMS** | | | |
| 1.1 | **Welcome, Group Chair's Opening Remarks and Apologies for Absence**<br>Sean Lyons, Group Chair | Verbal | Information | **09:00** |
| 1.2 | **Declarations of Interest**<br>Sean Lyons, Group Chair | Verbal | Assurance | |
| 1.2.1 | **Fit & Proper Person Test: Annual Declaration**<br>David Sharif, Group Director of Assurance | BIC(24)089 Attached | Assurance | |
| 1.3 | **Minutes of the Meeting held on Thursday, 11 April 2024**<br>Sean Lyons, Group Chair | BIC(24)090 Attached | Approval | |
| 1.4 | **Matters Arising**<br>Sean Lyons, Group Chair | Verbal | Discussion / Assurance | |
| 1.5 | **Action Tracker**<br>- **Public**<br>Sean Lyons, Group Chair | BIC(24)091 Attached | Assurance | |
| 1.6 | **Group Chief Executive's Briefing**<br>Jonathan Lofthouse, Group Chief Executive | BIC(24)092 Attached | Assurance | **09:15** |
| **2.** | **GROUP DEVELOPMENT** | | | |
| 2.1 | **Group Branding Launch**<br>Myles Howell, Group Director of Communications | BIC(24)094 Attached | Information | |
| 2.2 | **Group Memorandum of Understanding**<br>David Sharif, Group Director of Assurance | BIC(24)095 Attached | Approval | |
| **3.** | **BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS** | | | |
| 3.1 | **Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge**<br>Sue Liburd & David Sulch, Non-Executive Directors Committee Chairs | BIC(24)096 Attached | Assurance | **09:50** |
| 3.1.1 | **Annual Quality Account**<br>Amanda Stanford, Group Chief Nurse | BIC(24)098 Attached | Approval | **10:05** |
| 3.1.2 | **Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH**<br>Stuart Hall & Sue Liburd, NED Maternity & Neonatal Safety Champions | BIC(24)099 Attached | Assurance | **10:20** |
| 3.1.3 | **Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH**<br>Amanda Stanford, Group Chief Nurse | BIC(24)100 Attached | Assurance | **10:30** |
| | **BREAK – 10:40 – 10:55** | | | |

| 3.2 | **Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge**<br>Gill Ponder, Non-Executive Director Committee Chair | BIC(24)101<br>Attached | Assurance | **10:55** |
|---|---|---|---|---|
| 3.2.1 | **Annual Plan:  Operational Plan**<br>Ivan McConnell, Group Chief Strategy & Partnerships Officer | BIC(24)102<br>Attached | Approval | **11:10** |
| 3.3 | **Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge**<br>Tony Curry & Kate Truscott, Non-Executive Directors Committee Chairs | BIC(24)103<br>Attached | Assurance | **11:15** |
| 3.3.1 | **Freedom to Speak up Guardian Annual Report including Quarter Four**<br>Liz Houchin & Fran Moverley, FTSUG | BIC(24)104<br>Attached | Assurance | **11:30** |
| 3.3.2 | **NHS Equality Delivery System 2022 – Submission 2024**<br>Simon Nearney, Group Chief People Officer | BIC(24)105 | Approval | **11:40** |
| 3.4 | **Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge**<br>Simon Parkes & Jane Hawkard, Non-Executive Directors Committee Chairs | BIC(24)106<br>Attached | Assurance | **11:45** |
| 3.4.1 | **HUTH Annual Accounts & Reports 2023/24 formal delegation of authority to Audit, Risk and Governance Committees-in-Common**<br>Lee Bond, Group Chief Financial Officer | BIC(24)107<br>Attached | Approval | **12:00** |
| 3.5 | **Capital & Major Projects Committees-in-Common Highlight Report & Board Challenge**<br>Gill Ponder, Non-Executive Director Committee Chair | BIC(24)109<br>Attached | Assurance | **12:10** |
| **4.** | **GOVERNANCE & ASSURANCE** | | | |
| 4.1 | **Board Assurance Framework & Strategic Risk Register – NLaG and HUTH**<br>David Sharif, Group Director of Assurance | BIC(24)110<br>Attached | Assurance / Approval | **12:25** |
| **5.** | **OTHER ITEMS FOR APPROVAL** | | | |
| 5.1 | **Protocol for Reserving Matters to a Private Board Meeting**<br>David Sharif, Group Director of Assurance | BIC(24)111<br>Attached | Approval | **12:30** |
| 5.2 | **Division of Responsibilities Between the Group Chair and the Group Chief Executive**<br>David Sharif, Group Director of Assurance | BIC(24)112<br>Attached | Approval | **12:35** |
| 5.3 | **Health & Safety Policy Statement**<br>Lee Bond, Group Chief Financial Officer | BIC(24)113<br>Attached | Approval | **12:40** |
| **6.** | **ITEMS FOR INFORMATION / SUPPORTING PAPERS** | | | |
| 6.1 | **Items for Information / Supporting Papers (as per Appendix A)**<br>Sean Lyons, Group Chair | Verbal | Information / Assurance | |
| **7.** | **ANY OTHER URGENT BUSINESS** | | | |
| 7.1 | **Any Other Urgent Business**<br>Sean Lyons, Group Chair / All | Verbal | | **12:45** |

| | | | | |
|---|---|---|---|---|
| **8.** | **QUESTIONS FROM THE PUBLIC AND GOVERNORS** | | | |
| 8.1 | **Questions from the Public and Governors**<br>Sean Lyons, Group Chair | Verbal | Discussion | **12:50** |
| **9.** | **MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON** | | | |
| 9.1 | **To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common**<br>Sean Lyons, Group Chair / All | Verbal | Discussion | **12:55** |
| **10.** | **DATE OF THE NEXT MEETING** | | | |
| 10.1 | **The next meeting of the Boards-in-Common will be held on Thursday, 8 August 2024 at 9.00 am** | | | |

**KEY**:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

**APPENDIX A**

| 6. | ITEMS FOR INFORMATION / SUPPORTING PAPERS | |
|---|---|---|
| 6.1 | Quality & Safety Committees-in-Common | |
| 6.1.1 | **Quality & Safety Committees-in-Common Minutes – March and April 2024**<br>Sue Liburd & David Sulch, Non-Executive Director Committee Chair | BIC(24)115 Attached |
| 6.2 | Performance, Estates & Finance Committees-in-Common | |
| 6.2.1 | **Finance & Performance Committees-in-Common Minutes – March & April 2024**<br>Gill Ponder & Mike Robson, Non-Executive Director Committee Chair | BIC(24)116 Attached |
| 6.3 | Workforce, Education & Culture Committees in Common | |
| 6.3.1 | **Workforce, Education & Culture Committee-in-Common Minutes – March & April 2024**<br>Kate Truscott & Tony Curry, Non-Executive Director Committee Chair | BIC(24)117 Attached |
| 6.3.2 | **Guardian of Safe Working Hours Report – Quarter Four**<br>Dr Kate Wood, Group Chief Medical Officer | BIC(24)118 Attached |
| 6.4 | Other | |
| 6.4.1 | **Integrated Performance Report – NLaG and HUTH**<br>Ivan McConnell, Group Chief Strategy & Partnerships Officer | BIC(24)121 Attached |
| 6.4.2 | **Organ Donation Annual Report**<br>Dr Kate Wood, Group Chief Medical Officer | BIC(24)122 Attached |
| 6.4.3 | **Trust Boards & Committees Meeting Cycle**<br>David Sharif, Group Director of Assurance | BIC(24)124 Attached |

## PROTOCOL FOR CONDUCT OF BOARD BUSINESS

- Any Director wishing to propose an agenda item should send it with 8 clear days' notice before the meeting to the Group Chair, who shall then include this item on the agenda for the meeting. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the Group Chair.
- Urgent business may be raised provided the Director wishing to raise such business has given notice to the Group Chief Executive not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting.
- Board members wishing to ask any questions relating to those reports listed under 'Items for Information' should raise them with the appropriate Director outside of the Board meeting. If, after speaking to that Director, it is felt that an issue needs to be raised in the Board setting, the appropriate Director should be given advance notice of this intention, in order to enable him/her to arrange for any necessary attendance at the meeting.
- Directors / Board members should contact the Group Chair as soon as an actual or potential conflict is identified. Definition of interests **–** A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold." Source: NHSE – Managing Conflicts of Interest in the NHS.
- When staff attend Board meetings to make presentations (having been advised of the time to arrive by the Board Secretary), it is intended to take their item next after completion of the item then being considered. This will avoid keeping such people waiting for long periods.

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)089**

| **Name of Meeting** | Trust Boards-in-Common | |
|---|---|---|
| **Date of the Meeting** | 13 June 2024 | |
| **Director Lead** | David Sharif, Group Director of Assurance | |
| **Contact Officer / Author** | David Sharif, Group Director of Assurance | |
| **Title of Report** | Fit and Proper Persons Test: Annual Declaration | |
| **Executive Summary** | This paper sets out the annual assurance provided by the Group Chair that all Board directors remain fit and proper for their roles. It also details the current register of interests for Board members and highlights the work of internal audit to support their significant assurance opinion. | |
| **Background Information and/or Supporting Document(s)** (if applicable) | N/A | |
| **Prior Approval Process** | N/A | |
| **Financial Implication(s)** | N/A | |
| **Implications for equality, diversity and inclusion, including health inequalities** | N/A | |
| **Recommended action(s) required** | ☐ Approval<br>☐ Discussion<br>✓ Assurance | ☐ Information<br>☐ Review<br>☐ Other – please detail below: |

## Fit and Proper Persons Requirements: Chair’s Annual Declaration

### 1. Purpose

1.1. The purpose of this paper is to provide the annual assurance that all Board directors remain fit and proper for their roles. It also details the current register of interests for Board members (Appendix 2).

### 2. Background

2.1. As a health provider, the Trusts have an obligation to ensure that only individuals fit for their role are employed. Following the introduction of regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the ‘Fit and Proper Persons Test’.

2.2. The Group adopted a Fit and Proper Person Test (FPPT) Policy in April 2024 that reflected the requirements of the NHS England (NHSE) FPPT Framework published in August 2023 and the NHS Leadership Competency Framework for Board Members published on 28 February 2024. Section 2 of the FPPT policy specifies the scope of the staff who are included as: “all board members: executive and non-executive directors (permanent, interim (all contractual forms) and associate positions and irrespective of voting rights) and to those individuals who perform the functions of or functions equivalent or similar to the functions of a director.”

2.3. The Policy requires a full Fit and Proper Person Test (FPPT) to be completed on appointment and requires ongoing assurance “to ensure that those covered by the scope of this policy continue to meet the requirements of the FPPT and this will be undertaken through an annual assessment of ongoing fitness.” The Group Director of Assurance is responsible for initiating an annual audit of the compliance on behalf of the Trust Chair and for this compliance report to the Board (and Council of Governors).

2.4. Each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of the Group Chief People Officer or the Group Chair.

2.5. The 2023-24 process was completed by the staff in scope, the Group Director of Assurance deputies and HR. Appendix 1 details the tests applied on recruitment and for the purpose of the annual assessment of continued compliance.

### 3. Outcome of the Annual Fit and Proper Persons Checks

3.1. Working closely with the Group Director of Assurance deputies, HR has saved systematically the completed declarations and the outcome of the searches on each personal file. During the exercise a matrix of progress was maintained and colour-coded to enable a ready assessment of progress, completion and key issues. This approach identified:

- Where employees long did not acquire a fully FPPT-compliant reference (confirming their period of employment and reasons for leaving) due to their

long-standing employment at the Trust or prior employment at a non-NHS body.

- Different DBS approaches or understanding leading to a few staff who had not signed up to the annual subscription service – leading to need for a strengthened communication process for 2024-25.

- Some lapsed mandatory training – this led to some follow-up work by colleagues to resolve and will be a focus in 2024-25 to avoid last-minute chasing.

3.2. Furthermore, this approach has supported:

- An internal audit of **all** staff records for **every** item by Audit Yorkshire and RSM working in unison; and

- A spot check sample review by the Group Chair and Group Director of Assurance.

3.3. Internal audit has provided a draft report (at the time of writing) with a Significant Assurance opinion and confirmation that 'the Trusts have arrangements in place for ensuring compliance with fit and proper persons regulations, although some areas for improvement have been identified as part of our testing'. The report contained three moderate recommendations and five minor recommendations and will be received by the Audit, Risk and Governance Committee once finalised. The Trust has accepted all the recommendations. The three moderate recommendations aim to:

- Clarify the approach to be undertaken for the social media checks from NHSE;

- Gain staff approval to review the digital footprint of social media accounts; and

- Ensure the Chair signs off the completed FPPT assessment paperwork – now completed.

3.4. In determining the best route to meet the first two social media recommendations, the Trust is considering instigating an Ethics Committee to assess the available guidance and purpose of the test with an eye to the limitations of any such check and any personal privacy issues. Its outcome is likely to be reflected in a revised FPPT policy.

3.5. In addition, the Trust will be reviewing its review of Companies House company directorship registrations to ensure all disqualifications or insolvencies are recorded over the period covered by the FPPT.

3.6. As a result of the work of internal audit and further spot checks, the Trust has gained sufficient assurance that all Board directors remain fit and proper for their roles. A review of the Board register of interests has not identified any significant issues and supports this conclusion (Appendix 2).

3.7. During 2024-25 and in advance of year-end, colleagues will be reminded of the need to refresh their declarations (to meet the minimal requirement of one each year) and more if anything changes.

## 4. Recommendations

4.1. The Trust Board is asked to:

a) receive and take assurance that the Fit and Proper Persons Test has been conducted for the period 1 February 2024 to 31 March 2024 and that all Board members satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test;

b) note the key recommendations arising from the Internal Audit work that will be progressed for next year's FPPT; and

b) receive and note the Directors Register of Interest (Appendix 2).

**Sean Lyons**
**Group Chair**
**June 2024**

## Appendices

### Appendix 1 - Fit and Proper Person: On Recruitment and Annual Assessment of Continued Compliance

All new appointments are subject to a full Fit and Proper Persons Test that includes:

- Determination and evidence of employment history and specific qualifications/requirements set out within the job description and person specification and contained within an application form and/or CV and tested during a competency based interview (evidence of the latter may be provided in an interview pack or itinerary (which may include details of a presentation or the actual presentation) and/or interview notes)1
- Receipt of references
- Identity checks e.g. passport/birth certificate/driving licence
- Qualification checks
- Professional body registration checks, if applicable
- Occupational health checks
- Right to work checks e.g. passport/birth certificate/EU Visa/Non-EU Tier 2 Visa
- Disclosure and Barring Service (DBS) checks
- Fit & Proper Person Checks (in addition to the above listed standard employment checks):
  - Insolvency and bankruptcy register checks
  - Disqualified directors' register checks
  - Disqualified charity trustee checks
  - Web based or reasonable search of the individual using key words such as 'NHS', 'Criminal', 'Fraud', 'Dismissed', 'Investigation', 'Disqualified'

The annual assurance check consists of the following:

- The completion of an annual self-declaration of ongoing compliance with the Fit & Proper Persons Test
- Annual review and updating of the Register of Directors' Interests. (The Trust Board will undertake a formal annual review of the register. This is supplemented by the requirement at every Board meeting for confirmation of any new declarations to the Directors' register of interests and declarations of interest in any of the agenda items)
- Declarations of gifts and hospitality
- Declarations of secondary/outside employment
- Annual re-checks of the Fit & Proper Persons and other appropriate checks undertaken on recruitment; specifically, DBS, professional body registration checks, if applicable, insolvency and bankruptcy register checks, disqualified directors' register checks and disqualified charity trustee checks
- Annual appraisal and the agreement of objectives and, where required, the agreement of personal development plans and/or any managerial supervision
- The management of any performance management or disciplinary issues
- Monitoring of sickness absence

- Monitoring of mandatory training compliance and evidence of any continuing professional development
- An annual declaration by the Trust Chair at a Board meeting held in public that all those covered by the scope of this policy continue to meet the requirements of the Fit & Proper Persons Test
- Confirmation that Directors remain on the relevant professional register.

**Appendix 2 - Director Register of Interests 2024**

| Executive Directors and Other Directors Register of Directors Interests<br>At both the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals (HUTH) | |
|---|---|
| **Name and position** | **Interests** |
| Lee Bond, Group Chief Financial Officer | Trustee of WISHH Charity.<br>Immediate Past President, Healthcare Financial Management Association (HFMA). |
| Rob Chidlow, Interim Group Director of Quality Governance | None. |
| Andy Haywood, Group Chief Digital Information Officer | None. |
| Anita Jackson, Group Transformation Director | Director of own company – Kabhal Lrd.<br>Director of Marlabright Lrd.<br>Lt Col in the Army Medical Services. |
| Jonathan Lofthouse, Group Chief Executive Officer | Wife Volunteers with the Look Good Feel Better work with the Queens Cancer Centre. |
| Ivan McConnell, Group Director of Strategy and Partnerships | None. |
| Simon Nearney, Group Chief People Officer | Director at Cleethorpes Town FC / The Linden Club.<br>Family Members working at NLAG. |
| Neil Rogers, North Bank Managing Director | Director of own limited company – Neil Rogers Healthcare Management Solutions Ltd which is currently dormant. |
| Aswathi Shanker, South Bank Managing Director | None. |
| David Sharif, Group Director of Assurance | None. |
| Amanda Stanford, Group Chief Nurse | None. |
| Kate Wood, Group Chief Medical Officer | Husband is Trust employee - Theatres Manager at Diana, Princess of Wales Hospital Grimsby (DPOWH).<br>Associate for AQUA. |

| Non-Executive Directors at NLAG Register of Directors Interests | |
|---|---|
| **Name and position** | **Interests** |
| Julie Beilby, Associate Non-Executive Director | None. |
| Stuart Hall, Associate Non-Executive Director | Non-Executive Director/Vice Chair HUTH.<br>Partner is Lay Member of Yorkshire Clinical Senate.<br>Member of Advisory Committee on Clinical Excellence Awards. |
| Linda Jackson, Vice Chair/Non-Executive Director | Associate Non-Executive Director at HUTH.<br>Both Sister and Sister-in-law work at Diana Princess of Wales Hospital, Grimsby (DPoWH) (in Family Services). |
| Susan Liburd, Non-Executive Director | Managing Director and Principal Consultant of Sage Blue.<br>Director and Trustee of British West India Regiments Heritage Trust CIC. |
| Sean Lyons, Group Chair at both NLAG and HUTH | Daughter is a student nurse at Sheffield Hallam University. |
| Simon Parkes, Non-Executive Director | Director of Lincoln Science and Innovation Park (Unremunerated).<br>Lay Canon and Chair of the Finance Committee of Lincoln Cathedral.<br>Senior Independent Director of Lincolnshire Housing Partnership.<br>Director of Visit Lincoln (unremunerated).<br>Deputy Vice Chancellor and Chief Operating Officer of the University of Lincoln. |
| Gillian Ponder, Non-Executive Director and Senior Independent Director | None. |
| Kate Truscott, Non-Executive Director | Governing Council Member of the Bishop Grosseteste University, Lincoln.<br>Chair to West Nottinghamshire Further Education College having previously been Vice Chair and the position is not remunerated. |

| Non-Executive Directors at HUTH Register of Directors Interests | |
|---|---|
| **Name and position** | **Interests** |
| Tony Curry, Non-Executive Director | None |
| Stuart Hall, Vice Chair | Associate Non-Executive Director at NLAG.<br>Partner is Lay Member of Yorkshire Clinical Senate.<br>Member of Advisory Committee on Clinical Excellence Awards. |
| Jane Hawkard, Non-Executive Director | Director of JJJ+L Holdings Ltd (July 2020) |
| Linda Jackson, Associate Non-Executive Director | Vice Chair/Non-Executive Director at NLAG.<br>Both Sister and Sister-in-law work at Diana Princess of Wales Hospital, Grimsby (DPoWH) (in Family Services). |
| Sean Lyons, Group Chair at both NLAG and HUTH | Daughter is a student nurse at Sheffield.<br>Hallam University. |
| Dr Ashok Pathak, Non-Executive Director | Works as a medical expert for Medical Appeals Tribunals.<br>Son and daughter-in-law both are surgeons at St James Hospital, Leeds |
| Dr David Sulch, Non-Executive Director | Medicolegal reports on patients in the fields of stroke, geriatric or general medicine (split roughly 80:20 between defendant and claimant work). I have reported on the care of patients treated at HUTH and NLaG previously but do not do so now. |

# BOARDS-IN-COMMON MEETING IN PUBLIC

**Minutes of the meeting held on Thursday, 11 April 2024 at 9.00 am**

in the Main Boardroom, Diana, Princess of Wales Hospital

**For the purpose of transacting the business set out below:**

**Present:**

**<u>Core Members</u>:**

| | |
|---|---|
| Sean Lyons | Group Chair |
| Jonathan Lofthouse | Group Chief Executive |
| Lee Bond | Group Chief Financial Officer |
| Shaun Stacey | Group Chief Delivery Officer |
| Dr Kate Wood | Group Chief Medical Officer |
| Tony Curry | Non-Executive Director (HUTH) |
| Stuart Hall | Vice Chair (HUTH) |
| Linda Jackson | Vice Chair (NLaG) |
| Jane Hawkard | Non-Executive Director (HUTH) |
| Sue Liburd | Non-Executive Director (NLaG) |
| Gill Ponder | Non-Executive Director (NLaG) |
| Simon Parkes | Non-Executive Director (NLaG) |
| Mike Robson | Non-Executive Director (HUTH) |
| David Sulch | Non-Executive Director (HUTH) |
| Kate Truscott | Non-Executive Director (NLaG) |

**In Attendance:**

| | |
|---|---|
| Julie Beilby | Associate Non-Executive Director (NLaG) |
| Tracy Campbell | Director of Nursing – North |
| David Cuckson | Public Governor (NLaG) |
| Nicky Foster | Head of Midwifery (NLaG) (for item 4.1.2) |
| Neil Gammon | Health Tree Foundation Trustees' Committee Independent Chair |
| Jenny Hinchliffe | Director of Nursing - South |
| Myles Howell | Group Director of Communications |
| Ivan McConnell | Group Chief Strategy & Partnerships Officer |
| Rukeya Miah | Head of Midwifery (HUTH) (for item 4.1.2) |
| Simon Nearney | Group Chief People Officer |
| Ian Reekie | Lead Governor (NLaG) |
| David Sharif | Group Director of Assurance |
| Amanda Stanford | Airedale NHS Foundation Trust |
| Sarah Meggitt | Executive Assistant to the Group Chair (minute taker) |

**KEY**

HUTH - Hull University Teaching Hospitals NHS Trust

NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

## 1. CORE BUSINESS ITEMS

### 1.1 Welcome, Group Chair's Opening Remarks and Apologies for Absence

Sean Lyons welcomed board members and observers to the meeting and declared it open at 9.00 am.

Sean Lyons welcomed Julie Beilby, Associate Non-Executive Director, (ANED) NLaG, David Sharif, Group Director of Assurance and Tracy Campbell, Director of Nursing - North to their first meeting of the Trust Boards-in-Common. Amanda Stanford was also welcomed to the meeting; it was noted she was due to start on the 22 April 2024 as the Group Chief Nurse for NLaG and HUTH.

Sean Lyons also paid tribute to Mike Robson for his time at HUTH as a Non-Executive Director (NED) thanks were noted for his contribution in supporting the Board and Committees during this time. It was noted this was the second meeting of the Trust Boards-in-Common, Sean Lyons thanked everyone for the continued support particularly around the highlight reports from the Committees-in-Common. Attendees were asked to report on the significant issues the board needed to concentrate on during the meeting.

The following apologies for absence were noted:

Ashok Pathak Associate Non-Executive Director (HUTH)

It was noted the Council of Governors were due to meet on the 18 April 2024, NLaG Board members were asked to attend the meeting.

### 1.2 Patients Story – NLaG

Dr Kate Wood shared the story of Mr Pearson who had had a Medical Thrombectomy (MT) whilst being cared for at Castle Hill Hospital (CHH) following a stroke. Dr Kate Wood explained this was an excellent service that was provided Monday to Friday for an eight-hour period, however, a bid had been submitted to provide the service on a 24/7 basis. Jonathan Lofthouse advised the bid was now in the final stages and it was hoped the decision for funding would be made within the next four weeks. It was noted this was a very complex procedure that was regarded nationally as a platinum service at CHH. If funding was received the Hull site would become a Stroke Super Centre making it the second largest in the country. The next phase of considered development would be to expand the rehabilitation services at Hull on the CHH site. Linda Jackson queried whether Goole Neuro Rehabilitation would fit into the expansion at CHH. Jonathan Lofthouse advised the demographics for this were being reviewed over coming weeks.

Stuart Hall queried how far this service could be offered geographically. Dr Kate Wood explained this was a specialist service given the nature of the procedure. A system was currently being piloted where ambulance crews would be able to communicate with CHH to determine whether patients could be taken straight there that may require the procedure. On arrival, the patient would then receive a Computerised Tomography (CT) scan that would determine the required pathway. The results of the pilot were expected over coming months.



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Simon Parkes queried why the extended hours would only be offered if the Trusts were successful in securing a bid given the clear improvements of receiving the treatment. Jonathan Lofthouse advised this was a costly therapy to resource and was not the only expensive priority that could be offered to patients. In light of this it was necessary to secure bids to implement those types of services. Simon Parkes felt it would be helpful to have the detail of where such decisions were made in respect of bids for services as it had not previously been discussed at Board level. David Sulch highlighted the procedure was only suitable for a small number of patients as other factors also had to be considered. David Sulch queried how long it would take to implement the 24/7 service and whether there were any contingencies in place until the service was running. Dr Kate Wood explained there was no other 24/7 service available in the Northern Region.

1.3 **Declarations of Interest**

No declarations of interests were received in respect of any of the agenda items.

1.4 **To approve the minutes of the Boards-in-Common meeting held on Thursday, 8 February 2024 – BIC(24)050**

The minutes of the meetings held on the 8 February 2024 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Lee Bond referred to page six, item 1.10, the third paragraph referred to both Trusts receiving rebates from the Care Quality Commission (CQC). The wording needed to be amended as the rebates had been received, however, this was not from the CQC.

- Lee Bond referred to page eight, item 1.10. The wording in the paragraph needed to be amended to state, “underspent slightly”.

1.5 **Matters Arising**

Sean Lyons invited board members to raise any matters requiring discussion not captured on the agenda, no items were raised.

1.6 **Action Tracker – Public – BIC(24)051**

The following updates to the Action Tracker were noted:

**HUTH**

- Item 09.03, 12 September 2023 – Workforce, Disability Equality Standards Report. It was advised the Network Chair would be available to attend a board development session. It was agreed this action would be closed.

**NLaG**

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- Item 9.1, 5 December 2023 – Escalation from the Quality & Safety Committee (NLaG) – Lack of equipment. Lee Bond advised the purchase of some items of equipment had been brought forward. Further to some discussion it was advised the Capital & Major Projects Committees-in-Common and Performance, Estates & Finance Committees-in-Common had oversight of such actions. It was agreed this item could be closed.

- Item 9.2, 5 December 2023 – Escalation Report from the Finance & Performance Committee (NLaG) – MADE Events. Jonathan Lofthouse advised that himself and Shaun Stacey had co-ordinated with Partners on this issue. Shaun Stacey had also facilitated MADE events over the recent bank holidays which had been successful. It was agreed this action could be closed.

- Item 9.3, 5 December 2023 – Escalation Report from the Workforce Committee – Retention Update. Simon Nearney provided and update on this item. It was agreed this action could be closed.

- Item 9.4, 5 December 2023 – Escalation Report from the Audit, Risk & Governance Committee (NLaG) - Staff working in outside employment. Simon Nearney advised this was being progressed. It was agreed this action could be closed.

- Item 10.1, 5 December 2023 - Maternity & Neonatal Oversight Report – Maternity Safety Champions Action Log. Jenny Hinchliffe advised there were no concerns to escalate regarding this issue as work continued to be progressed. It was agreed this action could be closed.

- Item 4.5.1, 8 February 2024 – Chair of Health Tree Foundation Trustees' Committee – Extension of Tenure – Foundation Patron Role due to current Patron Standing Down. It was agreed this item would be addressed at item 4.5.

**1.7 Group Chief Executive's Briefing – BIC(24)052**

**1.7.1 Proposal to Adopt the Group Brand**

In respect of the leadership structure, Jonathan Lofthouse advised one vacancy remained for the role of Group Director of Estates. It had been agreed this would operate as a triumvirate leadership team on an interim basis, this would again be advertised in the future. The Group Director of Quality Governance role had been advertised with shortlisting due to commence.

Shaun Stacey reported that in respect of the care group structure, the final role would be interviewed for on the 18 April 2024, a further role had interim arrangements in place due to the current post holder being on secondment at another Trust. All staff had now commenced in new roles.

It was reported the second Top 100 Leadership Event was due to take place on the 16 April 2024. This included a session from Professor Michael West amongst other guest speakers. A further event would be held in the summer.

Jonathan Lofthouse reported the implementation of Lorenzo had impacted on some staff; it was clear post live that the additional support should have been in place for a longer period of time. The Cabinet have revisited this issue and agreed to supplementary support over the next year.

Jonathan Lofthouse advised staff had been allowed to vote on suggestions for the new Group Name, it was noted this did not affect the sovereign names of both organisations. Five names had been provided for the vote against national specification, the chosen name by staff was NHS Humber Health Partnership. Jonathan Lofthouse sought approval of the Group identity from the Trust Boards-in-Common. Sue Liburd queried whether there had been any issues raised from other providers in respect of the proposal. Jonathan Lofthouse advised none had been received. Linda Jackson felt it would be useful to know when the Group name should be used and when sovereign names should be maintained.

**The Trust Boards-in-Common approved the Group name NHS Humber Health Partnership.**

Jonathan Lofthouse advised of an intruder who had entered the Diana, Princess of Wales Hospital (DPoWH) Mortuary on the 17 March 2024. The individual was arrested and charged and would appear in court on the 22 April 2024. Should the individual plead guilty a custodial sentence would be given due to the nature of the crime. If the individual pleaded not guilty this would go to a full jury at a later date. All families affected by the incident had been treated with full disclosure and respect. Thanks were noted to Jenny Hinchliffe for liaising with the families involved. It was noted a letter had been sent to each family from Jonathan Lofthouse. All staff involved in the incident had been provided with welfare and wellbeing support of their choice. An independent assessment would now be undertaken in terms of guidance and assessment of that area as per regulatory guidelines by David Sharif. Sean Lyons advised the NLaG Governors had been briefed on the incident soon after.

Jonathan Lofthouse advised Ivan McConnell was now the lead for Health Inequalities for the Group. This would be reconfigured through the Service Design Policy and Accessibility to ensure improvements were made.

Shaun Stacey advised there had been a slight improvement in the four-hour Urgent and Emergency Care Standard at HUTH with a positive impact due to the opening of the Urgent Treatment Care Centre (UTC). Shaun Stacey referred to the data provided within the Group Chief Executive report. It was reported the overall flow did require further work as the minimum standards had not been met for 2024. Shaun Stacey referred to the information provided in respect of NLaG performance. It was anticipated NLaG would continue with the good performance on faster access diagnosis in terms of cancer. Shaun Stacey wanted to thank the operational teams who had supported maintaining the standards during a challenging time in respect of the implementation of Lorenzo and the move to the new care group structure. He was confident further improvements would continue to be delivered.

Jonathan Lofthouse advised that himself and Sean Lyons had attended various meetings in respect of shaping the System, included in this had been the financial aspects for NLaG and HUTH. Collective thanks were noted to the Boards for supporting the Group CEO's personal nomination to be the Systems Provider Chief



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Executive representative which was a full Board position of the Integrated Care Board (ICB). Declarations of interest for both organisations would be updated to reflect the role. It was noted the first Board meeting for this had been held the previous day, Wednesday, 10 April 2024. It was reported the 2024-25 Priorities and Operational Planning guidance had recently been received, Board members would be provided with information on requirements at a future Board Development session.

Ivan McConnell advised the consultation on the Humber Acute Services (HAS) had now concluded and the full feedback for this had now been received. It was noted the pre-engagement for the consultation had been recognised as platinum standard from NHS England (NHSE). Ivan McConnell wanted to thank the teams that had supported the consultation. It was reported that the Decision-Making Business Case (DMBC) would soon be finalised; this would make a recommendation to the ICB Board. Included in this was a recommended change that had previously been approved in principle by the ICB Board, final approval would be received at the June 2024 meeting. Ivan McConnell advised one of the concerns that arose from the consultation was around travel to other service providers, engagement with other providers would be undertaken to see if those issues could be resolved.

Jonathan Lofthouse reported the Cost Improvement Programme (CIP) remained at £84 million for both Trusts. It was advised further discussion was due to be held later that day in respect of reaffirming that position. Lee Bond advised that both Trusts still faced challenges with such a large deficit. Productivity, the management of beds and recruitment continued to impact both Trusts.

Simon Nearney explained the apprenticeship schemes were now embedded. This was offered in all areas including various clinical areas of the Trusts. Simon Parkes queried the number of apprenticeship roles on the South Bank. Simon Nearney explained the number was not as high as it was on the North Bank, however, it was recognised this needed to increase so improvements would be made. Simon Parkes offered support through Lincoln University to improve opportunities for apprenticeships at NLaG and HUTH. Jonathan Lofthouse felt this would be a positive option to progress in the future.

Jonathan Lofthouse highlighted the good news story in the Group Chief Executive Report in respect of the Portering Team at HUTH. The team had received a Portering Team of the Year Award.

Dr Kate Wood explained the CQC had visited the Emergency Department (ED) whilst at HUTH for a routine engagement meeting. During the visit the department had been busy, however, the CQC had reported it was calm and excellent clinical practice had been reported. Dr Kate Wood advised the CQC had previously raised concerns regarding the mental health rooms within ED. Following on from this concern, work had been undertaken with the Humber Mental Health team to support resolving those issues. At the visit, the CQC had advised the improvements made had been the best solution they had seen so far. A definite change in practice had been recognised and it was noted the staff had been very knowledgeable. However, one point needing to improve was the length of time patients were waiting to receive specialist care in ED. A further point raised was in respect of bare below the elbow and the inappropriate use of bloods. Dr Kate Wood advised the Communications Team were due to run a campaign for “Bare



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Below the Elbows" to address those issues. Tony Curry queried whether ED numbers had reduced due to the opening of the UTC. Jonathan Lofthouse advised this was the case. Tony Curry asked if data on this could be shared with the Boards. It was agreed Shaun Stacey would provide this information.

**Action: Shaun Stacey to provide Boards with data highlighting reduced numbers in ED at HUTH due to the opening of the UTC.**

Shaun Stacey explained the UTC was open until 10.00 pm with the last patients being received into the department by 9.00 pm. Tony Curry queried whether the issues with the implementation of Lorenzo had caused any delays to patients. Shaun Stacey advised there had been no delays to patients. The impact had been to staff using the system due to the number of areas that were required to be accessed when processing patients. It had been highlighted that once more experience was gained with the system, those issues improved.

## 2. GROUP DEVELOPMENT

### 2.1 Group Development

There were no items under this section.

## 3. STRATEGY

### 3.1 Engagement with External Stakeholders

Jonathan Lofthouse advised dialogue continued with the ICB. The Boards were advised of conferences Jonathan Lofthouse was due to attend over coming weeks. Sean Lyons advised of slides that had been circulated to Board members recently following an NHS Providers Event, this had included a session around current financial constraints and the challenges within the NHS.

## 4. BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS

### 4.1 Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)054

Sue Liburd referred to the report and noted key highlights. Dr Kate Wood advised further reviews would be undertaken in respect of the Summary-hospital Level Mortality Indicator (SHMI) on the North Bank. A new structure for SHMI across the Group would be developed to ensure improvements were made. Updates would continue to be provided through the Quality & Safety Committees-in-Common. Linda Jackson referred to the 29 February 2024 meeting in respect of NLaG and sought more understanding of what the issues were around sepsis and Electronic Prescribing & Medicines Administration (EPMA). Dr Kate Wood advised that in respect of sepsis this was a national issue and there were challenges at both Trusts. There had been some improvements in the recognition of deteriorating patients, however, improvements needed to be maintained. There were some issues around timeliness and the structures that were in place. A review of workloads also needed to be undertaken to enable improvements to be made. Although the action was NLaG specific this was a Quality Priority for both Trusts. Dr Kate Wood reported work continued with EPMA, although patients were being

weighed as they arrived in ED this was not always being recorded on EPMA. Sean Lyons queried whether anything further needed raising to the Boards. Sue Liburd explained the Committee would continue to closely monitor the quality priorities to ensure they were aligned.

4.1.1 **Maternity & Neonatal Safety Champions' Overview Assurance / escalation Reports – NLaG and HUTH – BIC(24)055**

Sue Liburd referred to the report and noted key highlights. The Boards attention was drawn to the appointment of the Director of Midwifery who would start in July 2024. The rating of Good was maintained for Goole Maternity Services which had been positive for that service. One point to note was in respect of mandatory training, in particular the safeguarding training. It was noted the Quality Improvement (QI) projects on the South Bank were progressing well with some being closed.

Stuart Hall wanted the opportunity to recognise the maternity patient survey and some of the achievements made. Shaun Stacey advised of hope that the Director of Midwifery would be in post sooner than July 2024, this would be confirmed shortly. Stuart Hall highlighted that during visits staff had not been made aware of the appointment of the Director of Midwifery and asked if this could be communicated. Shaun Stacey explained that once the start date had been confirmed this would be announced more widely. Lee Bond referred to the risks and concerns within the report around finances, it was noted there was no reserves from the ICB for maternity investment, this would need to be funded through both Trusts current resources. Jenny Hinchliffe explained there would still be some discussion around Ockenden funding which may be received, further information on non-recurrent funding and how this would be allocated was awaited.

4.1.2 **Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH – BIC(24)056**

Rukeya Miah shared the report and went through the highlights of the executive summary with the Boards. It was noted HUTH continued to work on meeting the year six standards for the Clinical Negligence Scheme for Trusts (CNST). Kate Truscott referred to the number of complaints not being closed within timescales and queried whether teams had a particular challenge in terms of not having the time to review them at the moment. Rukeya Miah explained this had been reviewed with the team around engagement with the patient experience team. Improvements had been made in terms of face-to-face opportunities to ensure themes and trends were reviewed. A process of reviewing issues prior to them being received as a complaint was also being introduced.

Jane Hawkard referred to point two in respect of the 50% reduction in deaths and queried how this was being monitored as it was not detailed within the report. Rukeya Miah explained HUTH was not an outlier in respect of this and the position was still in a better position than the National Standards. It was noted this could be detailed more within the report going forward.

Simon Nearney queried whether HUTH would be fully established in terms of staffing by October 2024 within this area. Rukeya Miah advised there was currently four vacancies. The biggest challenge was in respect of those on maternity leave as those staff were in post but were not supporting those areas physically. Some



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staff on maternity leave were also returning on reduced hours which was impacting the establishment. Simon Nearney asked whether it was an option to over recruit midwives going forward to ensure there was some backfill for staff going on maternity leave. Rukeya Miah advised HUTH were hoping to over recruit which would mean that by June 2024 the Trust should be in a plus position.

Nicky Foster shared the report and went through the key highlights within the executive summary with the Boards. It was reported that the CNST confirmation had been received for all ten standards at NLaG. Nicky Foster wanted to thank the teams for the hard work undertaken to achieve this. Sean Lyons also wanted to thank the teams on behalf of the Boards. In respect of the exit from the Maternity Support Programme this continued to progress and would be presented to the next NHSE Board in May 2024 with the exit then being finalised. Nicky Foster escalated to the Boards issues around the ante-natal clinic capacity. The demand of capacity meant the clinics were running with 246 clinic slots short per week across the NLaG sites. It was noted this was on the NLaG Risk Register. Sue Liburd explained this issue meant clinicians were currently working additional hours to ensure the service was provided, however, this was not sustainable in the long term. Jonathan Lofthouse explained this would go to the care group triumvirate for that area to seek a solution, this would then be reviewed by the Executive Cabinet. Sean Lyons sought assurance from Sue Liburd that the Quality & Safety Committee-in-Common would have oversight of this issue. Sue Liburd confirmed this was in place. Simon Parkes queried whether there was a capacity issue in terms of NLaG and HUTH and if there was an option for more midwives to be trained. Nicky Foster advised student numbers were determined by the Universities not the Trusts. However, the opportunity of introducing apprenticeships for midwifery was being reviewed. Simon Parkes advised that the University of Lincoln would welcome more students, however, there was an issue when finding the required number of placements. Nicky Foster agreed this became an issue as the Trusts were unable to support them in practice when they commenced on placement. Rukeya Miah explained shorter training programmes would be more beneficial, however, this was more costly. Jonathan Lofthouse advised this would be on the work plan for a wider discussion going forward for both Trusts.

Gill Ponder referred to the non-compliance of mandatory training and queried whether there were plans in place to address this. Rukeya Miah explained there was in place a training trajectory and progress was being made with additional sessions being scheduled. She reported that attendance was sometimes difficult due to capacity on the wards preventing staff release. Systems were being put in place to ensure this improved with mitigations in place.

Dr Kate Wood referred to the issue of clinic capacity and advised that a meeting was being held within the next week in respect of the obstetric consultant workforce to ensure mitigations were put in place. In respect of the issues around capacity to offer and placement of training places, it was explained this was not just a nursing issue as it also related to medical staff. Discussions were being undertaken on how simulation could be used more going forward. Jenny Hinchliffe advised that in respect of mandatory training, the sharing of resources across the organisations was also to be reviewed to support where possible. Mike Robson queried the process to show how HUTH was going to achieve actions against the Section 31 from the CQC. Dr Kate Wood advised that HUTH were aware not all actions had been completed. A review would be undertaken of the completed gap



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analysis to highlight where HUTH were in terms of plans. The CQC would then be asked to review the analysis to complete required actions.

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4.2 **Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)056**

Mike Robson referred to the highlight report and noted key highlights around matters to be escalated to the Boards. It was reported that deep dives had been undertaken at the Committee in respect of length of stay. It was acknowledged both Trusts had issues around this including No Right to Reside (NRTR) beds. A further update would be brought back to the Committee in three months' time. One risk was highlighted in relation to a deep dive around elective care. Although HUTH had done well reducing the long waiters, there had been an issue around unappointed patients due to them not being risk stratified. Dr Kate Wood explained that a meeting regarding this issue was due to take place the following week. Feedback on this would be discussed at the next Committee meeting. Sean Lyons sought assurance that the committee had oversight of what was required. Gill Ponder wanted to highlight the issue of late contract approvals. This had been discussed during the meeting and agreement had been made to review contract renewal prior to expiry dates. Sean Lyons felt this should be reviewed by the Executive Cabinet to ensure a more robust process was in place going forward. Mike Robson felt the Committee was more assured on performance than it had been previously. Sean Lyons recognised there had been considerable improvements over the last year which the organisations should be proud. It was also noted Lee Bond had achieved the financial plan which was something that should be recognised within all teams for this achievement.

At this point David Cuckson left the meeting.

4.3 **Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)060**

Tony Curry referred to the report and noted key highlights, it was noted there was no requirement for intervention from the Boards as there were no areas of concern. The Committee were seeking further assurance of specific plans particularly around mandatory training, where there was a need to address specific departments where compliance was not where it should be. Kate Truscott highlighted there had been a recommendation around consultant job planning which would be reviewed going forward.

Linda Jackson referred to the consultant vacancies and explained there had been a deep dive into this in respect of what could be addressed. A Medical Consultant Strategy would be introduced that would form part of how this would be addressed. This would also include reviewing those consultants there were over the age of 66 as this was a potential risk to the Trusts should they leave their roles. The organisational development (OD) support for the operational care group structures was also being developed as it was felt this was not sufficient, the Committee would have oversight of this going forward. Simon Nearney confirmed funding had been allocated to resource the OD for the development of the care groups, plans were now being finalised with Shaun Stacey with a paper being shared with the Committee later in April 2024. In terms of consultant staffing at NLaG there had previously been issues, however, going forward HUTH would support particular services to alleviate some of them. A review was being undertaken on current vacancies in the hope to recruit to them, including those that were currently supported by agency roles to resolve additional spend. One option was to have in place the clinical fellows that were able to progress into those roles. Linda Jackson



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felt there was a need to be more robust so that when updates were shared at the Committee there was something to measure against. Shaun Stacey advised there was a need to look at how patients are cared for that required access to those services and it should be recognised there may not be an easy solution to this in terms of capacity. There was a need to look at different ways of working in the future. Linda Jackson recognised this; however, the issue was that a similar deep dive had been undertaken the previous year and improvements had still not been made. Simon Nearney explained the priority had been around filling nursing vacancies at NLaG which would now be fully established by October 2024, the priority would now be for medical roles to ensure improvements were made. It was noted the Committee would receive a paper to address those queries at a future meeting.

Simon Parkes queried whether the mandatory training reported highlight related to patient safety as this was of course the most important. Jonathan Lofthouse advised this was not the case as specific training was mandatory and this did not always relate to patient safety. Sean Lyons advised it would be the care groups responsibility for staff that had not completed the required training and they would be held accountable for this. Tony Curry explained discussions had taken place as to whether compliance levels were achievable. Simon Nearney highlighted that all staff should aim to meet 100% compliance for mandatory training, however, overall data had to consider those staff that were of sick or on maternity leave. This discussion had previously been undertaken at the performance meetings where this would be addressed. Those meetings had ceased whilst new arrangements were being put in place for the Group. This would again be overseen by that meeting. Jonathan Lofthouse explained he had sight of the compliance of the top 100 leaders on a monthly basis, all those staff were contacted if training was not compliant. Sean Lyons reminded board members of their own compliance with mandatory training.

4.3.1 **Staff Survey Results – NLaG & HUTH – BIC(24)062**

Simon Nearney advised this had been presented at a board development session in March 2024 and had also been discussed at the Workforce, Education & Culture Committees-in-Common. The number of completed surveys had increased this year, however, both Trusts remained in the lower quartile in terms of reporting. It was explained meetings had been arranged with the care groups triumvirates to progress on actions in respect of the survey, work on this would be reported to the Workforce, Education & Culture Committees-in-Common. Sean Lyons advised Professor Michael West’s session at the leaders’ event the following week would also include a session on Staff Surveys.

4.4 **Capital & Major Projects Committees-in-Common Highlight Report / Escalation Repot & Board Challenge – BIC(24)063**

Mike Robson shared the highlight report noting this was the first meeting of the new Committee. One issue to be highlighted to the Boards was the inconsistency in terms of how risks were graded, further discussion regarding this would be undertaken. The main risks had related to the Community Diagnostic Centre (CDC) programme. It had been discussed that the Committee would receive more detailed reports in respect of digital at future meetings. Linda Jackson queried where issues in respect of Scunthorpe General Hospital (SGH) would be discussed going forward. Ivan McConnell advised that over the next four months



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the organisation would review capacity demand and workforce within the system, this would then form part of a review to agree where those issues would have oversight.

4.5 **Health Tree Foundation Trustees' Committee Highlight / Escalation Report & Board Challenge – NLaG – BIC(24)065**

Neil Gammon referred to the report and noted key highlights. The NLaG Board was asked to note the Key Performance Indicators (KPIs).

4.5.1 **Health Tree Foundation Update – NLaG – BIC(24)066**

Neil Gammon shared the presentation with the Board. It was noted the Charity at NLaG was sub-contracted to Smile. Neil Gammon drew the Boards attention to the Circle of Wishes within the presentation.

Sean Lyons thanked Neil Gammon for attending the meeting.

In respect of the item on the action tracker regarding appointing a Patron to the Charity, Sue Liburd reported a discussion had been held with Neil Gammon. It was advised one individual was considering undertaking the role, this would be confirmed in due course.

Sean Lyons wanted to note thanks on behalf of the NLaG Trust Board to Sir Reginald Sheffield who was due to stand down from the Patron role.

**5. GOVERNANCE & ASSURANCE**

5.1 **Board Assurance Framework (BAF) & Strategic Risk Register – NLaG & HUTH – BIC(24)067**

David Sharif shared the BAF with the Boards and advised this was a live document that was being developed to form a single BAF for the Group. It was reported discussions were being undertaken to harmonise current risks. David Sharif drew the Boards attention to the risk changes within the report, it was noted the in-year deficit referred to 2023/24 at HUTH. The deterioration of the leadership risk in relation to NLaG referred to the care group structure.

Gill Ponder queried the year-end position for NLaG as to whether this should be rated as eight for achieving the financial plan as this had been the rating for HUTH achieving the same. David Sharif advised that this reflected the difference in the risks themselves from the two different organisations previously. Lee Bond felt both could be rated as zero as the target had been achieved at this point. Jane Hawkard referred to the HUTH risk register in terms of the Integrated Care System (ICS) risk being rated as high as 20 as it was felt there had been contribution to the ICB development. In respect of the risk register Dr Kate Wood felt there was a need for further alignment as progress was made. Jonathan Lofthouse also recognised there would need to be some changes made. It was noted that a new Risk Meeting was now in place where those issues would be addressed as the reviews continued. Jonathan Lofthouse reported that the first joint BAF would be in place by September 2024 after completion of the strategy. Stuart Hall agreed the group continued to make progress updating the risks, discussion had taken place

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during the meeting as to whether the timescales were also realistic. Stuart Hall reminded the Boards this would also drive the Committee agendas in the future.

## 6. OTHER ITEMS FOR APPROVAL

### 6.1 Fit & Proper Persons Policy – BIC(24)068

Sean Lyons referred to the report and confirmed this had been approved in principle at the private board in March 2024. The Trust Boards-in-Common were asked to approve the Fit & Persons Policy.

**The Trust Boards-in-Common approved the Fit & Proper Persons Policy.**

## 7. ITEMS FOR INFORMATION / SUPPORTING PAPERS

### 7.1 Items for Information / Supporting Papers

- Quality & Safety CiC – January & February 2024
- Performance, Estates & Finance CiC – January & February 2024
- Workforce, Education & Culture CiC – January & February 2024
- Health Tree Foundation Trustees' – January 2024 (NLaG)
- Integrated Performance Report (IPR)
- Documents Signed Under Seal – NLaG
- Guardian of Safe Working Hours – NLaG & HUTH
- Trust Boards & Committees Meeting Cycle

## 8. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

## 9. QUESTIONS FROM THE PUBLIC AND GOVERNORS

No questions from the public or governors were received.

## 10. MATTERS FOR REFERRAL TO BOARD-IN-COMMON

10.1 There were no matters for referral to any of the other board committees.

## 11. DATE AND TIME OF THE NEXT MEETING

### 11.1 Date and Time of the next Boards in Common meeting:

Thursday, 13 June 2024 at 9.00 am in the Boardroom, Hull Royal Infirmary

The committee chair closed the meeting at 12:35 hours.

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## Cumulative Record of Board Director's Attendance 2024/25

| Name | Possible | Actual | Name | Possible | Actual |
|---|---|---|---|---|---|
| Sean Lyons | 1 | 1 | Simon Nearney | 1 | 1 |
| Jonathan Lofthouse | 1 | 1 | Ashok Pathak | 1 | 0 |
| Julie Beilby | 1 | 1 | Simon Parkes | 1 | 1 |
| Lee Bond | 1 | 1 | Gill Ponder | 1 | 1 |
| Tony Curry | 1 | 1 | Mike Robson | 1 | 1 |
| Stuart Hall | 1 | 1 | David Sharif | 1 | 1 |
| Linda Jackson | 1 | 1 | David Sulch | 1 | 1 |
| Jane Hawkard | 1 | 1 | Shaun Stacey | 1 | 1 |
| Sue Liburd | 1 | 1 | Kate Truscott | 1 | 1 |
| Ivan McConnell | 1 | 1 | Kate Wood | 1 | 1 |

**BIC(24)091**

# BOARDS-IN-COMMON
# ACTION TRACKER

# 2024

## ACTION TRACKER - CURRENT ACTIONS - 11 APRIL 2024

| Minute Ref | Date / Month of Meeting | Subject | Action Ref (if different) | Action Point | Lead Officer | Target Date | Progress | Status | Evidence |
|---|---|---|---|---|---|---|---|---|---|
| **NLaG ACTIONS** | | | | | | | | | |
| 4.5.1 | 08.02.24 | Chair of Health Tree Foundation Trustees' Committee - Extension of Tenure - Foundation Patron Role due to current Patron standing down | | Sue Liburd to seek more understanding on what was requried of the Patron role | Sue Liburd | June 2024 | Update to be provided at the Trust Boards in Common June 2024 meeting. | | |
| **Boards-in-Common ACTION** | | | | | | | | | |
| 1.7 | 10.04.24 | Group Chief Executive's Briefing - Data highlighting a reduced number of ED attendances | | Shaun Stacey to provide Boards with data highlighting reduced numbers in ED at HUTH due to the opening of the UTC | Paul Bytheway | June 2024 | Update to be provided at the June 2024 meeting. | | |

**Key:**

| | |
|---|---|
| Red | Overdue |
| Amber | On track |
| Green | Completed - can be closed following meeting |

## ACTION TRACKER - CLOSED ACTIONS

| Minute Ref | Date / Month of Meeting | Subject | Action Ref (if different) | Action Point | Lead Officer | Target Date | Progress | Status | Evidence |
|---|---|---|---|---|---|---|---|---|---|
| **HUTH ACTIONS** | | | | | | | | | |
| 09.03 | 12.09.23 | Workforce, Disability Equality Standards Report | | Chair of the Disabled Network to attend a Development Session in 2024 | Simon Nearney | June 2024 | It was agreed a session would be attended, date to be agreed. | | April 2024 minutes of the public Board meeting |
| **NLaG ACTIONS** | | | | | | | | | |
| 9.1 | 05.12.23 | Escalation from the Quality & Safety Committee (NLaG) - Lack of equipment | | Jonathan Lofthouse to discuss the lack of equipment issue raised in the Infection Prevention Control Annual Report with the Group Cabinet. | Jonathan Lofthouse | April 2024 | Update to be provided at the Trust Boards in Common April 2024 meeting.<br><br>At the February meeting it was reported a wider piece of work was to be completed that would be shared with the Boards. | | April 2024 minutes of the public Board meeting |
| 9.2 | 05.12.23 | Escalation Report from the Finance & Performance Committee - MADE Events | | It was agreed a dicussion would take place outside the meeting regarding next years MADE events. | Shaun Stacey / Jonathan Lofthouse | April 2024 | Update to be provided at the Trust Boards in Common April 2024 meeting.<br><br>At the February meeting it was confirmed the Flow Teams would lead on this piece of work. | | April 2024 minutes of the public Board meeting |
| 9.3 | 05.12.23 | Escalation Report from the Workforce Committee - Retention Update | | A Retention Update was requested for the next Board meeting. | Simon Nearney | April 2024 | Update to be provided at the Trust Boards in Common April 2024 meeting.<br><br>An update was provided on progress with this item at the February 2024 meeting. | | April 2024 minutes of the public Board meeting |
| 9.4 | 05.12.23 | Escalation Report from the Audit, Risk & Governance Committee - Staff working in outside employment | | It was agreed a discussion would take place outside the meeting to discuss staff working outside the Trust whilst off sick. | Simon Nearney / Jonathan Lofthouse | April 2024 | Update to be provided at the Trust Boards in Common April 2024 meeting.<br><br>An update was provided on progress with this item at the February 2024 meeting. | | April 2024 minutes of the public Board meeting |
| 10.1 | 05.12.23 | Maternity & Neonatal Oversight Report - Maternity Safety Champions Action Log | | Actions to be reviewed and completed as required. | Jenny Hinchliffe | April 2024 | Update to be provided at the Trust Boards in Common April 2024 meeting.<br><br>An update was provided on progress with this item at the February 2024 meeting. | | April 2024 minutes of the public Board meeting |

**Key:**

| Green | Completed - can be closed following meeting |
|---|---|

**Agenda Item No: BIC(24)092**

| | |
|---|---|
| **Name of the Meeting** | Trust Boards-in-Common |
| **Date of the Meeting** | Thursday 13 June 2024 |
| **Director Lead** | Jonathan Lofthouse, Group Chief Executive |
| **Contact Officer/Author** | Jonathan Lofthouse, Group Chief Executive |
| **Title of the Report** | Group Chief Executive's briefing |
| **Executive Summary** | This report updates the Trust Boards in Common on the pre-election period guidance and includes updates and the headlines of patient safety, quality, finance and performance. |
| **Background Information and/or Supporting Document(s)** (if applicable) | N/A |
| **Prior Approval Process** | N/A |
| **Financial implication(s)** (if applicable) | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/A |
| **Recommended action(s) required** | ☐ Approval ☐ Information<br>☐ Discussion ☐ Review<br>✓ Assurance ☐ Other – please detail below: |

**Group Chief Executive Officer**

**Briefing to the Trust Boards in Common**
**Thursday 13 June 2024**

## 1. Introduction

1.1 I would like to start my report by drawing the Trust Boards in Common's attention to the NHS England pre-election period guidance, which has been circulated to all of our staff via my weekly bulletin. Whilst we continue business as usual for our patients during this pre-election period, we have ensured our reports to Trust Boards in Common public and private meetings are in keeping with pre-election requirements.

1.2 I would like to acknowledge the publication on 20 May 2024 of the report from the national Infected Blood enquiry, chaired by Sir Brian Langstaff. On behalf of our organisation, and as a centre where we did give blood products to patients during the 70s, 80s and early 90s, we thank the Inquiry for its hard work and final report. It should be noted, the report does mention the north bank legacy organisation and previous leadership by name. I have received official correspondence from NHS England which has assured us that the Inquiry's detailed recommendations will be considered by a clinically-led NHS England task and finish group, with next steps shared as soon as possible. A number of teams worked hard on our response to the publication of the Inquiry report. A clinical team has put in place a pathway to deliver blood tests to anyone concerned about their health. Our PALS team has taken calls from concerned members of the public and recorded their details so that we can contact them for testing and clinical advice. Finally our communication team published details of our helpline and other useful links on our website. Thank you to all those colleagues involved in this work.

1.3 Trust Board members will recall the Fuller Inquiry in to NHS mortuary arrangements. We have been notified that Northern Lincolnshire and Goole NHS Foundation Trust has been invited to participate in Phase 2 of the Fuller Inquiry, which is a deeper dive into mortuary practice nationally. There have been eight criteria used by the national Inquiry team to select Trusts to be invited to participate. This is to enable the Inquiry to hear from a range of different types of NHS Trusts across the geography of England, who serve different communities, and to have Trusts with different CQC ratings and performance against Human Tissue Authority standards. I have indicated to the national inquiry that we will be embrace this invitation to participate and will provide our full cooperation with the requirements of this review.

1.4 Much of my time since the last Trust Boards in Common meeting has been given to meeting the requirements of the 2024/25 Operational Planning guidance. This has been both for our Group organisation as well as at system level, particularly in my role as the Integrated Care Board Collaborative of Acute Providers Chief Executive lead. The culmination of this most recent work being an executive check and challenge review held on 22 May in person with Amanda Pritchard, NHS England CEO and her Senior Leadership team.

1.5 There is a specific item on today's agenda that takes Trust Board colleagues through the submission by our Group organisation against the 2024/25 Operational Planning requirements.

1.6 Since the last Trust Boards in Common meeting, we have taken the next steps in our Group model and held the first round of Performance and Accountability meetings in our new governance structure. This has meant that the North and South Site Triumvirate teams have met formally with all 14 Care Group triumvirates, concluding the cycle with the first Executive Cabinet to Site Triumvirate Performance and Accountability meetings held on 30 May 2024. I have included updates from these reviews within this report.

1.7 I am also pleased to report that the cross-cutting elements of the Group Governance structure have also been stood up, replacing individual Trust-levels meetings from our previous structure. The Group-wide Boards on Urgent and Emergency Care, Planned Care, Cancer and Diagnostics have been stood up in the last two months, with operational delivery groups underneath these. The Groups new senior leadership meeting, of which all Chiefs of Service are members takes place a little later this month.

1.8 As a new set of principles and governance processes, this has started on a strong footing and I would like to thank all of our senior leadership teams, as well as our Group Cabinet and Director colleagues, particularly Ivan McConnell and Adam Creeggan, supported by the Site triumvirate teams and the information teams, for the efforts to get this in place. I am confident that over time, this structure will give us grip vertically and horizontally across our Group organisation, and enable us to focus on identifying and managing exceptions in patient safety, quality, finance, workforce and performance as they arise.

1.9 I would also like to express my thanks for Amanda Stanford hosting two visits from national colleagues so soon after starting in the organisation. These visits have both been to our maternity and neonatal services on the north bank: the first from Donna Ockenden, Chair of the National Maternity Services Review, on 30 April 2024. The second was from Dame Ruth May, NHS Chief Nurse, on 25 May 2024. Both were positive visits with constructive feedback received. We are very grateful for their time and engagement. I would also like to thank our numerous colleagues who undertook the necessary preparatory work to ensure the visits covered all the areas that our national colleagues wanted to see. I am very appreciative of their efforts.

On Friday 24 May there was a CQC engagement visit to the Emergency Department at Diana Princess of Wales Hospital led by Amanda. The CQC team had the opportunity to meet the Care Group leadership Team who walked them through the patient pathway, the visit was positive and the feedback from CQC showed recognition of the improvement journey the service has been on since the last formal CQC inspection.

1.10 I am grateful to Amanda introducing a new Group-wide governance structure for the continued work on maternity and neonatal improvement. The Group continues to focus on making the required improvements in its services. The purpose is also to ensure a robust evidence base is in place to confirm when change is embedded. This Group governance structure will ensure we maintain robust oversight of the issues we need to address as well as providing a governance structure for staff to embed new ways of working and see their hard work come to fruition.

1.11 I have continued to meet fortnightly with my Cabinet together with the two Site Triumvirate teams as part of a Financial Improvement Delivery Board. This Board is coordinating the delivery actions of our Group requirements on waste reduction, staffing

and workforce requirements as well as service transformation. We have put a programme management approach in place to capture the impact of cost improvement plans, service transformation and pathway changes, to aim for top quartile performance by maximising our capacity and assets as well as adopting best in class pathways and service models. The equality impact assessment of suggested schemes occurs within the parameters of this Group.

1.12 This will work in conjunction with the work we are undertaking at system level through the Collaborative of Acute Providers, as to how we maximise our system capacity, particularly our elective capacity, for the best benefit to our patients across our geography.

## 2. Patient Safety, Quality Governance and Patient Experience

2.1 Our Group was notified on 29 April 2024 that Northern Lincolnshire and Goole NHS Foundation Trust has moved up into Tier 1 in NHS England's Elective Recovery Programme National Tiering Process. We were also notified on this date that Hull University Teaching Hospitals NHS Trust remains in Tier 1.

2.2 Tier 1 is the highest level of oversight scrutiny. We will be attending the regular review meetings with NHS England's team, which are most frequent for Tier 1 Trusts. These will focus on the review of performance progress and improvement against the 62 day referral to treatment and 28 day Faster Diagnosis Cancer Waiting Times Standards and any actions associated with recovery. On behalf of the Board, Performance, Finance and Estates Board Sub Committee, will continue to provide detailed oversight against plan.

2.3 Whilst both organisations are showing positive progress against the Faster Diagnosis standard, our first round of Executive Cabinet to Site Triumvirate Performance and Accountability meetings demonstrated that we have some particular issues around sustaining this performance and removing variation in performance across several tumour sites. This will take continued effort to bring about change, which also needs to be levied at making a significant improvement in achieving the 62-day standard. It is the 62-day standard that means both our Group organisations are in Tier 1 for Cancer performance and will be subject to this continued scrutiny at national level.

2.4 To illustrate this point, our latest reported performance for these two cancer standards are: March 2024 62-day cancer performance was 63.2% and Faster Diagnosis Standard 81.8% for Hull University Teaching Hospitals NHS Trust. For the Faster Diagnosis Standard, improvement actions have been identified in three tumour sites in order to maintain FDS achievement.

2.5 For Northern Lincolnshire and Goole NHS Foundation Trust, 62-day performance for March 2024 was 71.6% and Faster Diagnosis achievement for March 2024 was 71.4%, which was a deterioration in performance. Actions have been identified against 5 specific tumour sites to move to an improvement again against this standard.

2.6 Since my last report to the Trust Boards in Common, we have received written confirmation of our annual accreditation status for both our Endoscopy suites on the south bank from the Joint Advisory Group on GI Endoscopy. I would like to express my sincere thanks for the continued hard work of our teams to maintain these standards for a further year.

2.7 Last month, we received notification from the National Institute of Health Research via the Clinical Research Network for Yorkshire and Humber of our funding allocation and recruitment targets for health research for national portfolio studies. These are national, high calibre clinical trial projects that lead to improved treatments and outcomes for thousands of NHS patients each year. I am very pleased that we have been asked to maintain the excellent recruitment rates that we achieved last year, which will see us aim to enrol as a Group at least 5,800 patients locally into these national portfolio studies. This is recognition of the growing capacity and capability we are starting to demonstrate in our sovereign organisations, and a solid foundation on which to grow a Group approach to research, development and innovation, with national portfolio studies being only one of the strands of research work undertaken by our teams.

**3. Urgent and Emergency Care and Elective Care**

3.1 The headline data position for each of our Group organisations on ambulance handover and the four-hour Emergency Department standard for April 2024 are set out below.

3.2 The four-hour standard is now measured on a 'footprint' basis against the 78% standard set nationally, accounting for all Type 1 and Type 3 activity. The 'footprint' for the north bank is the Emergency Department at Hull Royal Infirmary and the Urgent Treatment Centres in Hull and the East Riding, run by City Health Care Partnership.

3.3 While on a 'footprint' basis, our collective four-hour performance for April 2024 was 77.5%, we know that the HUTH ED contribution was less than 50% on average, which is clearly not what we should be achieving for our patients. The Urgent Care Board has requested to understand the targeted actions that are being taken over the next two months to improve performance, taking account of root cause analysis that has been undertaken on the steps in the ED pathway, and flow in to the hospital.

3.4 The ambulance handover position for the north bank in April 2024 is a worsening position, with circa 1,000 hours of ambulance crew time lost due to delayed handovers. The root cause is flow and volume within the Emergency Department, and is a focus of the Unplanned Care Board for targeted improvement actions

3.5 The south bank 'footprint' performance in April 2024 for all Type 1 and Type 3 activity, including the UTC in Goole, was 76.9%, which continues the performance increase seen in March 2024.

3.6 The ambulance handover position for the south bank in April 2024 is an improving position, for the second month in a row. Circa 300 hours of ambulance crew time was lost due to delayed handovers. Targeted actions are being taken to further improve and embed better ways of working. It is important to recognise that emergency related services on the south bank are substantively more costly to run than those on the north bank. The Care Group triumvirates are reviewing spend profiles.

3.7 In respect to elective care, the 65-week position remains under heavy scrutiny. This is an improving position for both sovereign Trusts. There is a plan on how the reduction to zero 65-week waits in Hull University Teaching Hospitals NHS Trust (HUTH) needs to be achieved by the end of September 2024, with HUTH holding the large majority of patients in the 65-week+ bracket for our Group organisation. The detail of the data analysis and actions being taken subject to scrutiny by the Performance, Estates and Finance Committee on 29 May 2024.

3.8 It is noteworthy that 61% of the waiting list (PTL) in HUTH is awaiting first outpatient appointment. Specific specialities have been identified for targeted improvement action.

3.9 The 65-week position in Northern Lincolnshire and Goole NHS Foundation Trust has also been subject of specific data analysis, and actions put in place to achieve national standards by end September 2024.

3.10 I am pleased to report to the Trust Boards in Common that HUTH moved out of the tiering process with the national NHS England for elective care as of 19 April 2024. This was due to demonstrable improvements in the number of long waiting patients. I am grateful to all of our staff who have worked so hard to reduce our waiting times to move entirely out of national tiering. We must not let up the pace of improvement while we clear our 65+ week waiting patients and also focus on those waiting more than one year for definitive treatment. Northern Lincolnshire and Goole NHS Foundation Trust was not in a tier for elective waiting times with the NHS England team.

**4. Strategy and partnership developments**

4.1 As noted at the beginning of my report, this section is subject to the pre-election guidance. I would like to reassure the Trust Boards in Common that the work to develop our first Group strategy continues at pace, with excellent engagement across our stakeholders. During the pre-election period, this work will continue, but will not be reported in detail publically. We remain on schedule for this Group strategy to be published in July 2024.

**5. Financial Performance and Estates and Facilities updates**

5.1 In respect of the Group financial position, the Month 1 position was reported to the Performance, Estates and Finance Committee on 29 May 2024. We are £2m away from plan for income and expenditure, and Group capital spending was £2.3m behind plan. The Group has spent £5.4m on agency and bank pay year to date. This is £1.6m less than the same period in 2023/24, and is one of the first actions coming out of our grip and control on financial management. Due to the complexities of national direction and structure of internal phasing, a detailed financial report will be shared in Private Board.

5.2 As noted in paragraph 1.9, I am meeting fortnightly with my Cabinet and the site triumvirate teams to provide challenge and robust decision-making on the £85m savings requirement we have for 2024/25 as a Group organisation. We have seen and approved the foundation of a cross-Group transformation plan, which will focus on four key areas: theatre productivity, No Criteria to Reside, outpatients and diagnostics. Alongside this, Care Groups and Cabinet post holders are held to account for the creation and delivery of their own Cost Improvement Plans. The outputs of this work will continue to be reported through the Performance, Estates and Finance Committee.

5.3 Work on our ongoing capital developments continues. The detail of the current building works for the Community Diagnostic Centres, the Day Case Theatre centre at Castle Hill at as well as the Endoscopy Centre at Castle Hill Hospital are our most visible major capital projects and I am pleased to report to the Trust Board that some key improvements in respect of flooring at our hospital estate at Diana, Princess of Wales Hospital has progressed in the last two months, which has had an immediate positive impact on the hospital environment. The teams are also busy installing environmentally friendly LED lighting in both Scunthorpe and Grimsby hospitals.

5.4 Scunthorpe hospital has been awarded £20.6 million in funding from the Public Sector Decarbonisation Scheme. It will enable improvements including site-wide glazing replacements and roof upgrades, replacing the main boiler house, putting in an improved Building Management System and Air Handling Units and installing more solar panels.

**6. Workforce Update**

6.1 We are discussing key workforce metrics in our new Care Group Performance and Accountability meetings. We had an engaged discussion around support to our staff, and in particular to staff mental well-being at our Cabinet to Site triumvirate team meetings. Whilst our overall sickness absence is carefully managed, with managers having supportive conversations with members of staff, mental health and well-being is a key underlying reason for staff absence at the present time.

6.2 We have agreed a full programme of support from our Organisational Development team to both of the site triumvirate teams, the 14 care group triumvirate teams, as well as to the two support directorates coming under the site triumvirates. This will be an extensive, tailored package of support, including 'storming' and 'norming' time, strategy and service development, coaching and psychological safe space to support these new senior leadership teams. I am very proud to be using the expertise of our organisational development team to support our new senior leadership teams to galvanise the capacity and capacities of our new Group organisation at pace, in order to bring out significant improvement for our patients.

**7. Equality, Diversity and Inclusion (EDI)**

7.1 We raised the Inclusion flag on each of our 5 hospital sites on Tuesday 4 June 2024 to mark the start of the LGBTQIA+ Pride season. This is a moment of joy and reflection for all of our staff and I was honoured to be invited to be part of the flag raising at Hull Royal Infirmary. A big thank you to the team. We have a number of Pride events in our area over the next two months and I know that lots of our staff, their family members and friends, proudly fly the NHS and Inclusion flags at all of these events. There will be a number of activities for the next two months for LGBTQIA+ inclusivity and I encourage all staff to participate, show solidarity and ally-ship, and be proud of the diversity in our workforce.

7.2 A big thank you to the Organisational Development and Human Resources teams who have supported our teams to move to a Group level Equality, Diversity and Inclusion Steering group. The planned start for this will be in June 2024. This will include a wide range of stakeholders from across our Group organisation, including our staff networks. I am pleased to report that Ivan McConnell has taken up the Cabinet-level sponsorship of this crucially important work, in his role of health inequalities lead.

7.3 I enjoyed a catch up meeting with the three elected chairs of our staff networks on the north bank in May 2024. Thank you again to Dr Yoghini Nagandran, chair of the BAME Staff Leadership network, Tom Rust, chair of the LGBTQIA+ Staff Network, and Tracey Sargeson, chair of the Disability Staff Network. Congratulations to Tracey on her recent election and a huge thank you to Elaine Hillaby, the inaugural chair of the network, who has moved on after 3 years in the role. Our network chairs gave me some immediate food for thought with their suggestions as to how I and my Cabinet can give more prominence to the staff networks and encourage more staff to take part. I really appreciate their time and input, and will definitely reflect on their suggestions.

## 8. Good News Stories and Communications Updates

8.1 Recent good news from across the Group include:

- North Lincolnshire Endometriosis centre securing a renewed accreditation as an Endometriosis centre for the fourth year in a row.
- Health Minister Andrew Stephenson visited both Grimsby and Scunthorpe with a focus on the capital investment in Urgent and Emergency Care, as well as capital improvement requirements.
- Mrs Elizabeth Fairchild very generously has left Northern Lincolnshire and Goole NHS Foundation Trust £326,000 in her Will, for Scunthorpe General Hospital. We are spending the money on improved dementia facilities across the hospital, with Ward 17 the latest to receive these improvements. The mystery of why Mrs Fairchild, who lived in America, has also been solved following extensive media coverage, including national radio.
- The launch of a new physiotherapy service in Scunthorpe, where 115 patients with musculoskeletal (MSK) problems were invited to a special Community Appointment Day (CAD) at The Pods, the sports and leisure facility next to Central Park in the town.
- One of the benefits of being a group is we're able to offer more flexibility and use local NHS resources to their full capacity, to reduce waiting times. For patients coming in for a procedure at one of our Endoscopy departments at Hull, Scunthorpe, Castle Hill or Grimsby hospitals, it means they could now be offered an appointment sooner at one of the other sites. There is no obligation for them to take up the invite; if patients are not able to travel, they can choose to be seen at their local hospital. This applies to Colonoscopies, Flexible Sigmoidoscopies and Gastroscopies.

**Jonathan Lofthouse**
Group Chief Executive
5 June 2024

**Trust Boards-in-Common Front Sheet**

**Agenda Item No: BIC(24)094**

| **Name of Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Simon Nearney, Group Chief People Officer |
| **Contact Officer / Author** | Myles Howell, Group Director of Communications |
| **Title of Report** | Branding update |
| **Executive Summary** | This paper offers an update for the board on our group brand and roll out of assets and messaging, including applications, brand guidance and associated campaign. |
| **Background Information and/or Supporting Document(s)** (if applicable) | The brand and style guide is attached. |
| **Prior Approval Process** | The group brand has been discussed at board development and cabinet. |
| **Financial Implication(s)** (if applicable) | There are no significant financial implications. The brand has been developed in-house. |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | There is no impact on EDI, however the Flow campaign is being developed to improve the patient experience across all demographics. |
| **Recommended action(s) required** | ☐ Approval ☐ Discussion ✓ Assurance ✓ Information ☐ Review ☐ Other – please detail below: |

NHS HUMBER HEALTH PARTNERSHIP

GROUP BRANDING UPDATE

13 June 2024

1. Purpose

Following discussion at board development and cabinet, this paper offers an update for the board on our group brand and the launch and continuing roll out of assets and messaging.

2. Introduction

Since the adoption of the group brand name - NHS Humber Health Partnership – and the development of group values and vision in April, the group Communications Team has been working to develop a distinctive visual identity for the Partnership. This is intended to enable the organisation to communicate a clear strategic direction, unite the two sovereign organisations under one identity and support key objectives for the Partnership.

A brand is everything we say and do – it is our promise. And, by using a consistent brand, we will build recognition, engagement and trust. It is underpinned by our vision: United by Compassion: Driving for Excellence; and our values: Compassion, Honesty, Respect and Teamwork.

A brand and style guide has been developed in order to help the workforce use the brand in corporate documentation, including presentations, letterheads, emailers, in line with national NHS branding guidance.

3. The brand

The visual identity for the Partnership has been developed in-house by our multi national award winning design team – the Remarkable People Extraordinary Place and Give Soap a Chance campaigns were both shortlisted for HSJ awards and won at the national marketing industry Drum Awards. The design is based on the Humber estuary, which truly unites our five hospitals in a way that the Humber bridge does not and which is arguably rather overused in regional brands.

The estuary is in our name: the NHS Humber Health Partnership. It symbolises flow and efficiency: the efficient flow of patients, of care; efficient flow of resources – money and equipment. The efficient flow of workforce, from recruitment and retention, career development through to retirement.

Flow speaks to all staff – clinical or non-clinical. Everyone can buy-into the need for better flow whether you are a doctor, a porter, a nurse, a physio, an HR professional; whether you work in procurement or finance. We all have a part to play in improving efficiency/flow. That will be at the heart of our messaging; our communications golden thread.

The visual is clean and professional. It can be adapted for presentations, for corporate documents, for email bulletins, for our values. It's flexible. It's simplicity enables us to adapt the imagery, incorporating pictures of people, of hospitals, of landmarks.

4. Communicating our identity

At the most superficial level we will apply the brand and Partnership logo to a whole host of templates and corporate documentation including but not limited to:

- Powerpoint templates
- Email signatures
- Screensavers
- Email templates (CEO bulletin, weekly news, core brief etc)
- Group intranet – Bridget
- Letterheads
- Posters
- Window decals

Full brand guidance will be available to staff to ensure the logo and branding is applied consistently and correctly. This has been adapted and amended following discussion at board development and in cabinet and is submitted to the board along with this update.

An accompanying campaign – Flow – will be rolled out across the group and the region, from July. It is one campaign to address multiple issues .The purpose of Flow is to unite our workforce and that of our partners behind a drive to improve efficiency, reduce bureaucracy, and eliminate 'waste' from our processes and our finances.

Flow has been developed in discussion with our new care groups, site teams, and corporate teams. Feedback has been extremely positive internally and externally where the ICB is keen to adopt the campaign for all partners to use across boundaries. It is our ambition to create an identity for our Partnership and our region that sets us apart as the region which is tackling, arguably our most pressing issue and the one which will have the greatest positive impact for our patients.

5. Recommendation

The boards in common are asked to acknowledge the work that has been undertaken to date on developing an identify for our Partnership and approve the continuing roll-out of the brand and its assets.

Myles Howell

Group Director of Communications and Engagement

# BRAND STYLE GUIDE

## Helping you to produce clear communications

**Quick tips on making your messages clear, impactful and compliant with NHS identity guidelines**

# What is a brand?

It's much more than a logo.
A brand is everything you say and do – it is your promise. And by using a consistent brand, you build recognition, engagement and trust.
Think about Apple where strong design is used to create a great user experience.

Design comes across in the logo, their products and their marketing, but user experience shines in how their products work, how their shops are set up, how their website is structured and in the innovations they create.

# So, what about the NHS brand?

The white and blue lozenge is instantly recognisable. The NHS brand is one of the most cherished, recognised, trusted and powerful in the world.

To ensure it is protected there is a national NHS Identity Policy which sets out strict guidelines as to how to use it.

We are legally obliged – as part of our NHS contract – to follow NHS branding guidelines.

NHS England: NHS Identity Guidelines

# Do I have to use the NHS brand?

Quite simply YES. Please do not create your own!

You must use our partnership brand for all internal and external communications.

You should NOT be creating separate, alternative identities or logos for your departments or team. We ARE the NHS.

What you can use – other than the above logo – is the group's vision, values, and assets agreed by the group's boards. However, these too must be used correctly.

Our values are:

# Compassion
# Honesty
# Respect
# Teamwork

Think Apple again. To create an excellent patient experience we have to live our values, in every interaction with patients, service users and colleagues.

Our vision:

United By Compassion : Driving For Excellence

# How to use our group logo

- No other version should be used
- It isn't necessary to use on internal documentation
- It should never be cropped
- Do not change its dimensions (stretch or squash)
- Do not change the colours – transparent and 'reversed' white versions are available on request by emailing: nlg-tr.comms@nhs.net
- It should never be resized so that the font is less than size 18
- It should always be justified to the right and ideally placed top right but can be used bottom right
- Keep white space around the logo
- Don't place the logo over busy pictures
- Don't place the logo on bright colours

NHS England: How to use the NHS logo

# Using the logo alongside other organisations

- Logos of other partners should be placed top left or bottom right
- Never include more than one NHS organisation's logo on one page, just use the NHS lozenge
- On letterheads, Powerpoint front pages and the front page of reports such as the annual report, we are required to be clear which NHS organisations make up the group or partnership.  In these instances we should list our two constituent trusts in alphabetical order in plain text on the bottom left-hand corner of these documents:

  NHS Humber Health Partnership is:

  Hull University Teaching Hospitals NHS Trust

  Northern Lincolnshire and Goole NHS Foundation Trust

NHS England: How to use the NHS logo

# Group or trust?

Unless you are referring to a specific trust board, set of accounts, CQC report, survey etc., then use the group logo, and our group name:

**NHS Humber Health Partnership**

# Arial all the way…

Arial is the NHS font **and therefore our font.**

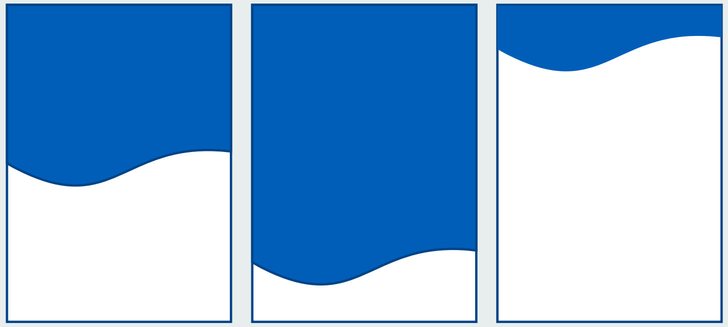
The NHS is really strict about this. Why?
Because it's clear and easy to read.

There's guidance online, or feel free to get in touch for more info:
nlg-tr.comms@nhs.net

# ‘Estuary’

The estuary is what draws us together and symbolises our group. That’s why we created *the wave*.

Use it in the middle, the bottom or the top.



## Use *the wave* in your design…

# Use the NHS colour palette

| 100% | 80% | 60% | 40% | 20% |
|---|---|---|---|---|
| White RGB:255/255/255 #FFFFFF | | | | |
| NHS Blue RGB:0/94/184 #005EB8 | RGB:51/126/198 #337EC6 | RGB:102/158/212 #669ED4 | RGB:153/191/227 #99BFE3 | RGB:204/223/241 #CCDFF1 |
| NHS Dark Blue RGB:0/48/135 #003087 | RGB:51/89/159 #335999F | RGB:102/131/183 #6683B7 | RGB:153/172/207 #99ACCF | RGB:204/214/231 #CCD6E7 |
| NHS Bright Blue RGB:0/114/206 #0072CE | RGB:51/142/216 #338ED8 | RGB:102/170/226 #66AAE2 | RGB:153/199/235 #99C7EB | RGB:204/227/245 #CCE3F55 |
| NHS Light Blue RGB:65/182/230 #41B6E6 | RGB:103/197/235 #67C5EB | RGB:141/211/240 #8DD3F0 | RGB:179/226/245 #B3E2F5 | RGB:217/240/250 #D9F0FA |
| NHS Aqua Blue RGB:0/169/206 #00A9CE | RGB:51/186/216 #33BAD8 | RGB:102/203/226 #66CBE2 | RGB:153/221/235 #99DDEB | RGB:204/238/245 #CCEEF5 |
| NHS Black RGB:35/31/32 #231f20 | RGB:79/76/77 #4F4C4D | RGB:123/121/121 #7B7979 | RGB:167/165/166 #A7A5A6 | RGB:211/210/210 #D3D2D2 |
| NHS Dark Grey RGB:66/85/99 #425563 | RGB:104/119/130 #687782 | RGB:142/153/161 #8E99A1 | RGB:179/187/193 #B3BBC1 | RGB:217/221/224 #D9DDE0 |
| NHS Mid Grey RGB:118/134/146 #768692 | RGB:145/158/168 #919EA8 | RGB:173/182/190 #ADB6BE | RGB:200/207/211 #C8CFD3 | RGB:228/231/233 #E4E7E9 |
| NHS Pale Grey RGB:232/237/238 #E8EDEE | RGB:237/241/241 #EDF1F1 | RGB:244/244/245 #F1F4F5 | RGB:246/248/248 #F6F8F8 | RGB:250/251/252 #FAFBFC |
| NHS Dark Green RGB:0/103/71 #006747 | RGB:51/133/108 #33856C | RGB:102/164/145 #66A491 | RGB:153/194/181 #99C2B5 | RGB:204/225/218 #CCE1DA |
| NHS Green RGB:0/150/57 #009639 | RGB:51/171/97 #33AB61 | RGB:102/192/136 #66C088 | RGB:153/213/176 #99D5B0 | RGB:204/234/215 #CCEAD7 |
| NHS Light Green RGB:120/190/32 #78BE20 | RGB:147/203/77 #93CB4D | RGB:174/216/121 #AED879 | RGB:201/229/166 #C9E5A6 | RGB:228/242/210 #E4F2D2 |
| NHS Aqua Green RGB:0/164/153 #00A499 | RGB:51/182/173 #33B6AD | RGB:102/200/194 #66C8C2 | RGB:153/219/214 #99DBD6 | RGB:204/237/235 #CCEDEB |
| NHS Purple RGB:51/0/114 #330072 | RGB:92/51/142 #5C338E | RGB:133/102/170 #8566AA | RGB:173/153/199 #AD99C7 | RGB:214/204/227 #D6CCE3 |
| Dark Pink RGB:124/40/85 #7C2855 | RGB:150/83/119 #965377 | RGB:176/126/153 #B07E99 | RGB:203/169/187 #CBA9BB | RGB:229/212/221 #E5D4DD |
| NHS Pink RGB:174/37/115 #AE2573 | RGB:190/81/143 #BE518F | RGB:206/124/171 #CE7CAB | RGB:223/168/199 #DFA8C7 | RGB:239/211/227 #EFD3E3 |
| NHS Dark Red RGB:138/21/56 #8A1538 | RGB:161/68/96 #A14460 | RGB:185/115/136 #B973888 | RGB:209/161/175 #D0A1AF | RGB:232/208/215 #E8D0D7 |
| Emergency Services Red RGB:218/41/28 #DA291C | RGB:225/84/73 #E15449 | RGB:233/127/119 #E97F77 | RGB:240/169/164 #F0A9A4 | RGB:248/212/210 #F8D4D2 |
| NHS Orange RGB:237/139/0 #ED8B00 | RGB:241/162/51 #F1A233 | RGB:244/185/102 #F4B966 | RGB:248/209/153 #F8D199 | RGB:251/232/204 #FBE8CC |
| NHS Warm Yellow RGB:255/184/28 #FFB81C | RGB:255/198/73 #FFC649 | RGB:255/212/119 #FFD477 | RGB:253/226/167 #FDE2A7 | RGB:255/241/210 #FFF1D2 |
| NHS Yellow RGB:250/225/0 #FAE100 | RGB:251/231/51 #FBE733 | RGB:252/237/102 #FCED66 | RGB:253/243/153 #FDF399 | RGB:254/249/204 #FEF9CC |

# The look and feel

A few practical tips

# Sub-brands

Too many sub-brands or logos and straplines can get confusing – for staff and for patients as well.

If you want to make your campaign stand out, then you don't necessarily need a logo or sub-brand. Sometimes it is just something visual to represent what you are doing makes the most impact and tends to 'stay' with people.

# Posters

The average reading speed is about four words a second, so a poster with 50 words will take about 15 seconds to read. People DO NOT look at them for that length of time, especially if they are one of many pinned to a board.

Wordy posters are a waste of time as they WILL be ignored.

Always ask yourself, 'Who am I talking to and what do I want to say to them?

Then keep it short and simple.

# Photographs, pictures and film

You must only use images / pictures / film  you have permission to use. Photos, pictures, or graphics you get from the internet may be under copyright – you MUST check whether they are free to use or share.

Try one of these *royalty-free* sites instead:

unsplash.com
pixabay.com
pexels.com

If you are using a picture or film of anyone identifiable, they will need to sign a simple consent form. These are available from the comms team.

And make sure there’s no patient information in the image; check the walls, desks and screens.

# Images

## Images provide added value.

Images capture the attention of the user, enhance understanding of the content and keep users engaged with the written content

Any images used should be:

- Relevant to what is being written about in the text
- Should always be high quality
- Should be in JPEG or PNG format
- Photos of patients and staff must have written consent for use (see previous slide)

# Screensavers

Please remember:

- Everyone can see them, including patients and public
- Your message must be clear, brief, and succinct
- Any artwork or photos must be landscape, not portrait
- Less is more. Avoid clutter. Love empty space
- You MUST only use 16 words and no more
- A picture can speak 1,000 words
- Use colour to make key points ‘pop’ but don’t overuse it
- Please don’t ask for a design with 10 pictures and 20 key messages!

# Tone of voice

Our tone of voice is how we get across our unique personality in our written communications.

We want to capture the personality of a region that's kind, caring and compassionate about the things that really matter, yet tinged with a humour that is humble, self-deprecating and, where appropriate, dry. Quietly proud, never pompous, always polite, endlessly passionate. This encompasses all that we stand for.

If used correctly, our distinctive tone of voice can become as recognisable as our logo, colours or design choice and will help to reinforce the other aspects of our brand.

Please do not:

- SHOUT using capital letters
- Use colours to emphasise your point, as this can be seen as aggressive
- Overuse underlining, **bold type** or exclamation marks (see style guide) to emphasise a point!!!!

# Keep it simple

NHS written communications should support and uphold the principles and values set out in the NHS Constitution. They should be clear, concise, straightforward, honest, open, professional, respectful and accessible.

If you are writing to patients and the public, make sure your style is both personal and direct. Your written communication should be capable of being spoken out loud and sound as if it is being addressed to an individual.

When communicating about difficult subjects, your tone should communicate genuine understanding and respect. The listener or reader should feel empowered and informed.

If you are writing about complex subjects, use words which are as simple and accessible as possible. Avoid jargon, acronyms and unnecessary technical language.

The Plain English Campaign provides information and advice on writing clear, concise public information. Visit the Plain English Campaign website for more details.

# Inclusivity

Create content for and about people in a way that is inclusive and respectful.

The language we use is incredibly powerful and can help to create a sense of belonging, teaching us to value people for who they are.

The Humber and North Yorkshire Health and Care Partnership has created an inclusive language guidance document, in partnership with a diverse group of colleagues from minority groups across health and care.

Visit the website and download the guidance

# Accessibility

In July 2015, NHS England published the 'Accessible Information Standard'

The aim of the Standard is to make sure that people who have a disability or sensory loss get given information in a way they understand and communication support if they need it.

Accessible information is information which is made easier to understand and/or in a format that is able to be understood by the person or group who needs it, for example easy read and braille.

It can be audio or visual information.

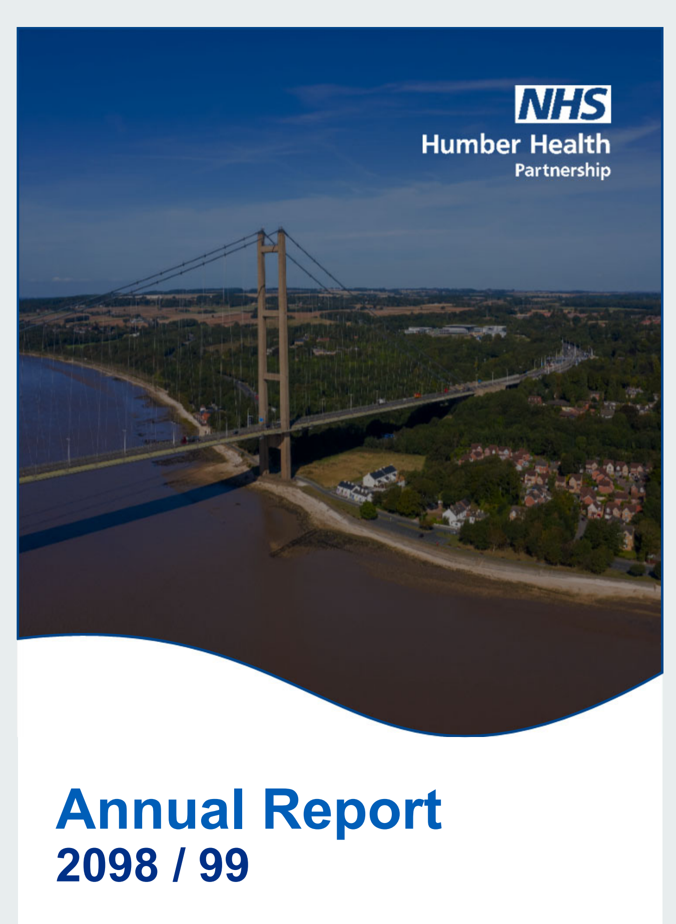
**It is the law that we follow the Standard.**

Whether it's a website, a leaflet, a video or a podcast we have to ensure we provide an accessible version or ensure the published content is as accessible as possible for any audience.

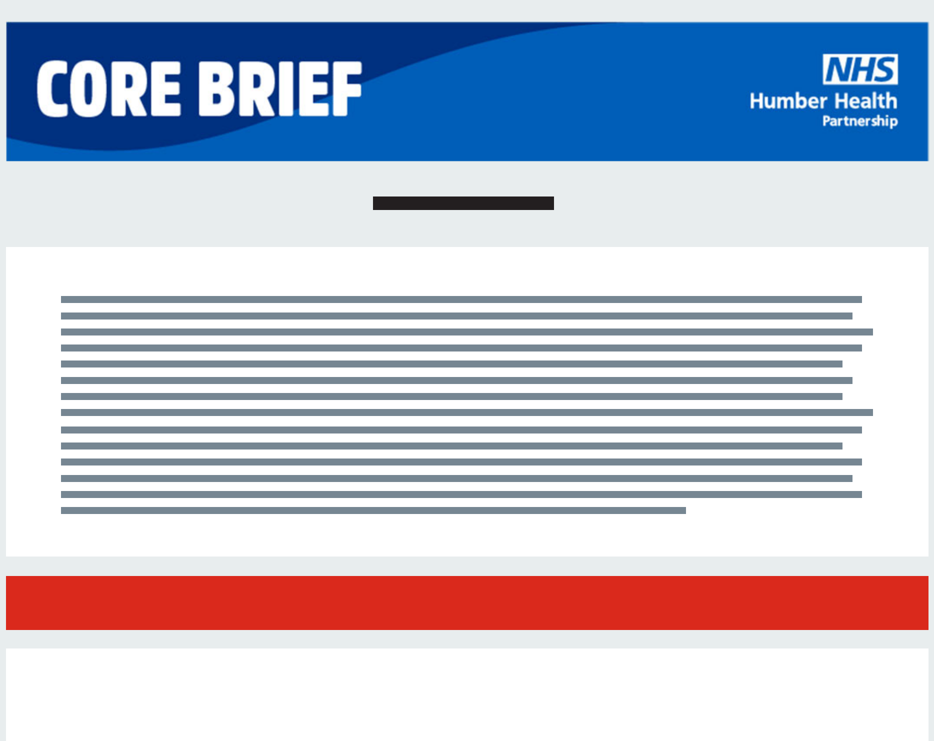
For more information about accessibility visit the NHS England website.

# How the brand might look: Presentations

# How that might look: Annual Report



# Emailers



# Recruitment

# How that might look: Campaigns

**Let's get it *right*...**

An acute hospital gets it right when it provides acute care.

An Emergency Department gets it right when it provides emergency care.

The NHS gets it right when we work together.

Help your colleagues.
Help our patients.
Put care in its **rightful** place.

# Talk to us

If you need any support with posters, screensavers, images or logos, please speak to us.

We're very happy to help:

nlg-tr.comms@nhs.net

craig.lazenby@nhs.net

matthew.graby@nhs.net

# Style guide

The Government Digital Service style guide is a comprehensive document covering style, spelling and grammar. It offers helpful tips and advice to enable you to write professional and accurate content for any publication, including digital content and emails.

Visit the A-Z style guide here

A specific section on healthcare can be found here

# Our in-house group style guide

- Group or group?
- Chief Executive or chief executive?
- 6 June 2024, or June 6th, 2024?
- DPOW or DPOWH?
- Trust Board or trust board

**A few examples…**

### abbreviations and acronyms

The first time you use an abbreviation or acronym, spell out the full version in words followed by the abbreviation in brackets (for example: atrial fibrillation (AF). You can then just use the abbreviation.

Do not use an acronym if you are not going to use it again later in the text.
There is no need to spell out: NHS, GP, and UK.
Don't invent your own acronyms.
Do not use full stops in abbreviations or acronyms: 'NHS', not 'N.H.S.'

### accident and emergency

We might call it the Emergency Department internally, and so ED as an abbreviation is fine once we have used its full title in a document, but externally the advice remains to call it A&E. There is no need to write out "accident and emergency".

BA(LAGNFT0

### addresses

Punctuate addresses when you write them horizontally:

Scunthorpe General Hospital, Cliff Gardens, Scunthorpe, North Lincolnshire, DN15 7BH

Do not punctuate when you write them vertically:

Scunthorpe General Hospital
Cliff Gardens
Scunthorpe
DN18 7BH

**Slide 31**

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**BA(LAGNFT0** Could we strengthen this - we MUST use this externally?
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## ampersand

An ampersand is the ‘&’ symbol.
Do not use & because not everyone understands what it is.
Unless you use in a name such as: A&E.

## apostrophes

If you’re really not sure, leave it out and you’ll be right more often than not.

However, there is a full guide to using apostrophes here.

# B

## board

Always lower case unless it's part of a proper title: so upper case for the Northern Lincolnshire and Goole NHS Foundation Trust Board, but lower case for "the hospital's board of directors met last week."

## bold

Avoid using bold text apart from in headings and subheadings.

## brackets

Punctuate inside brackets where a full sentence falls inside the brackets. (This is the way to do it.)
Punctuate outside brackets where only part of the sentence falls in brackets (this is the way to do it).
Only use square brackets to indicate comments added by an editor. Avoid using brackets inside brackets.

## bullet points

Bullet points break text into short, digestible sections and help to highlight important points.

Always use a lead-in line that ends with a colon and make sure that:

- Each bullet point makes sense when read after the lead-in line
- You do not put 'or' or 'and' after each bullet
- You do not put a semicolon, comma, or full stop at the end of any bullet in the list, including the last one
- You do not use more than one sentence per bullet point - use commas or dashes to expand on an item

Bulleted lists should be aligned left.

# C

## capitals

DO NOT USE BLOCK CAPITALS FOR LARGE AMOUNTS OF TEXT AS IT'S QUITE HARD TO READ.

Use capitals for job titles not descriptions of job roles, e.g. Melanie Smith, Director of Finance. But the finance director of NLaG. Same goes for teams: Melanie Smith from the group Finance Team, but not "our finance teams won an award".

north, south, east and west are only capitalised if they are part of an actual place name. As 'south bank' and 'north bank' are not actual place names they do not need to be capitalised.

## Castle Hill Hospital

This should be written out in full wherever possible, exactly as above. Internally, CHH is fine to use as an abbreviation once the full name has been used and the abbreviation has been shown in brackets. However, "CHH" must never be used in an external document.

## colons

A colon is used:

- At the end of a lead-in line before a list or bullet points (as above under bullet points)
- Directly before a direct quote e.g. Melanie said: (do not use a comma)

## coronavirus (COVID-19)

Write 'coronavirus' in lower case. We use the full term 'coronavirus' (COVID-19)' when we first mention the illness. After that, we use 'coronavirus' as that is what most people call it and search for.

In some contexts, you may need to use language more precisely: 'COVID-19' is the infectious disease caused by 'SARS-CoV-2', which is a type of 'coronavirus'.

D

**dates**

Dates are written ‘day month year’ with no punctuation: ‘22 April 2021’.

Do not use ‘nd’ ‘st’ ‘th’ and ‘rd’ except when referring to centuries, anniversaries or positions.

In general, use ‘to’ for date ranges, not hyphens or dashes (for example: ‘10 November to 21 December’).

However, to refer to a financial year, use a slashes not dots, hyphens or dashes: 2022/23.

**Diana, Princess of Wales Hospital**

This should be written out in full wherever possible, exactly as above. Internally, DPoWH is fine to use as an abbreviation once the full name has been used and the abbreviation has been shown in brackets. However, “DPoWH” must never be used in an external document.

**email**

Not ‘e-mail’.

**exclamation marks**

If what you are saying does not involve immediate physical danger or great surprise, you should think twice before using an exclamation mark. If you have thought twice and the exclamation mark is still there, think about it three times, or however many times it takes until you delete it.

Never use multiple exclamation marks.

## G

### general practitioner, GP and general practice

‘GP’ can be used interchangeably with ‘general practitioner’. Don’t capitalise the spelled-out version. It is not necessary to spell out the abbreviation on first use if the meaning is clear.

### Goole and District Hospital

This should be written out in full wherever possible, exactly as above. Internally, GDH is fine to use as an abbreviation once the full name has been used and the abbreviation has been shown in brackets. However, “GDH” must never be used in an external document.

### group

Use a capital letter when used in a specific job title, e.g. Jonathan Lofthouse, Group Chief Executive. Do not use capitals when referring to ‘our group of hospitals’ or ‘group staff’.

## H

### healthcare

One word.

### NHS Humber and North Yorkshire Integrated Care Board (ICB)

NHS Humber and North Yorkshire ICB is a statutory organisation accountable for NHS spend and performance. The ICB is a core member of the NHS Humber and North Yorkshire Health and Care Partnership

# H

## NHS Humber and North Yorkshire Health and Care Partnership

The Health and Care Partnership is one of 42 Integrated Care Systems (ICSs) which cover England to meet health and care needs across an area. The ICB (see above), Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust are all members of the NHS Humber and North Yorkshire Health and Care Partnership.

## Hull Royal Infirmary

This should be written out in full wherever possible, exactly as above. Internally, HRI is fine to use as an abbreviation once the full name has been used and the abbreviation has been shown in brackets. However, HRI must never be used in an external document.

## Hull University Teaching Hospitals NHS Trust

This should be written out in full wherever possible, exactly as above. Internally, HUTH is fine to use as an abbreviation once the full name has been used and the abbreviation has been shown in brackets. However, HUTH must never be used in an external document.

## hyphens

Use:

- where two or more words are taken together and read as one (‘day-to-day’)
- to join two words that act together like one adjective (for example: ‘five-minute presentations’)
- when expressing fractions or numbers in text (‘two-thirds’ or ‘thirty-four’)
- to avoid ambiguity (for example, ‘re-cover’ not ‘recover’)

## J

### job titles

Use capitals for job titles not descriptions of job roles, e.g. Jonathan Lofthouse, Group Chief Executive. But the finance director of NLaG.

## N

### Northern Lincolnshire and Goole NHS Foundation Trust

This should be written out in full wherever possible, exactly as above. Internally, NLaG is fine to use as an abbreviation once the full name has been used and the abbreviation has been shown in brackets. However, NLaG must never be used in an external document.

### numbers

One to ten should be written out, any number higher should be 11, 12, 13 etc.
The exception to this is percentages (see below).

## P

### partnership

Use a capital letter when referring to our specific partnership, e.g. “Humber Health Partnership Board meets regularly”. In general writing do not capitalise, e.g. “the partnership’s board of directors meets regularly”.

### percentages

Always use ‘%’ with a number i.e. 50%.
When spelling out the word, use ‘per cent’ not ‘percent’.
However, it is often better not to use a percentage. Instead of 50%, for example, you could say “one in two” or “half”.

BA(LAGNI

**Slide 38**

**BA(LAGNFT0** This needs to change to 50%!!!!

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S

## spacing

Use a single space after a full stop rather than two.

## Scunthorpe General Hospital

This should be written out in full wherever possible, exactly as above. Internally, SGH is fine to use as an abbreviation once the full name has been used and the abbreviation has been shown in brackets. However, “SGH” must never be used in an external document.

T

## times

- ‘5:30pm’ (not ‘1730hrs’)
- ‘midnight’ (not ‘00:00’)
- ‘midday’ (not ‘12 noon’, ‘noon’ or ‘12pm’)
- ‘6 hours 30 minutes’
- ‘to’ in time ranges, not hyphens or dashes: ‘10am to 11am’ (not ‘10-11am’)

## trust

Always lower case unless it’s part of a proper title: so upper case for the Northern Lincolnshire and Goole NHS Foundation Trust Board, but lower case for “the trust’s board of directors met last week.”

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)095**

| **Name of Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | David Sharif, Group Director of Assurance |
| **Contact Officer / Author** | David Sharif, Group Director of Assurance |
| **Title of Report** | Group Memorandum of Understanding |
| **Executive Summary** | This Memorandum of Understanding (MoU) is an agreement (not a legal binding contract) between the Trusts which recognises the sovereignty of the trusts as independent statutory bodies and sets out the framework through which both have a shared commitment to working more closely together. Its purpose is to document and formally approve the intentions and responsibilities of the participating trusts and in doing so creates the foundation for the provision of a shared workforce between the two trusts (documented separately in a shared workforce MoU). |
| **Background Information and/or Supporting Document(s)** (if applicable) | The development of the MoU was one of the key Trust documents included in the Corporate Governance Workstream 'Move to a Group Leadership Model'. The shared workforce MoU (referenced in this Group MoU) was previously reviewed and approved by the Workforce, Education and Culture Committees-in-common. |
| **Prior Approval Process** | N/A |
| **Financial Implication(s)** (if applicable) | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | This MoU reinforces the values of Compassion, Honesty, Respect and Teamwork. |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

# NLaG : HUTH Group Model – Memorandum of Understanding

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## 1.0 Introduction

1.1 After over 25 years of collaboration, Northern Lincolnshire & Goole NHS Foundation Trust and Hull University Hospitals NHS Trust ("**the Trusts**") have formed a group.

1.2 Working as a group ensures more joined-up decision-making for the benefit of the populations we serve, with a focus on improving clinical outcomes, reducing inequalities of access and addressing the known workforce and infrastructure challenges faced by both trusts.

1.3 The trusts remain separate, sovereign organisations but with a Group Chair, Group Chief Executive and a single executive leadership team and aligned corporate governance and decision-making arrangements.

1.4 This Memorandum of Understanding is an agreement between the Trusts which sets out the framework through which we have formalised our shared commitment to working more closely together.

## 2.0 Parties to the Memorandum of Understanding

2.1 The parties to this Memorandum of Understanding are:

- Northern Lincolnshire & Goole NHS Foundation Trust (NLaG); and
- Hull University Teaching Hospitals NHS Trust (HUTH)

Referred to in this agreement as "the participating trusts".

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Scunthorpe General Hospital and Goole and District Hospital for NLaG and Hull Royal Infirmary and Castle Hill Hospital for HUTH.

2.4 As parties to the Memorandum of Understanding, the trusts agree to the governance and accountability arrangements set out herein, commit to a shared strategy, vision and values for the group, and to maximising the benefits to patients and local communities of strengthening the collaboration between the trusts.

## 3.0 Purpose of the Memorandum of Understanding

3.1 The purpose of this Memorandum is to set out the intentions and responsibilities of the participating trusts, specifically:

- the purpose of the group;

- the principles and operational approach of the group;
- the governance, decision-making and accountability arrangements for the group;
- the arrangements for resolving disagreements and disputes;
- the duration of the agreement;
- provisions for the approval, variation and termination of the agreement;
- the liabilities of the trusts;
- the arrangements for the sharing of information between the Trusts under the agreement.

3.2 This Memorandum of Understanding is also the foundation for the provision of a shared workforce between the two trusts. A separate, standalone Memorandum of Understanding sets out how the Group members will work together to address the collective workforce needs of the two trusts. It is attached to this Memorandum of Understanding as an annex for ease of reference.

3.3 The Memorandum of Understanding does not create a new organisation, but rather establishes new ways of working for the benefit of our patients and for meeting the changing needs of our local communities. The Memorandum of Understanding does not and is not intended to replace or supersede the Constitution / Establishment Order, Standing Orders, Scheme of Delegation including Reservation of Powers to the Boards and Standing Financial Instructions of either Trust. However, as part of the aligned governance and decision-making arrangements for the group, these governing instruments will be developed to reflect the new group arrangements and to ensure consistency in process and delegations within the trusts across the group.

3.4 The Memorandum of Understanding is not a legal contract between the Trusts. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the parties from this Memorandum. It is a formal understanding between the trusts which have entered into this Memorandum of Understanding intending to honor all obligations under it.

3.5 The Memorandum of Understanding does not replace or override the legal and regulatory frameworks that apply to the trusts as statutory bodies established under the National Health Service Act 2006 (as amended). Instead, this Memorandum sits alongside and complements the existing statutory and regulatory frameworks, accountabilities and reporting requirements relating to each of the trusts.

3.6 Nothing in this agreement is intended to, or shall be deemed to, establish any external partnership or joint venture between the parties to the Memorandum of Understanding, constitute a party as the agent of another, nor authorise either of the parties to make or enter into any commitments for or on behalf of the other party.

**4.0 Purpose and Scope of the Group**

4.1 The overriding purpose of the group is to maximise the benefits of

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collaboration across the two trusts, in particular:

- Enhanced clinical quality and sustainability through greater scale in the provision of acute, community and specialist care;
- More effective and efficient corporate functions delivered once on behalf of two statutory bodies;
- Maximising the capacity of management resources to deliver change;
- Enhancing the ability of the participating trusts to speak with one voice to key stakeholders including Integrated Care Systems and regional and national system leaders and to engage effectively at Place;
- Learning from good practice working across the two trusts and within local health and care system.
- Strengthening our patient focus and voice to improve patient pathways and clinical outcomes, access and continuity of care, population health and reduce health inequalities, improve quality and patient experience and reduce in harm and enhance research opportunities

4.2 Work is already underway to develop a single group-wide strategy which will provide a clear direction and set of objectives and priorities for the journey ahead.

**5.0 Principles and Operational Approach of the Group**

5.1 This Memorandum of Understanding recognises the sovereignty of the trusts as independent statutory bodies. It also recognises that the operation of the group relies on the agreement of the two trust boards to delegate powers to committees and individuals to give effect to the group arrangements.

5.2 To ensure the effective operation of the group, the trusts commit to maintain a positive and trusting relationship and promote co-operation and efficient use of resources.

5.3 The trusts recognise that there will be a need to review the scope and nature of the group on a regular basis, and that the group's approach will need to be flexible and responsive and this may necessitate review and adjustments to the group model and its governance & decision-making arrangements over time.

**6.0 Governance & Accountability Arrangements for the Group**

<u>Leadership and Management of the Group</u>

6.1 At the Executive level, the Group will be managed by a single leadership team led by the Group Chief Executive who will act as the accountable officer for each of the Trusts. The senior leadership team consists of the following posts:

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Tier 1:

- Group Chief Financial Officer
- Group Chief Nurse
- Group Chief Medical Officer
- Group Chief Delivery Officer
- Group Chief People Officer
- Group Chief Strategy and Partnerships Officer
- Group Director of Assurance

Tier 2

- Group Director of Estates
- Group Director of Quality Governance
- Group Digital Information Officer
- Group Transformation Director
- Group Director of Performance
- Group Director of Communications
- North & South Bank Managing Directors

6.2 The North and South Bank Managing Directors lead a site-based leadership team which is structured around the specific needs of each site and supports the group-wide Care Group structure.

Group Governance, Decision-Making & Accountability Arrangements

Boards and Committees

6.3 Each trust within the group will continue to be led by their trust board under the leadership of a Group Chair. The Trust Board for each trust will continue to be responsible for setting strategy, ensuring accountability, and shaping a healthy culture.

6.4 The two boards meet 'in-common' bi-monthly with joint board development sessions on a group basis being held in the intervening months.

6.5 An aligned Board Reporting Framework has been prepared and approved by both boards.

6.6 The boards of each trust through the board-in-common will continue to provide effective oversight of the management of the interests of Group directors.

6.7 The trust boards are supported by a committee structure which provides the boards with assurance in relation to the issues within agreed terms of reference and work plans.

6.8 As part of the approval of the governance & decision-making arrangements for the group, the boards agreed that the following

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board committees will meet 'in common' with the corresponding committee of the other trust:

- Quality & Safety
- Performance, Estates & Finance
- Workforce, Education & Culture
- Remuneration
- Audit, Risk & Governance
- Capital & Major Projects

6.9 Whilst the committees of each board remain separately constituted committees, recognising the sovereignty and accountability of each organisation, terms of reference, work plans, and committee templates have been harmonised.

6.10 A *'Boards & Committees-in-Common Principles Framework'* has been developed to ensure:

- there is collective understanding of committee-in-common principles;
- that both trusts can continue to make decisions and operate in accordance with the statutory & regulatory requirements that apply to them; and
- there is continued robust corporate reporting.

6.11 NLaG Governors attend board committees-in-common as observers.

6.12 The charitable committees of NLaG Health Tree Foundation and HUTH WISHH Foundation remains as separate committees.

<u>Executive & Trust / Site Management Meetings & Group</u>

6.13 Each Care Group is accountable to the Group Chief Executive who will determine which 'management' meetings are required to run the organisations and support the group operating model. To date, this has included the setting up of an Executive Cabinet and a Group Senior Management Team (which bring together the group and trust / site leadership teams).

6.14 The design and operation of group management meetings will reflect the respective schemes of delegation approved by each trust to support the operating model of the group i.e. they will comply with the reserved matters and powers set out in the trusts' Standing Orders and Scheme of Delegation and conferred at a group executive and site level.

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Group Operating Model

6.15 A group operating model has been developed which sets out the role of the group executive and the role of the site-based leadership teams. The following principles underpin the group operating model:

- focusing on the delivery of benefits to our patients and staff working together as a group;
- ensuring the two organisations continue to be clinical directors, managerially enabled:
- empowering Care Groups and clinical teams to develop solutions and deliver operational performance;
- taking decisions that affect the group with a single mind, and fostering a collective / shared purpose across the wider leadership teams;
- ensuring clarity of roles and responsibilities at all levels across the group to avoid duplication, supported by standard governance and decision-making and a clear accountability framework;
- supporting clinical collaboration and reduce unwarranted clinical variation whilst supporting sites to respond to the different needs of their local communities;

6.16 The aims of the group operating model are:

- To ensure the delivery of sustainable, high-quality services to the populations we serve.
- To improve access and outcomes for patients.
- To transform the delivery of services, harnessing the positive improvements in practice and technology;
- To invest in staff, develop new roles, innovate training programmes and enhanced partnerships with academic and training bodies.
- To invest in infrastructure.
- To deliver services more effectively and efficiently.

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6.17 In high level terms, accountability for day-to-day operations, safety and performance will be devolved to sites. This will include responsibility for: implementation of group strategy at site level; local service transformation; oversight of clinical safety; delivery of operational performance standards; delivery of cost improvement plans; site-based workforce planning; site-level risk management; management of local estates and site infrastructure; oversight of place interface; and oversight of research and educational delivery.

6.18 The leadership team of the Group set out at 6.1 will be responsible for strategic direction and support to sites. This will

include development of group-wide strategy; oversight of group benefits; enabling site performance; developing group-wide policies, standards and frameworks; developing a group-wide approach to risk; leadership of corporate governance; promoting cultural alignment across the group; leading equality, diversity and inclusion across the group; leading engagement with the ICSs; and development of the group and group communications.

<u>Group Shared Services</u>

6.19 The group executive will develop plans for the establishment of shared, group-wide corporate services where these plans assist in the delivery of the anticipated group benefits.

6.20 Any group-wide corporate services will be developed within a framework which will set out clearly arrangements for the hosting and / or employment of staff, exit arrangements, and communications plans. These arrangements are incorporated as an annex to this Memorandum of Understanding entitled *"The Provision of a Shared Workforce in Response to the Creation of the Group Structure between Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire & Goole NHS Foundation Trust'.*

**7.0 Duration**

7.1 This Memorandum of Understanding shall commence on the date of the signature of the parties, following review and approval by the two trust boards.

7.2 The agreement shall be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the group. It shall thereafter be subject to an annual review of the arrangements by the trust boards of the participating trusts.

**8.0 Variation**

8.1 This Memorandum of Understanding, and any schedules to it, may only be varied by written agreement of both parties, following review and approval by the trust boards of the participating trusts.

**9.0 Termination**

9.1 The agreement shall remain in force until it is terminated. Either of the trusts may terminate this agreement with the approval of its board by giving a minimum of six months' notice in writing. Where a notice for termination of the agreement expires on the last day of the financial year, the agreement shall terminate on that date. Where the notice expires on any other date, the agreement shall terminate at the end of the financial year in which the notice expires.

**10.0 Resolving Disagreements and Disputes**

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10.1 The trusts will be led by their individual boards, under the leadership of a Group Chair and Group Chief Executive, supported by a Group Executive Team. These arrangements are expected to minimise the scope for disagreements and disputes between the trusts.

10.2 In the event of disagreements and disputes, the trusts will take all reasonable steps to reach a mutually acceptable resolution. They will attempt to resolve disputes in good faith and at the lowest possible level. Decisions on matters related to the overall governance of the group are reserved to the boards of each trust.

**11.0 Charges and Liabilities**

11.1 Except as otherwise provided, the trusts shall each bear their own costs and expenses incurred in complying with their obligations under this agreement.

11.2 By separate agreement, the trusts may agree to share specific costs and expenses (or equivalent) arising in respect of the agreement between them.

11.3 The trusts shall each remain liable for any losses or liabilities incurred due to their own or their employees' actions.

**12.0 Sharing of Information**

12.1 The trusts will provide to each other all information that is reasonably required in order to achieve the objectives of the establishment of the Group as provided for in this Memorandum.

12.2 The trusts have developed a separate Information Sharing Agreement to facilitate joint working and the effective discharge of roles and functions which work across the group. This agreement has been approved by both boards.

12.3 The trusts recognise they have obligations to comply with data protection legislation. The trusts will therefore ensure that they share information, and in particular personal data, including special categories of personal data and other confidential information, in such a way that is compliant with data protection legislation.

12.4 Each trust shall keep in strictest confidence all confidential information it receives from the other party to this agreement except to the extent that such confidential information is required by law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by one of the parties. Each party shall use confidential information received from the other party solely for the purpose of complying with its obligations under this Memorandum and for no other purpose. Neither party shall use any confidential information received under this Memorandum of Understanding for any other purpose including its own commercial gain

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outside of the group or to inform any competitive bid without the express written permission of the disclosing party.

12.5 To the extent that any confidential information is covered or protected by legal privilege, then disclosing such confidential information to the other party to this Memorandum of Understanding does not constitute a waiver of privilege or of any rights which a party may have in respect of such confidential information.

12.6 Nothing in this paragraph will affect the parties' regulatory or statutory obligations, including but not limited to competition law and data protection law.

**May 2024**

**MEMORANDUM OF UNDERSTANDING – THE PROVISION OF A SHARED WORKFORCE IN RESPONSE TO THE CREATION OF THE GROUP STRUCTURE BETWEEN HULL UNIVERSITY TEACHING HOSPITALS AND NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST**

**BETWEEN:**

1. Hull University Teaching Hospitals NHS Trust Hull Royal Infirmary, Anlaby Rd, Hull HU3 2JZ ("**HUTH"**); and

2. Northern Lincolnshire and Goole NHS Foundation Trust of Diana Princess of Wales Hospital, Scartho Rd, Grimsby DN33 2BA ("**NLAG**").

   Together HUTH and NLAG shall be referred to in this MOU as the "**Group Members**" and each individually a "**Group Member**".

**FOREWORD:**

HUTH and NLAG came together as a newly formed NHS Group in 2023 to enable the provision of better care to a population of over 1.5 million people (the "Group Operating Model"). To enable the progressive and collaborative work between the two organisations a single harmonised executive team and leadership structure has been implemented to support the transition into the Group Operating Model.

The Group Operating Model will comprise of a number of Group wide care groups which will bring together services from HUTH and NLAG.

The Group Operating Model aims are to:

- To ensure the delivery of sustainable high-quality services to the population in the long term
- To improve access and outcomes for patients
- To transform the delivery of services, harnessing the positive improvement in practice and technology that have developed during COVID
- To invest in staff, develop new roles, innovate training programmes and enhanced partnerships with academic and training bodies
- To invest in estates infrastructure
- To deliver services more effectively and efficiently

This MOU sets out the agreed provision taken by the newly formed Group Board of the Group Members enabling staff from both Group Members to work within the Group Operating Model in an approach that is integrated to meet the needs of the and objectives of providing high quality services. Further collaborative agreements are being put in place in relation to other areas of collaboration surrounding the HASR Programme and this MOU should be read in conjunction with those agreements.

**INTRODUCTION:**

A. This Memorandum of Understanding (the "**MOU**") sets out the intention of the Group Board in respect of how the Group Members will work together to address collective workforce requirements in order to provide clinical services within the remit of the Group Operating Model to incorporate normal working practices of both clinical and non-clinical workforce.

B. This MOU relates to all members of staff ("**Staff Members**") who are substantively employed by one Group Member (the "**Employing Group Member**") in both clinical and non-clinical roles/services, but who are provided to work for another Group Member (the "**Receiving Group Member**").

C. The MOU removes the requirement for honorary contracts or secondment agreements to be put in place for Staff Members to enable ease of movement across the Group as part of the development of the care group structure.

D. This MOU will also apply in exceptional circumstances such as staff shortage issues arising from dealing or as a consequence of any surges in demand or resource challenges.

E. This MOU is intended to serve as an overarching agreement between the Group Members to enable the mobility of the Staff Members in furtherance of the above objectives. In accordance with the Group Operating Model, the Group Members have committed to working together in a collaborative and mutually supportive way for the benefit of their patients, staff and the wider public as set out in this MOU and via the use of the Passport document which is set out at Appendix 1 of this MOU.

F. The Group Members wish to ensure the proper observance of clinical governance requirements, while avoiding unnecessary bureaucracy which may impede the movement of Staff Members specifically (for example in relation to pre-employment checks and training requirements).

G. The terms below set out the basis on which such arrangements take place. This MOU does not impact upon or supersede any other arrangements that may already exist and be in place between any of the Group Members and individuals in the form of honorary contracts, however, the Group Members agree to review any existing staff sharing arrangements in place and where it is deemed appropriate, replace those arrangements with those outlined in this MOU.

H. It is not envisaged that TUPE will apply to any of the arrangements provided within this MOU, however, the Group Members will continue to review any arrangements which are put in place to meet the requirements of TUPE and the guidance set out in the Cabinet Office Statement of Practice on Staff Transfers in the Public Sector.

I. Although, with the exception of paragraphs 7.-11. and 14.-18., it is recognised that this MOU is not intended to be legally enforceable, the Group Members agree to provide each other with reasonable cooperation and assistance when operating the provisions of this MOU. Furthermore, this MOU shall not impact any future arrangements that the Group Members may specifically negotiate and agree, including any specifically negotiated and agreed honorary contracts or collaboration agreements.

**THE GROUP MEMBERS AGREE AS FOLLOWS:**

## 1. SCOPE

This MOU in no way changes or modifies any existing substantive contracts of employment or honorary contracts held by a Staff Member with their Employing Group Member, the Receiving Group Member and/or with any other NHS organisation.

## 2. COMMUNICATION BETWEEN GROUP MEMBERS

The Group Members shall cooperate with each other in an honest, open and timely manner addressing any requests under this MOU and in providing information to each other in order to ensure the effective operation of it.

## 3. STAFF MEMBERS

3.1 By agreement between the Group Members, a Staff Member may carry out the responsibilities relating to their role to work for a Receiving Group Member at one of the Receiving Group Member's facilities. Employees in all cases will be engaged with by their relevant employing Group Member to ensure all workforce movement is planned so far as is reasonably practicable.

3.2 Where permanent changes to working arrangements are or become evident in terms of base of work or regular working location, normal consultative practice will apply.

3.3 The Group Members agree that the Staff Member shall remain an employee of their Employing Group Member at all times and that nothing in this MOU creates (or is intended to create) an additional employment relationship between the Staff Member and the Receiving Group Member and the Staff Member shall not be entitled to receive any salary, pension, bonus or other benefits or payments from the Receiving Group Member. For the avoidance of doubt, no Staff Member shall be required to enter into a secondment agreement with their Employing Group Member and/or the Receiving Group Member.

3.4 Whilst doctors in training are based at clinical sites and are employees providing service, they have different governance arrangements. No doctor in training shall be moved without discussion and written approval of the Postgraduate Dean. Should approval be received this MOU will then apply.

## 4. ASSURANCE RELATING TO STAFF MEMBERS

4.1 The Group Members are satisfied and give assurance to one another that they have in place appropriate processes which have verified that the Staff Members have passed any necessary mandatory checks and training for that Staff Member to practice safely in their role at the Employing Group Member. This includes that the Staff Member has met the NHS Employment Check Standards issued under Health Circular HSC2002/008 (as revised from time to time), at the time of recruitment (if applicable) and on an ongoing basis, and that the Staff Member has completed mandatory and other training requirements deemed sufficient by their Employing Group Member to work in their substantive role.

4.2 The Group Members provide further assurance to each other that they will not provide any Staff Member to another without having carried out any reasonable medical checks and surveillance to ensure as far as they reasonably can that the Staff Member is fit for work.

4.3 Where a Staff Member requires reasonable adjustments for a disability under the Equality Act 2010, the Employing Group Member shall give the Receiving Group Member reasonable notice of the same so as to enable a decision to be taken as to whether it is feasible that the Staff Member is provided to the Receiving Group Member including whether any adjustments which are required are reasonable, subject to any legal obligation not to do so including but not limited to the Data Protection Act 2018. The Receiving Group Member shall make all reasonable endeavours to accommodate any adjustments which have been deemed reasonable by the Employing Group Member.

4.4 The Employing Group Member agrees to update the employment checks, as required by the NHS Employment Checks Standards, and continue to provide the Staff Member's professional and mandatory training for the duration of any period that a Staff Member may be working at another Receiving Group Member. Each specialty will need to review the mandatory training requirements for their specialty to ensure the correct training is agreed and completed. Whilst it is envisaged that many clinical pathways, Standard Operating Procedures and policies will become aligned over time, any site-specific training will be delivered by the Receiving Group Member as part of a Staff Member's induction to that site.

4.5 Should, following the provision of a Staff Member by the Employing Group Member, any change(s) occur to any checks or any circumstance arises which leads the Employing Group Member to reasonably conclude that any Staff Member provided to a Receiving Group Member is not safe to practice / to work in the role for which they are employed, the Employing Group Member shall notify the Receiving Group Member of this as soon as practicable.

4.6 Each Group Member gives assurance that it shall comply with all health and safety obligations and exercise such duty of care over Staff Members received from an Employing Group Member as if such Staff Members were the Receiving Group Member's own employees.

## 5. WORKING ARRANGEMENTS

5.1 The Group Board shall remain accountable and responsible for all aspects of the performance of the Group Members, including, for the avoidance of doubt, those aspects in respect of which a Group Member has received or provided, or is receiving or providing under this MOU.

5.2 The Receiving Group Member will be responsible for the overall direction and supervision of the Staff Member whilst they are working for the Receiving Group Member, including the rostering of shifts. The Receiving Group Member will refer to the Employing Group Member any concerns regarding a Staff Member's conduct and actions during the period of time that the Staff Member may be provided to the Receiving Group Member.

5.3 The Employing and Receiving Group Members agree to co-operate fully and promptly with each other in respect of workforce matters ("**Matters**") concerning a Staff Member.

5.4 Save where agreed otherwise, the Group Members agree that the Employing Group Member

remains responsible for the following Matters in relation to their Staff Members:

5.4.1 disciplinary and capability issues for all staff;
5.4.2 grievances;
5.4.3 appraisals and performance-related procedures with input from the Receiving Group Member;
5.4.4 remuneration including pay progression;
5.4.5 other leave such as but not limited to sickness absence, maternity leave or compassionate leave. However, each specialty should determine the reporting procedures for the Employing Group Member and Receiving Group Member; and
5.4.6 annual leave, although it is acknowledged in most cases it is likely this will be approved in conjunction with the Receiving Group Member.

5.5 Save where agreed otherwise, the Group Members agree that in respect of the following Matters:

5.5.1 protected disclosures under the Employment Rights Act 1996; and
5.5.2 requests for personal data under the Data Protection Act 2018,

the Group Member where the alleged behaviour took place or where the Staff Member was working at the relevant time is responsible for investigating, progressing and/or resolving these Matters. Where such Group Member is the Receiving Group Member it shall notify the Employing Group Member as soon as reasonably practicable of the circumstances giving rise to the Matter.

5.6 If the Receiving Group Member becomes aware of any matter that may give rise to a claim (or similar action or challenge) by or against the Staff Member, notice of that fact shall be given as soon as possible to the Employing Group Member and the Group Members shall cooperate in (as appropriate) investigating, responding to and defending such claim.

5.7 The Group Members agree that where job evaluation has been undertaken in respect of a role which would be applicable across the Group Members, the same job evaluation decision shall be utilised across the Group Members without the need for a further evaluation process.

5.8 Each Group Member shall keep a record of staff supplied and received under this MOU and the hours worked. For the avoidance of doubt, the Employing Group Member shall remain responsible for the payment of the Staff Member during any period of time in a Receiving Group Member. The Group Board will agree the approval process for any additional hours worked above basic pay. Where rostering of shifts affects the pay of an individual the Receiving Group Member shall supply to the Employing Group Member the required information in accordance with reporting timelines to ensure that the Staff Member is appropriately paid by the Employing Group Member.

5.9 The Employing Group Member shall at all times be responsible for all income tax liability and National Insurance or similar contributions in respect of any payment the Staff Member.

5.10 Where a Staff Member has been released to work for the Receiving Group Member they will receive an email from the Receiving Group Member to confirm the practical arrangement, which references this MOU including the Passport set out at Appendix 1 of this MOU.

Attendance at a Receiving Group Member site shall be deemed to be acceptance by the individual of the Terms of the Passport.

5.11 The payment of reasonable expenses legitimately incurred by the Staff Member shall be made by the Employing Group Member.

5.12 The Receiving Group Member will ensure it completes a local induction with all staff in scope which will cover all statutory and reasonable elements of site safety and specifics related to carrying out the responsibilities of the role on a Receiving Group Member site.

5.13 Group Members will ensure that all staff in scope are connected to their management infrastructure and have a clear understanding of how they can access support and escalate any concerns. Group Members will be responsible for ensuring that the correct and accessible management infrastructure is in place that allows for multisite and multi Group Member working arrangements.

5.14 The Receiving Group Member will ensure that arrangements are in place that facilitate the work of all impacted Staff Members – specifically this will include, access to the Receiving Group Member's premises as is reasonably required, car parking, ID badge, IT equipment, systems access, uniform, clinical / other space and any other elements that are deemed essential for the completion of the role.

## 6. GOVERNANCE

6.1 Decision making in relation to this MOU shall be made by the Group Board.

6.2 The Group Board will take responsibility for any proposed improvements, investment in Staff Members, premises or training and/or service changes ("Improvements"). The Group Board shall agree any costs, risk and saving sharing between the Group Members in respect of any specific Improvements.

## 7. CONFIDENTIAL INFORMATION

7.1 The Group Members agree to keep confidential all Confidential Information (defined below) of the other Group Member which comes into their possession or knowledge and that they shall not disclose any Confidential Information in whole or in part to anyone other than in connection with the provision of the Shared Clinical Services under this MOU.

7.2 The Employing Group Member shall take all reasonable steps to ensure that each Staff Member keeps confidential all Confidential Information of the Receiving Group Member which they have access to and that they shall not, during the period working for the Receiving Group Member or at any time thereafter:

7.2.1 use the Confidential Information nor reproduce the Confidential Information in whole or in part in any form except as may be required by this MOU;

7.2.2 disclose any Confidential Information in whole or in part to anyone other than those authorised to receive it in connection with the provision of the Shared Clinical Services under this MOU; or

7.2.3 alter, delete, add to or otherwise interfere with the Confidential Information (save where expressly required to do so by the terms of this MOU).

7.3 For the purposes of this paragraph 7. "**Confidential Information**" shall mean any information of a confidential or secret nature relating to any and all aspects of the business of a Group Member and/or any associated organisation and/or their patients, directors, officers, agents, employees, customers and suppliers including but not limited to treatments, treatment planning, personal and sensitive personal data, financial information, budgets, reports, business plans, strategies, know-how, formulae, designs, data, specifications, research, processes, procedures and programs, pricing, sales and marketing plans and details of past or proposed transactions whether or not written or computer generated or expressed in material form.

7.4 The obligations under this MOU shall not apply to information which may come into the public domain otherwise than through unauthorised disclosure by a Staff Member and/or either of the Group Members.

7.5 Nothing in this paragraph 7. shall prevent the Group Members or a Staff Member from disclosing Confidential Information where it is required by law, for regulatory compliance purposes or for the purpose of making a protected disclosure under the whistle-blowing legislation ('speaking up').

## 8. DATA PROTECTION

8.1 The Group Members agree to comply with their respective obligations under the Data Protection Legislation and to use all reasonable efforts to assist each other to comply with their obligations under the Data Protection Legislation. For the avoidance of doubt, this includes providing reasonable assistance to each other to comply with any subject access requests served under the Data Protection Legislation.

8.2 For the purposes of this paragraph 8., "**Data Protection Legislation**" means all applicable data protection and privacy law in force from time to time in the UK including the General Data Protection Regulation ((EU) 2016/679) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018 and amended by the Data Protection, Privacy and Electronic Communications (Amendments etc.) (EU Exit) Regulations 2019 (the **"UK GDPR"**); the Data Protection Act 2018; and the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426) as amended.

8.3 For the purposes of clarity, there will be a requirement to share employee related data between the Group Members and each Group Member shall ensure that such data is only processed in accordance with the other Group Member's instructions and in compliance with all NHS guidance in relation to information security and data protection. Each Group Member shall be required to take such technical and organisational measures against unlawful processing of such data and information and against accidental loss or destruction of, or damage to, such data and information as appropriate.

## 9. LIABILITY, INDEMNITIES AND THE HANDLING OF INCIDENTS, COMPLAINTS, CLAIMS AND INQUESTS

9.1 Save where alternative arrangements regarding liabilities and indemnities are agreed in writing between the Group Members which are expressly stated to override the provisions in this paragraph 9. the following shall apply.

9.2 Any incidents, complaints, claims and inquests shall be handled in accordance with the separate Service Level Agreement (SLA) on Incidents, Complaints, Claims and Inquests entered into between the Group Members and as amended from time to time.

9.3 Each Group Member shall remain solely liable for any act or omission on the part of a Staff Member arising out of or resulting from any act or omission of the Staff Member during any time they are working for that Group Member.

9.4 The Group Members hereby indemnify each other against any and all claims, liabilities, actions, proceedings, costs (including legal fees), losses, damages, fines, expenses and demands suffered or incurred by the other Group Member arising out of or resulting from the acts or omissions of the indemnifying Group Member including but not limited to:

9.4.1 any clinical negligence claim or other claim whether jointly or severally, made against the Group Members, in connection with the delivery of the services or their employed role generally by the Staff Member whilst under the control and supervision of that Group Member;

9.4.2 any Staff Member's death or personal injury, accident or illness suffered claim whether jointly or severally, by any Staff Member against the Group Members in connection with the performance of the services under this MOU or their employed role generally by the Staff Member at that Group Member's premises;

9.4.3 its breach of this MOU;

9.4.4 in the case of an Employing Group Member, the employment or termination of employment of the Staff Member, breach of contract or in tort, unfair dismissal, equal pay, discrimination of any kind or under any legislation applicable in the United Kingdom; or

9.4.5 in the case of a Receiving Group Member, any acts or omissions relating to a Staff Member during a period in which they are working for the Receiving Group Member including breach of contract or in tort, unfair dismissal, equal pay, discrimination of any kind or under any legislation applicable in the United Kingdom,

provided in each case that the indemnifying Group Member shall not be liable to the extent such claim arises as a result of the other Group Member's act or omission.

## 10. INSURANCE

10.1 For the purposes of this clause, the **"NHSR Indemnity Scheme"** shall mean any indemnity scheme operated by NHS Resolution including:

10.1.1 The Clinical Negligence Scheme for Trusts which applies where healthcare professionals are working under a contract of employment and the negligence occurs in the course of the employment or where the individual owes a duty of care to the person injured. For the avoidance of doubt, services provided at the Receiving Group Member shall be in the course of employment of Staff Members who are

employees of the Employing Group Member;

10.1.2 The Liabilities to Third Parties Scheme; and

10.1.3 The Property Expenses Scheme.

10.2 During the term of this MOU and for a period of 21 years the Group Members shall at their own cost and in compliance with Good Industry Practice procure and maintain in force appropriate insurance, may elect to self-insure, or take up membership of an NHSR Indemnity Scheme to cover the services provided within the scope of this MOU.

10.3 The Receiving Group Member shall, on request from the Employing Group Member, provide documentary evidence of membership of a relevant NHSR Indemnity Scheme, that such insurance is in place or that the decision has been taken to self-insure.

## 11. INTELLECTUAL PROPERTY

11.1 For the purposes of this paragraph:

11.1.1 "**Intellectual Property Rights**" patents, rights to Inventions, copyright and related rights, trade marks, trade names and domain names, rights in get-up, goodwill and the right to sue for passing off or unfair competition, rights in designs, rights in computer software, database rights, rights to preserve the confidentiality of information (including know-how and trade secrets) and any other intellectual property rights, in each case whether registered or unregistered and including all applications (or rights to apply) for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which may now or in the future subsist in any part of the world; and

11.1.2 "**Inventions**" means inventions, ideas and improvements, whether or not patentable, and whether or not recorded in any medium.

11.2 Any and all Intellectual Property Rights created by a Staff Member during any they are working for the Receiving Group Member shall remain the absolute property of the Employing Group Member.

11.3 Notwithstanding the provisions of paragraph 11.2, the Employing Group Member hereby licences the Receiving Group Member to utilise any Intellectual Property Rights which are created by a Staff Member during a period they are working for the Receiving Group Member to use those rights for the duration of this MOU.

## 12. ESCALATION

12.1 If a Group Member has any issues, concerns or complaints concerning the services provided and/or any provision of this MOU, it shall in the first instance seek to resolve that issue by a process of consultation with the other Group Member. The Group Members shall in good faith use all reasonable efforts to resolve the issue(s) through internal consultation as soon as reasonably practicable.

12.2 If the dispute is not resolved within a reasonable time, then either Group Member may refer the matter to the Group Board, who shall decide on the appropriate course of action to take.

## 13. RELATIONSHIP BETWEEN THE GROUP MEMBERS

Nothing in this MOU is intended to, or shall be deemed to, establish any partnership or joint venture between the Group Members or shall be deemed to constitute any Group Member as the agent of the others or allow any Group Member to hold itself out as acting on behalf of the other.

## 14. TIMETABLE AND TERMINATION OF THIS MOU

14.1 This MOU will be effective on and from the date that it is authorised by the Group Board and shall continue in full force and effect unless and until terminated by the Group Board.

## 15. ENTIRE AGREEMENT

Subject to Recital G, this MOU constitutes the whole agreement between the Group Members relating to the subject-matter of this MOU and supersedes any previous arrangement, understanding or agreement between them relating to the subject matter of this MOU.

## 16. VARIATION

The provisions of this MOU may be varied only by approval by the Group Board.

## 17. COSTS

Except as otherwise provided, each Group Member shall bear its own costs and expenses incurred in connection with the Shared Clinical Service whether or not they proceed (including without limitation the preparation and negotiation of this MOU).

## 18. GOVERNING LAW AND JURISDICTION

This MOU, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and where applicable, the Group Members irrevocably submit to the exclusive jurisdiction of the courts of England.

SIGNED on behalf of the Group Board of **Northern Lincolnshire & Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust**

Signed ........................................................................................................................

Name ........................................................................................................................

Position ........................................................................................................................

Date ........................................................................................................................

**APPENDIX 1 – Employee 'Points of Clarity' and 'Responsibilities under the MOU'**

1. **Points for clarity :**

a) Any staff member who is employed by HUTH or NLaG (the Trusts), is automatically covered by the Memorandum of Understanding (MOU) between the Trusts governing the movement of staff between the Trusts.

b) When a staff member leaves the employment of their Trust they will no longer be covered by the MOU, unless they take up employment with the other Trust.

c) **The MOU is not a change to your Contract of Employment and doesn't affect your Terms and Conditions.** Instead the MOU is simply a way of allowing you to:

- Work at the other Trust site(s) to deliver the work you are trained and employed to do.
- Have access the other Trust's patient data/information systems in order to do your job.

d) When working under the MOU you will remain employed by your substantive employer and continue to be paid for all work done by the Trust which employs you. Working at the other Trust site(s) does not entitle you to extra pay but you may be entitled to any out of pocket expenses, such as car parking costs and additional travel mileage. You should claim these in the normal way through your own Trust. Please remember to keep receipts as proof of payment.

e) When working at the other Trust's site(s) you may report to another supervisor or manager on those days and need to follow the other Trust's operating policies and procedures. However, for all employment matters you will always be covered by your employing Trust's HR policies.

f) If you are asked to undertake work at the other Trust's site(s), including being asked to work different days/hours as a short term measure, this will be to help the service deploy its staff in the best way to meet the needs of its patients. Any request will be made with as much notice as possible. Please remember any request for you to work at the other Trust's site(s), or to work different hours/shift pattern, will always be done in agreement with you. However, should there be a longer term requirement to change your working hours or changes to your role, this will be done via consultation in line with the relevant Organisational Change policy.

a) Please be aware that in order to provide you with appropriate management support your employing Trust may be required, under the HUTH and NLaG Data Sharing Agreement (see below), to provide the other Trust with information including, but not limited to: your name, job title, professional qualifications, professional registration details, type of employment (FTC / permanent), number of weekly hours contracted to work, normal place of work, flexible working arrangements, relevant occupational health information (to uphold our/their duty of care for you) and your mandatory training compliance details.

2. **Your responsibilities when working under the MOU:**

a) When working under the MOU at the other Trusts site(s):

- You will receive a site induction and orientation on your first day and told about reporting arrangements, ID badges, training, operating policies and procedures, access to facilities, training and uniform etc.
- You will only be asked to undertake the job you normally do, or a similar one that you are trained to do.
- If you are asked to undertake any duties that you do not have the necessary skills, experience, qualification or training to do notifying your site(s) supervisor as soon as reasonably possible. Under both Trusts health and safety policies you should never undertake a task that could lead to harm or injury to a patient, yourself or a colleague.
- If, due to sickness, or for any other reason, you are unable to attend your work, you must inform your supervisor at the other Trust site(s) as soon as possible, in addition to your normal line manager

b) You must maintain your professional registration, regardless of where you work, and uphold all

professional code of standards which apply to your registration.

c) If, when working at the other Trusts site(s), you have a concern (grievance) you should raise this informally in the first instance with that sites supervisor/manager. Should the matter not be resolved to your satisfaction you should discuss this with your normal line manager and can raise a formal grievance/concern under your employing Trust's grievance policy.

d) Whilst working at the other Trust's site(s), or working remotely using the other Trust's information systems, you are likely to have access to information of a confidential nature. This could be confidential patient, staff or business information. Such confidential information must always be treated as confidential and you must not:

- use the confidential information in any way except for the purposes of doing your job;
- reproduce the confidential information (in whole or in part) in any form except for the purposes of doing your job;
- disclose any confidential information to anyone other than those authorised to receive it in connection with the running of the service;
- alter, delete, amend the confidential information unless you required to as part of your job and to deliver the service.

e) Please note nothing in the MOU prevents you from disclosing confidential information where:

- the disclosure is required by law
- for regulatory compliance purposes, or
- when making a protected disclosure under whistle-blowing legislation ('speaking up').

f) You must to ensure that any serious incidents and clinical incidents which you experience or which come to your attention are reported in accordance with the Incident Reporting Policy of the Trust you are working at.

g) Please note that any claims made by patients relating to their treatment in which you were involved will be covered by the Clinical Negligence Insurance of the Trust where the incident took place. For more information please see the HUTH and NLaG Service Level Agreement (see below).

**Trust Boards-in-Common Front Sheet**

**Agenda Item No: BIC(24)096**

| **Name of the Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Sue Liburd and David Sulch, Non-Executive Director and Chairs of the Quality and Safety Committees in Common |
| **Contact Officer/Author** | Sue Liburd and David Sulch, Non-Executive Director and Chairs of the Quality and Safety Committees in Common |
| **Title of the Report** | Quality and Safety Committees in Common highlight and escalation reports from:<br>• 25 April 2024<br>• 23 May 2024 |
| **Executive Summary** | The attached report highlights the work of the Quality and Safety Committees in Common at both its 25 April 2024 and 23 May 2024 meetings.<br><br>The report highlights matters considered by the Committees, matters for escalation to the Boards, any additional assurance required, confirm and challenge of the BAF and any action required of the Boards. |
| **Background Information and/or Supporting Document(s)** (if applicable) | The attached reports provide Committees in Common highlights and escalations to the Boards in Common. |
| **Prior Approval Process** | The attached report has been approved by the Committees in Common Chairs. |
| **Financial implication(s)** (if applicable) | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/A |
| **Recommended action(s) required** | ☐ Approval ☐ Information<br>☐ Discussion ✓ Review<br>✓ Assurance ☐ Other – please detail below: |

# Committees-in-Common Highlight / Escalation Report to the Trust Boards

| | 13 June 2024 |
|---|---|
| | Quality and Safety Committees in Common |
| | 25 April 2024<br>23 May 2024 |
| | Yes on both occasions |

## 1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their meeting(s) held on 25 April 2024 and 23 May 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

## 2.0 Matters considered by the committees

**2.1 25 April 2024**

- Operational Pressures (Verbal update)
- Board Assurance Framework
- Integrated Performance Report
- CQC Action plan NLAG
- CQC Action plan HUTH
- NLAG Maternity
- HUTH Maternity
- HUTH CQC Section 31 Action plan
- HUTH Safeguarding
- NLAG safeguarding
- HUTH/NLAG PSIRF
- HUTH Patient Experience
- NLAG Patient Experience
- ED Deep Dive
- Annual PLACE Report

**2.2 23 May 2024**

The committees considered the following items of business:

- Operational Update
- Board Assurance Framework
- Risk Register Report
- Group Integrated Performance Report
- CQC Improvement Plans – NLAG/HUTH/Maternity
- Maternity action update
- PSIRF
- CLIP Report
- Quality Impact Assessment
- Register of External Interests
- Mortality and learning from deaths
- Clinical Effectiveness Report
- CQUINs

- CQC Statement of Purpose IPC Board Assurance Framework
- Nursing assurance reports HUTH/NLAG
- Mental Health Strategy update

## 3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting / escalation to the Trust Boards:

**25 April 2024**

a) **HUTH/NLAG** CQC action mapping exercise – Work is ongoing to ensure that Care Groups know who owns each action.

b) **HUTH** Maternity – There are still triage issues out of hours but these are being managed with fortnightly KPI monitoring meetings.

**HUTH** Maternity – workforce issues reported which included:

- 12.28 wte midwives on maternity leave
- Inability to recruit to vacancies
- A new proposed Midwifery establishment/leadership structure has been recommended and is awaiting executive/ICB approval

c) **HUTH/NLAG** Friends and Family Test improvements in A&E and Outpatients

d) **HUTH** - ED Deep Dive – overdue 90 day plan of the ground floor model. Work is ongoing but progress is limited. Insufficient patient movement through the hospital but there are a number of Quality Improvement actions in place to improve ED performance and patient care. 2 high risks on the risk register – ED Crowding and persistent failure of the ED 4 hour target.

**23 May 2024**

a) The Deputy Chief Nurse commended HUTH and NLAG staff on their joint working arrangements following a particularly difficult on-call session.
b) The new Care Groups are to review their CQC actions and highlight any risks to the services. The Committees in Common would continue to receive the progress updates.
c) **HUTH** IPC BAF would be presented as a quarterly report to the Committees in Common and annually to the Board. Key concerns, actions to address and timescales to be highlighted in the quarterly report. This process would be replicated at NLAG. The Committees in Common were assured by this approach.
d) After further review it was reported that the **HUTH** CQUIN relating to nutrition was now on track to achieve the target for full achievement.

## 4.0 Matters on which the committees have requested additional assurance:

4.1 The committees requested additional assurance on the following items of business:

**25 April 2024**

a) **HUTH/NLAG** joint BAF process position update, moderate assurance received.

b) **NLAG** CQC Action plan – 122 actions down to 72. Closed actions are still tracked but removed from the action plan. Good progress was being made, significant assurance was received relating to the process. Moderate assurance was received for the outcomes as actions were not yet embedded.

c) **HUTH** CQC Action plan – Good progress being made, significant assurance received regarding the process, limited assurance received for the outcomes. Outcomes.

d) **NLAG** Maternity – Good progress regarding year 6 CNST standards and the exit plan for the Maternity Support Programme resulted in significant assurance being received.

e) **HUTH** Maternity – Processes now in place to manage OOH triage, but limited assurance received as the CIC required further assurance on this matter. This was compounded by vacancies within midwifery both midwives and the senior team arrangements.

f) **NLAG/HUTH** - PSIRF – Work was ongoing regarding the joint process and significant assurance was received for both organisations.

g) **HUTH/NLAG** - Patient Experience – The CICs were reasonably assured regarding the processes but there was more work regarding alignment and performance outcomes.

h) **HUTH** ED CQC Assurance visit – CQC had given positive feedback regarding the development plans in place and risk awareness. Limited assurance was received due to the amount of work yet to do regarding the Ground Floor development.

i)**HUTH/NLAG** - PLACE Annual Reports received and significant assurance was received regarding the processes in place.

**23 May 2024**

a) Risk reporting – a review of all risks was being carried out with the Care Groups. A report to be received detailing progress would be received at the October 2024 CIC.
b) **HUTH** - There were 11 CQC maternity actions that were now off track. The Committees in Common requested that any actions proving difficult to achieve should be flagged to the Committees in Common.
c) **NLAG** SHMI – clarification was required regarding the 7 point downward direction and this would be presented to the next Committees in Common.
d) **HUTH** SHMI – A report was received which highlighted trauma operating capacity/sepsis/FNOF/cardiology and oncology. The Committees in Common gave limited assurance. The Mortality Group was in place to review the issues and further progress updates would be received.

e) The Clinical Effectiveness report was presented and limited assurance was received due to NICE guideline compliance. NLAG 87.4% and HUTH 73%.

## 5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

5.1 The committees considered the areas of the BAFs for which it has oversight and has proposed the following change(s) to the risk rating or entry:

**25 April 2024**

The **HUTH/NLAG** BAF was presented to the Committee for information to show the progress being made relating to the development of the Group BAF.

The committee considered the areas of the BAF for which it has oversight and no changes are proposed.

**23 May 2024**

The Q4 BAF risk ratings were ratified and the Committees in Common agreed to recommend approval by the Boards in Common in June 2024. There were no changes proposed.

The Q1 BAF risk ratings were also received and would be presented to the Boards in Common in June 2024.

## 6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the issues reported/escalated to the Boards in Common 25 April/23 May 2024
- Note the assurance received by the Committees in Common 25 April/23 May 2024

***David Sulch***

***24 May 2024***

## Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)098**

| **Name of Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | Thursday 13 June 2024 |
| **Director Lead** | Dr Kate Wood, Group Chief Medical Officer<br>Amanda Stanford, Group Chief Nurse |
| **Contact Officer / Author** | Robert Chidlow, Interim Group Director of Quality Governance<br><br>**NLAG**<br>Richard Dickinson, Associate Director of Quality Governance<br>Fiona Moore, Head of Quality Assurance<br><br>**HUTH**<br>Michela Littlewood, Associate Director of Quality<br>Leah Coneyworth, Head of Quality Compliance and Patient Experience |
| **Title of Report** | **Annual Quality Account 2023/24** |
| **Executive Summary** | Each year Trusts are required to publish an Annual Quality Account by the national deadline of 30 June 2024.<br><br>The attached *draft* Quality Accounts for HUTH and NLAG provide an overview of each Trust's performance, particularly the progress made against the Quality Priorities for 2023/24 and sets out future priorities going into 2024/25. Both trusts have set common quality priorities for 2024/25, as approved by the Quality and Safety Committees in Common.<br><br>Each Trust is required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. However, some national data collection was paused during the COVID-19 pandemic leading to delays in future publications. Consequently, to retain consistency and to comply with the national guidance the tables within the report have been populated with the latest published data that is available from NHS Digital. Where appropriate the narrative provides a local update. As per national guidance no external audit is required for this year's publication.<br><br>Approval is requested from the Trust Boards-in-Common for the draft Quality Accounts to be released for publication once final stakeholder feedback is received. |
| **Background Information and/or Supporting Document(s)** (if applicable) | Each Trust has shared its draft Quality Account with the relevant external stakeholders for consultation: the ICB, Overview and Scrutiny Committees, Trust Governors and the local Healthwatch.<br><br>Representatives from NLAG attended NLAG's Member and Public Engagement Assurance Group on the 21 May 2024 and the Lincolnshire County Council Health Scrutiny Committee on the 4 June 2024 to present the draft Quality Account. Positive verbal feedback was received. |

| | |
|---|---|
| | To date, NLAG has received statements from stakeholders for inclusion in the Quality Account have been received from North East Lincolnshire Place - Humber and North Yorkshire Integrated Care Board (ICB) and Lincolnshire ICB, Healthwatch North East Lincolnshire, Healthwatch North Lincolnshire, Healthwatch East Riding of Yorkshire, North Lincolnshire Council – Health, Integration and Performance Scrutiny Panel and the Trust's Council of Governors. The Trust is awaiting final stakeholder statements from the Lincolnshire County Health Scrutiny Committee, East Riding of Yorkshire Council and North East Lincolnshire Council. These will be included before final publication.<br><br>HUTH is pending receipt of stakeholder feedback which will be updated and presented to Quality and Safety Committees in Common on 27 June 2024. |
| **Prior Approval Process** | The Quality and Safety Committees in Common received an update on the progress made against each Trust's 2023/24 Quality priorities in March 2024 and approved 2024/25 Group Quality Priorities. The workplan of the Quality and Safety Committee in Common has periodically reviewed the core data within the Quality Account. |
| **Financial Implication(s)**<br>(if applicable) | Not applicable |
| **Implications for equality, diversity and inclusion, including health inequalities**<br>(if applicable) | Not applicable |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

# Hull University Teaching Hospitals NHS Trust
# Quality Accounts 2023/2024

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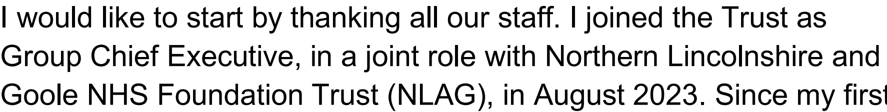
# Part 1: Introducing our Quality Account

This section includes:


- 1.1 Statement on Quality from the Chief Executive
- 1.2 What is a Quality Account?
- 1.3 About Us
- 1.4 What our patients said in 2023/24
- 1.5 Celebrating Success in 2023/24

# 1.1 Statement on Quality from the Group Chief Executive

I am pleased to present Hull University Teaching Hospitals NHS Trust's Quality Account. The Quality Account is an annual report, which reviews our performance and progress against the quality of services we provide and sets out our key quality and safety improvement priorities for 2023/24. It demonstrates our commitment to continue improving our services and provide high quality, safe and effective care to our patients, their carers and their families. This means that it is essential that we focus on the right quality and safety priorities for the forthcoming year.



I would like to start by thanking all our staff. I joined the Trust as Group Chief Executive, in a joint role with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG), in August 2023. Since my first week I have spent much time visiting services across our sites and speaking with staff. I am privileged to have met so many committed, hard-working staff who want to make a real difference to patients.

As with every part of our NHS, our services are under pressure. The Covid-19 pandemic had an impact on already long waiting lists and I am sorry for the extended waiting times that a number of our patients have had. I am pleased that our Trust was able to continue treating some of its elective patients during the pandemic, working in partnership with neighbouring organisations. Our staff worked hard to treat patients who had waited the longest in this reporting year of 2023-24 and I thank all the teams involved in doing that.

Our Emergency Department on the Hull Royal Infirmary site has continued to experience sustained pressure during 2023/24. Greater numbers of patients have presented to our ED as well as an increase in ambulance conveyances, similar to other parts of the country. We have continued to experience a higher proportion of patients with *No criteria to reside* which has meant that our patient wards have had consistently high levels of occupancy.

The target to see and admit or discharge patients in Emergency Departments was set nationally at 76% for March 2024, and despite making significant improvements, was a target we were not able to meet. Whilst we did manage to see and treat most patients in four hours 61% of the time, this is not good enough and I am sorry that this has been our patients' experience. I am optimistic that the opening of the Urgent Treatment Centre on the Hull Royal Infirmary site in February 2024, and increased hours of opening since April 2024, will assist in further improving the local healthcare system's ability to see patients in a timely and safe manner and reduce pressure in our Emergency Department.

Our staff remained focused on patient care during periods of industrial action taken by medical staff around their national terms and conditions. Thank you to everyone who worked over these periods as well as staff who have worked closely with patients whose appointments had to be cancelled and rescheduled. We did, by the end of the year, make significant progress in clearing the long backlogs against the targets directed by NHS England.

Since joining the Trust in August 2023, I have been working with senior staff to put in place a single shared Group Executive team as well as a new clinical service structure for the NHS Humber Health Partnership, the new branding name for the Group organisation. Going into 2024/25 we have new leadership teams in place in our 14 clinical service care groups. The next financial year will be one where we can really start to realise the benefits of Group working.

*Improving the quality of our care*

The Trust reported in its 2022/23 Quality Account that the Care Quality Commission (CQC) had inspected its services in November 2022 and issued its report in March 2023. Unfortunately this rated the Trust overall as '*Requires Improvement'*, but rated the Trust as *Inadequate* for the Safe domain primarily driven by ratings in Urgent and Emergency Services and Surgery.

Prior to my arrival as Group Chief Executive in August 2023, the CQC subsequently reported on its March 2023 inspection as part of its national maternity inspection programme. This was a focused inspection of the maternity service, looking only at the safe and well-led key questions. Unfortunately both of these domains were rated as *Inadequate.*

We set out more detail of our response to these CQC inspection findings in **section 2.3.5.** I am heartened by the progress the Trust is starting to embed against its action plans during a period of organisational change towards Group collaboration and responding to reducing our backlogs arising from the covid pandemic. We do, however, have significant more work to do on our improvement journey which is the Board's focus going into 2024/25, supported by our system partners.

I would like to draw out some of the many improvements during 2023/24 as follows:

*Urgent and Emergency Care*

- We opened the Urgent Treatment Centre on the Hull Royal Infirmary site on 6 February 2024 which has been successful in diverting patients to a more appropriate setting and allow patients requiring urgent and emergency treatment to be seen in the Emergency Department in a more timely manner;
- Our celebrating success summary in section 1.5 draws out that the Trust's Emergency Department team won the national 2023 Health Service Journal (HSJ) Award for Patient Safety, arguably one of healthcare's most sought-after titles. This was for their project focusing on improving the diagnostic detection of thoracic aortic dissection. I am excited by the further potential of the Group going forward to harness the opportunities from the foundations both trusts have laid in respect of quality improvement.

*Surgery*

- The actions we have taken through our theatre improvement programmes in response to the findings as part of the CQC inspection of surgery has significantly reduced the number of Never Events to one during 2023/24;
- The opening of the state-of-the-art Day Surgery Centre at Castle Hill earlier in the year has provided additional theatre capacity and pre-assessment facilities and marked the first phase of expansion.
- The Trust has been stepped down from NHS England tiering for elective recovery as a result of demonstrable improvements in the reduction of number of long waiting patients at the trust. The number of patients feeding back negatively on waiting times has reduced in year as captured in section 1.4.

*Maternity*

- Within our Maternity services, we have undertaken a number of physical and digital improvements during the year. At the time of our CQC inspection, our planned and unplanned activity was seen in the same small physical space. We quickly addressed this before opening the new Maternity Triage Unit in November 2023. This has driven significant improvement to ensure that women attending the hospital are triaged, assessed and streamlined in a timely manner by appropriately skilled and qualified staff. The Maternity services implementation of BadgerNotes / BSOTS commenced on 12 March 2024. The Trust

has embedded performance in excess of 90% of patients seen within 15 minutes in the 2024 calendar year to date which is described in more detail in section 2.3.5.
- Healthwatch East Riding of Yorkshire and Healthwatch Kingston upon Hull have recently conducted a review of maternity services between October 2023 and January 2024 and concluded that 'there has been many improvements made by the staff of HRI to improve patient experience following the CQC report published in 2023', These included the improvements to triage made, but also rightly drew out the need to sustain our staffing models. We look forward to working with Healthwatch, and more widely the Hull Maternity and Neonatal Voices Partnership who have separately provided the Trust with superb support and feedback to further embed the feedback from patients.

*2024/25 Quality Priorities*

In Part 3 of this report we set out the quality and safety improvement priorities for 2024/25.

As part of our work as a Group, we have established a Group wide quality improvement team. The Trust has agreed to combine the quality priorities as a Group and the below list demonstrates the approved quality priorities for HUTH and NLAG organisations for 2023/2024 which will be rolled forward into 2024/2025.

- End of Life;
- Deteriorating Patient;
- Sepsis;
- Medication Safety; and
- Mental Capacity.

During 2023/24 the Trust has made good progress against the 2023/24 priorities set at the start of the year. These were set prior to the receipt of the CQC findings, to which our teams have placed significant energy and focus to making progress against. Therefore, our 2024/25 priorities acknowledge that the 2023/2024 priorities we set and have made progress against are still very important for the 2024/2025 period. These will operate in addition to other trust-wide quality improvement projects, such as Falls, Tissue Viability and VTE. We will continue to embed learning from incidents and learning from deaths as part of the normal course of our everyday operations and governance oversight.

At Hull University Teaching Hospitals NHS Trust, we have two new priorities for 2024/25 in *End of Life* and *Deteriorating Patient*. We will harness some of the opportunities presented to us by our new Group structure as our teams at NLAG have already progressed work against these priorities in 2023/24. As Group Chief Executive, I am pleased that these form part of our priorities for the forthcoming year. I personally read and sign off for approval every complaint letter response within the Trust to our patients and their relatives that have taken time to provide feedback. The learning we take from complaints has helped to inform this important work we need to undertake to improve both our experience for patients and communication with families in these areas.

I can confirm that the Board of Directors has reviewed the 2023/24 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

**Jonathan Lofthouse**
**Group Chief Executive**

# 1.2 What is a Quality Account?

**What is a Quality Account?**

The Quality Account is an annual report published to the public from providers of NHS healthcare about the quality of the services it provides. The report provides details on progress and achievements against the Trust's quality and safety priorities for the previous year and what the Trust will focus on in the next year.

**What should a Quality Account look like?**

Some parts of the Quality Account are mandatory and are set out in regulations (NHS Quality Account Regulations 2010 and Department of Health – Quality Accounts Toolkit 2010/2011). The toolkit can be accessed via: https://www.gov.uk/government/news/quality-accounts-toolkit.

The Quality Account must include:

### Part 1: Introduction

- A statement from the Board (or equivalent) of the organisation summarising the quality of NHS services provided

### Part 2: Looking back at the previous financial year's performance

- Organisation priorities for quality improvement for the previous financial year
- A series of statements from the Board for which the format and information required is prescribed and set out in the regulations and the toolkit

### Part 3: Priorities for the coming financial year

- A review of the quality of services in the organisation for the coming financial year. This must be presented under three domains; patient safety, clinical effectiveness and patient experience
- A series of statements from Stakeholders on the content of the Quality Account

### What does it mean for Hull University Teaching Hospitals NHS Trust?

The Quality Account allows NHS healthcare organisations such as Hull University Teaching Hospitals NHS Trust to demonstrate its commitment to continuous, evidence-based quality improvement and to explain its progress against agreed quality and safety priorities, how the organisation performed in other quality areas e.g. service delivery and to inform the public of its future quality plans and priorities.

### What does it mean for patients, members of the public and stakeholders?

By putting information about the quality of services into the public domain, NHS healthcare organisations are offering their approach to quality for scrutiny, debate and reflection. The Quality Accounts should assure the Trust's patients, members of the public and its stakeholders that as an NHS healthcare organisation it is scrutinising each and every one of its services, providing particular focus on those areas that requires the most attention.

### How will the Quality Account be published?

In line with legal requirements all NHS Healthcare providers are required to publish their Quality Accounts electronically and ensure the documents is made available and accessible on the Hull University Teaching Hospitals NHS Trust website: http://www.hey.nhs.uk/about-us/corporate-documents/.

# 1.3 About Us

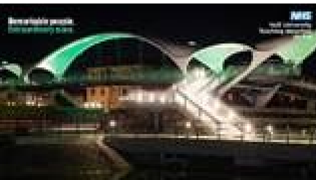
We employ just over **8,995 whole time equivalent staff** and are supported by over **500 volunteers**

We saw over **130,000** patients in our **Emergency Department** last year

We have **two** main hospital sites:
**Hull Royal Infirmary**
**Castle Hill Hospital**

We admitted over **94,000** patients into our **wards** last year

We have an **annual income** of circa **£886 million**



Over **880,000** patients attended an **Outpatient Department** last year

We delivered over **5,245** babies in our **Women's and Children's Hospital** last year

Secondary care services are provided to a catchment population of approximately **600,000** in the **Hull and East Riding of Yorkshire** area

The Trust also provides specialist and tertiary services to a catchment population of between **600,000 million and 1.25 million** extending from **Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire** respectively

Going forward the Trust has formed a Group with Northern Lincolnshire and Goole NHS FT. The Group is known as the NHS Humber Health Partnership.

The Group has a new Vision:
**United by Compassion: Driven by Excellence;**
This is underpinned by our values of: Compassion, Honesty, Respect and Teamwork

# 1.4 What our patients said in 2023/24

The Trusts Friends and Family provider was replaced in January 2020 and Healthcare Communications now help with the Trust methodology for the Friends and Family Test (FFT). The Emergency Department and the Radiology department have been working with Healthcare Communications since 2017 and since working with them, the Trust has been able to obtain rich data from our patients and their relatives with regards to their experience whilst being cared for in the Trust, working with Healthcare Communications has given patients and relatives the opportunity to feedback to the Trust on five different platforms SMS (Text messaging) IVM (Interactive voice messages) a webpage, QR code and paper feedback forms, Volunteers have been trained to assist patients with access to iPads who are struggling to complete the survey, to improve response rates and accessibility.

During 2023/2024 the Trust collected **120k** responses from patients and is grateful for the **99k** comments that patients made whilst completing our survey to help us improve our services. This is broadly similar to the response rate in the prior year and the Trust has continued to achieve an overall star rating of 4.5 out of 5, with some progression in our overall rating. Whilst we have received fewer negative elements of feedback, there is significant work for us to drive forward and improve our experience for patients.

The main themes of feedback are contained in the below tables with a year on year comparison:

| 2022/23 | | | 2023/24 | | |
|---|---|---|---|---|---|
| # | Top 5 positive themes | % respondents feedback | # | Top 5 positive themes | % respondents feedback |
| 1 | Staff attitude | 44.14% | 1 | Staff attitude | ↑ 49.07% |
| 2 | Implementation of care | 27.51% | 2 | Implementation of care | ↑ 28.67% |
| 3 | Environment | 16.76% | 3 | Environment | ↑ 19.04% |
| 4 | Patient mood/feeling | 11.90% | 4 | Patient mood/feeling | ↑ 13.76% |
| 5 | Communication | 11.40% | 5 | Communication | ↑ 13.06% |

| 2022/23 | | | 2023/24 | | |
|---|---|---|---|---|---|
| # | Top 5 negative themes | % respondents feedback | # | Top 5 negative themes | % respondents feedback |
| 1 | Staff attitude | 4.35% | 1 | Staff attitude | ↓ 3.96% |
| 2 | Waiting time | 3.97% | 2 | Environment | ↓ 3.18% |
| 3 | Environment | 3.60% | 3 | Waiting time | ↓ 3.12% |
| 4 | Implementation of care | 2.95% | 4 | Communication | ↓ 2.54% |
| 5 | Communication | 2.79% | 5 | Implementation of care | ↓ 2.52% |

We are pleased that nearly half of our patients (49%) take the time to positively feedback on the attitude and caring nature of our staff. This is the most improved theme during 2023/24, but we recognise there is more work to do. Our staff survey results are documented in section 2.2.4 which shows some positive improvement in staff engagement during 2023/24. During the year we have successfully increased our staffing establishments across the Trust, better ensuring we can meet the timely needs of our patients. This has also helped to reduce the volumes of negative feedback we have received from patients in respect of the theme of waiting times.

However, as a Trust we recognise we have more work to do to act on the significant feedback patients give to us through the Friends and Family Test, Patient Advice and Liaison Service and through formal complaints. This will remain a key focus during 2024/25 to enact changes in a timely manner.

HUTH has shown progression against the four core FFT national benchmarks as follows during the year:

- Our **FFT A&E** score has improved during the winter period which is against the reducing national trend and significant regional capacity pressures. We ended 2023/24 with a score of **70%,** which fell short of the regional performance of 76% and national performance of 77%. We opened the Urgent Treatment Centre on the Hull Royal Infirmary site which we hope will further contribute to reduced waiting times and better prioritisation of our Emergency patients during 2024/25.
- Our **FFT Outpatients** score has improved to **94%** at the end of 2023/24 and is consistent with other regional providers. We are striving to exceed the national target score of 95%.
- Our **FFT Inpatients** score has increased by +5% during 2023/24 since our CQC inspection was reported in March 2023, with a score of **90%** in March 2024. We are targetting significant improvement for our inpatients feedback and are seeking to exceed regional and national benchmarks of 94%.
- Our **FFT Birth** score achieved **100%** for 7/12 months during 2023/24, including the last 5 months of the year from November 2023. The Trust is seeking to collect additional feedback from our antenatal and postnatal patients to further our learning and improvement initiatives in Maternity.

Examples of feedback provided by our patients include:

After waiting 3 months for the 'hot clinic' following a referral from A&E my referral was declined with no explanation why it was inappropriate. A&E suggested after a CT and MRI that I have brain lesion, my anxiety is through the roof being left in the dark.

Great recovery service midwives we're really helpful and supportive and offered lots of great advice for me

The staff go above and beyond. They are so friendly and lovely, nothing is too much trouble.

I was seen in a very timely manner, courteous staff all the way through. Very efficient and accommodating with my appointment

My mum was brought into A&E by ambulance. All staff were so lovely and all introduced themselves by name, made sure she heard and understood what was going and took the time to care. I am a nurse myself and the team made me proud of my profession

Prior to the Nephrostomy procedure I asked the person doing it to please ensure that all the joints and connections where tight, because of previous problems, afterwards while I was getting changed, I had to tighten the accessible joints, then at 0500 the following morning I had to return to castle hill hospital ward 15 because the Nephrostomy was leaking the nurse who checked it said all the connections under the dressing where loose/undone, the nurse tightened them and redressed the Nephrostomy, this incident is not isolated, and has happened on a number of other occasions, very inconvenient.

Nobody knew what was wrong so basically they let me go with the same problems I went in with

# 1.5 Celebrating success

Like many NHS providers across the country, in 23/24, the Trust faced another challenging year. Although the Trust has experienced a number of difficulties, staff across the Trust continue to rise to the challenge with many examples of amazing successes and accomplishments achieved throughout the year. Some of this year's successes are highlighted below.

# Moments of magic

The Moments of Magic is a Trust established recognition scheme, which acknowledges staff who go above and beyond to provide great care to patients, staff and visitors. Whether it is a friendly gesture, an act of kindness or simply a way of putting people at ease when they may be anxious or upset, these are the kinds of thing which can make a big difference to people in our care, and which make us all proud of our local hospitals and the wider NHS. Below is a sample of some of the 'moments of magic' that were recognised within the last year:

**Thank you Tracey Walker, Gynaecology Outpatients**
Tracey is passionate about supporting vulnerable patients attending the Pregnancy Advisory Service. Tracey has developed strong links with local networks to safeguard patients in abusive relationships to ensure they can access the help they require. Tracey ensures that patients are supported throughout their journey in the clinic with the CNS's and will meet and greet patients on the day of surgery to ensure they feel safe and reassured. Tracey has recently created a patient information board in the Early Pregnancy Assessment Unit to raise awareness about Domestic Violence and provide details of local support agencies. Thank you Tracey.

**Thank you Leanne Hall, Paediatric Outpatients**
I would like to send a big thank you to our Volunteer Leanne. Leanne has such a good, joyous attitude and has helped transform Paediatric Outpatients. She really makes a difference to all the children coming through our department. At Christmas she dressed as an elf and gave out good list stickers which patients and their families loved. Nothing is too much trouble for her and she works between POPD and Woodland Ward trying to make Children's experience in Hospital a positive one.

**Thank you C14, Upper GI**
During a shift that was already difficult due to patient acuity and staffing levels, a patient had an acute mental health crisis. The student nurses, auxiliary nurses, and nursing team worked under unfamiliar circumstances, which were stressful and distressing, not only for the patient concerned but also for other patients and staff on the ward. Everyone worked well and offered emotional support to one another. A special nod to ward Sister Lucy and Michelle.

**Thank you ED Resus critical care outreach team HRI, Critical Care Outreach Service**
My mum came into ED resus recently and sadly passed away. What has helped me through this difficult time is the professionalism and the care and compassion and empathy from the Ed Majors resus team and critical care outreach who were on shift had to break bad news to us. I feel as a staff member these teams go unrecognised by what they do. They were truly amazing fantastic in the way they thought to save my mums life, and could not. These teams are truly exceptional human beings and should be commended for their excellent care just simply amazing. I shall never forget what they did that evening and I am truly proud to be part of the NHS.

# Internal staff awards

The Trust presents staff with Golden Hearts Awards and the awards recognises staff across the Trust for their amazing and outstanding contributions towards patients and colleagues. The final Hull University Teaching Hospitals NHS Trust staff awards ceremony was held in 2023. A fresh new start is coming in 2024 for our first ever NHS Humber Health Partnership awards, Golden Stars!

The 2023 categories and winners were:

**Making it Better: Rapid Diagnostic Operational Project Group**

**Patient Safety: Urgent Cancer Pathway Development Team**

**Patient Experience: Respiratory Virtual Ward**

**Outstanding Contribution to Equality, Diversity and Inclusion: Elaine Hillaby**

**Zero 30: The SENTINEL Project Team**

**Excellence in Research, Development and Innovation: The TEM-PAC Study Team**

**Outstanding Team of the Year: Non-Clinical: Clinical Administration Services**

**Unsung Hero: Ann Brown**

**Great Leader: Lucy Vere**

**Rising Star: Sebastian Spencer**

**Lifetime Achievement: Professor Sunil Bhandari**

**Health Group Award: Clinical Support Services**

# External staff awards

**Hull A&E team scoops national award for patient safety**
Hull University Teaching Hospitals NHS Trust's Emergency Department was awarded the 2023 Health Service Journal (HSJ) Award for Patient Safety, arguably one of healthcare's most sought-after titles.

Emergency Department staff received the award for their project: "Improving the diagnostic detection of thoracic aortic dissection in the Emergency Department." The category was intensely competitive with over 100 applications and 9 short-listed projects. It was fantastic to see one of the Trust's many Quality Improvement projects get such national recognition.

Acute Aortic Dissection (AAD) can affect adults of all ages, but can be difficult to diagnose as it only accounts for around 1 in every 1,000 cases of atraumatic chest pain, so misdiagnosis is not unusual.

The project involved data monitoring, ensuring timelier access to CT scans and investigations, and creating an open and honest forum for discussion with staff, bringing in knowledge and experience from colleagues in radiology, vascular and cardiothoracic surgery. The proactive involvement of the Thoracic Aortic Dissection Charitable Trust was also considered invaluable.

**National award for hospital porters**
The Portering Team in the Trust were celebrated nationally the award in 2023 for one of the key achievements upon which the team's award nomination was based this year is the 'Ready to Go' model, which is designed to make the process of discharging a patient from hospital or to another ward or unit more efficient. When booking a job, ward staff are asked to consider the MINTED* model and ensure all essential stages of preparation such as medication and transport have been arranged before the porter attends.

Being recognised nationally as 'Portering Team of the Year' is outstanding their responsibilities and duties go far beyond simply pushing a stretcher or moving a bed.

**Head of Midwifery honoured by University of Bradford**
The University of Bradford has conferred an honorary degree on Rukeya Miah, Head of Midwifery at Hull Royal Infirmary.

Described as a midwife with a very special history with the University of Bradford, Rukeya has been awarded the Outstanding Contribution Award as part of the Winter Graduation Ceremonies held at the university. The university said the award was in recognition of her outstanding career as an award-winning midwife and her advocacy for equality and inclusion within healthcare and leadership.

Rukeya's work has seen her recognised by the Nursing and Midwifery Council as BAME Midwife of the Year 2022, British Journal of Nursing Public Health Nurse of the Year 2023 and shortlisted in three categories in the Nursing Times Awards 2022. On top of that, she has been named as one of Bradford's most influential South Asians in 2021 and awarded the British Empire Medal in the Queen's birthday honours in June 2022.

**Hospitals nurses winners of prestigious UK award for staff support scheme**

The nursing workforce and education team at Hull University Teaching Hospitals NHS Trust had been selected from 920 entries as winners in the Workforce Initiative category of the RCN Nursing Awards 2023. The award was sponsored by NHS Professionals.

Chair of the judging panel Joanne Bosanquet, chief executive of the Foundation of Nursing Studies and Fellow of the RCN, said: “The Hull nursing team’s recruitment and retention programme really stood out. At a time when there is a workforce crisis it has managed to turn their vacancies around through investing in local and international recruitment, supporting existing staff to progress and retain essential skills. The nursing team has transformed lives as well as improving outcomes for patients due to the reduction of supplementary staffing. This could be replicated in other organisations and have a huge impact UK-wide”

**Hull’s Interventional Radiology Day Unit named best in UK**

Hull University Teaching Hospitals NHS Trust has been named as having the best performing Vascular Interventional Radiology (IR) Day Unit in the country, conducting almost 1,200 minimally invasive treatments in a single year.*

The Unit’s commitment to excellence has led to its recognition as the highest performing interventional centre in the UK for 2022, as acknowledged by the National Vascular Registry.

As a teaching hospital, the Radiology Day Unit plays a pivotal role in training future radiologists. By actively participating in research and innovation, the Unit contributes to advancements in the field of radiology, improving patient outcomes and driving progress in healthcare.

The Trust takes immense pride in the transformative work accomplished by the Unit. Through unwavering commitment to excellence, innovative approaches to diagnosis and treatment, and dedication to advancing the field, the Unit continues improve the lives of patients.

* Vascular IR data can be found at National Vascular Registry

**HUTH Travel Team scoop top national award**

Congratulations to HUTH’s Travel Team after they beat off competition from around the country to scoop the title of “Team of the Year” at a prestigious national awards ceremony.

HUTH held off competition from Leeds City Council, South Gloucestershire Council and the Bikeability Trust to claim the title at the National Modeshift Convention after being nominated by NHS England.

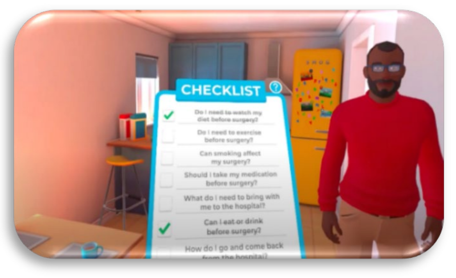
The staff travel project was launched as part of our Zero 30 campaign and the trust now offers staff a range of free bus services on routes to the north, south, west and east of the city to Hull Royal Infirmary and Castle Hill.

# Innovation

**We're better than that: Hospitals' commitment as new Zero Tolerance to Ableism Framework is launched**
It's a form of discrimination that often goes under the radar; and comes in many forms, affecting people with both overt and hidden disabilities across our region on a daily basis.

Hull University Teaching Hospitals NHS Trust (HUTH) has launched its Zero Tolerance to Ableism Framework. The framework reinforces the Trust's commitment to creating an environment where staff members, irrespective of any disability or impairment they may have, can expect to be treated with dignity and respect by their patients, visitors and colleagues they work with. Like our Zero Tolerance to Racism Framework, the Zero Tolerance to Ableism Framework reflects the Trust's dedication to eradicating this form of discrimination and ensuring every staff member feels valued and supported.

**Patients offered custom virtual reality experiences to help prepare them for surgery**
Patients preparing for planned surgery at Hull Royal Infirmary and Castle Hill Hospital will be given on-demand access to virtual reality (VR) education resources. The content has been designed to support patients in the run-up to their surgery and to speed up their postoperative recovery. The initiative, My Pre-op Assistant, is predicted to reduce the number of last-minute cancellations, improve patient flow through the hospital, and subsequently reduce elective surgery wait times across the Trust.




The programme designers consulted with Hull patients to learn more about the types of questions and concerns that they experienced in the run up to surgery, and to establish their preferred way of accessing and consuming multimedia content. The content can be accessed via Meta Quest VR headsets whilst patients are at the hospital, and when they return home they can access My Pre-Op Assistant content via Cognitant's Healthinote digital patient learning platform on any internet-enabled device

**New wellbeing programme for patients awaiting surgery**
Patients in Hull and the East Riding who are waiting for potentially life-changing hip and knee operations are being offered help to stay fit and well for surgery.
The new 'Waiting Well – Orthopaedics' programme is a joint venture between Hull University Teaching Hospitals NHS Trust and Forum and is aimed to provide wellbeing advice and access to group activities for appropriate patients to ensure, when the time comes for surgery, they have the best possible chance of success.

Almost 800 patients waiting for procedures such as hip and knee replacements and other complex procedures will be invited to join the Waiting Well programme, including some who have been waiting for several months and others who have more recently joined the hospital's lists.

# Part 2: Priorities for Improvement and Statements of Assurance from the Board

This section includes:


- 2.1 Performance against priorities 2023/24
- 2.2 Performance against other quality and safety indicators
- 2.3 Statements of assurance from the Board

# 2.1 Performance against Priorities 23/24

This section covers

- Patient Safety:
    - Learning from incidents
- Safer Care:
    - Sepsis
    - Medication Errors
- Focused:
    - Mental Health Triage in the Emergency Department
- Effective and Learning:
    - Learning from deaths

# Patient Safety: Learning from Incidents

### Why this was important

Patient safety is fundamental for healthcare organisations. However, as humans, we can make mistakes. As a Trust, we need to minimise the potential for error by learning from patient safety incidents.

Responding to and learning from patient safety incidents is key to identifying the systems and processes currently in place and to inform continuous improvement making sure that this is aligned with a patient safety culture. Learning should focus on identifying system factors that contribute to patient safety incidents not individual root causes.

A system-based approach and systems thinking recognises that Healthcare is a complex system and explores multiple contributory factors moving away from the simple linear cause and effect of Root Cause Analysis.

### What did we aim to achieve?

The aims from the quality priority centred on the following:

- Implementing the national Patient Safety Incident Response Framework (PSIRF);
- Implementing a human factors and systems based approach when responding to patient safety incidents; and
- Implementing learning from excellence.

### Objectives of the project

The objectives of the project included:

- Reduction in the number of Never Events on the previous year;
- Increase in the number of no harm and near miss incidents being reported;
- Increase excellence reporting;
- To improve the quality, timeliness of investigations with the involvement patients and/or their families;
- Increase the number of after action reviews(AARs) and Thematic Reviews being undertaken;
- Increase the number of Learning Response Leads having received 'PSIRF' training;
- Implementation of Patient Safety Partners; and
- Review of the DATIX incident reporting form to align with the National Learn from Patient Safety Events (LFPSE) service.

### Benefits of the project

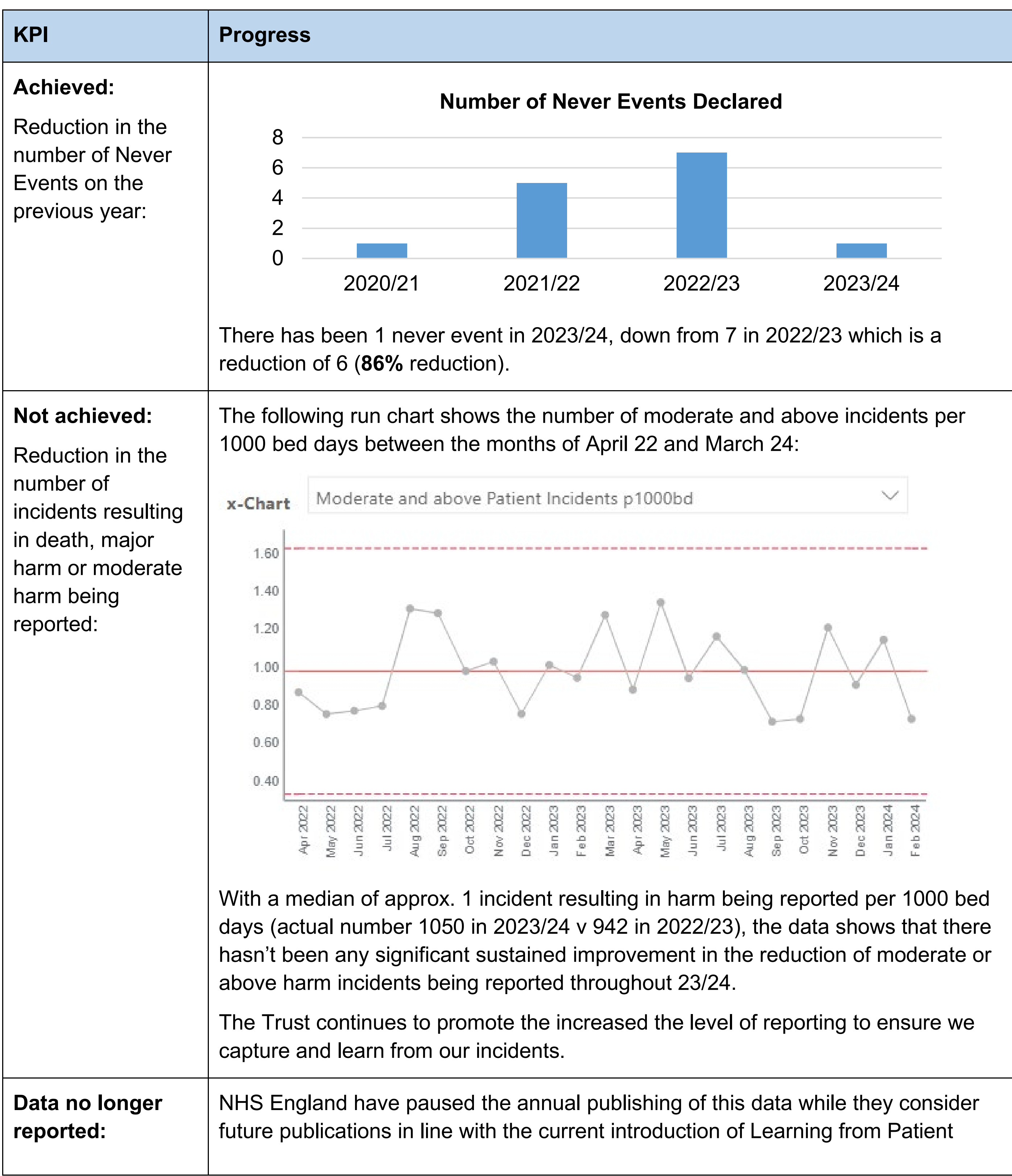
The identified benefits from implementation of the project included:

- **Patient Experience**: Compassionate engagement with patients and their families to ensure they are listened to and have their questions answered in an open and transparent way to reduce the breakdown of trust and a feeling that duty of care has been removed. To ensure the offer of a meaningful apology is provided following a patient safety incident in line with the Duty of Candour.
- **Quality Experience**: Learning from patient safety incidents and alignment with continuous quality improvement to ensure a joint approach to translating learning into action.

- **Staff Benefits**: Engaging with staff affected by patient safety incidents improves the understanding of what happened and potentially how to prevent a similar incident in the future. Ensuring correct support mechanisms are available where necessary ensures a restorative just culture and to ensure staff are 'heard'.
- **Organisational Benefits**: Delivery of the Patient Safety Strategy.

**How did we perform?**

A number of Key Performance Indicators (KPIs) were used to measure progress against the quality priority for learning from incidents and the following table outlines the progress made throughout 23/24:



| KPI | Progress |
|---|---|
| **Achieved:**<br>Reduction in the number of Never Events on the previous year: | **Number of Never Events Declared**<br>8 6 4 2 0<br>2020/21 2021/22 2022/23 2023/24<br>There has been 1 never event in 2023/24, down from 7 in 2022/23 which is a reduction of 6 (**86%** reduction). |
| **Not achieved:**<br>Reduction in the number of incidents resulting in death, major harm or moderate harm being reported: | The following run chart shows the number of moderate and above incidents per 1000 bed days between the months of April 22 and March 24:<br>x-Chart Moderate and above Patient Incidents p1000bd<br>1.60 1.40 1.20 1.00 0.80 0.60 0.40<br>Apr 2022 May 2022 Jun 2022 Jul 2022 Aug 2022 Sep 2022 Oct 2022 Nov 2022 Dec 2022 Jan 2023 Feb 2023 Mar 2023 Apr 2023 May 2023 Jun 2023 Jul 2023 Aug 2023 Sep 2023 Oct 2023 Nov 2023 Dec 2023 Jan 2024 Feb 2024<br>With a median of approx. 1 incident resulting in harm being reported per 1000 bed days (actual number 1050 in 2023/24 v 942 in 2022/23), the data shows that there hasn't been any significant sustained improvement in the reduction of moderate or above harm incidents being reported throughout 23/24.<br>The Trust continues to promote the increased the level of reporting to ensure we capture and learn from our incidents. |
| **Data no longer reported:** | NHS England have paused the annual publishing of this data while they consider future publications in line with the current introduction of Learning from Patient |

| KPI | Progress |
|---|---|
| Achieve top 25% quartile reporting to the National Reporting Learning System/LFPSE | Safety Events (LFPSE) service to replace the National Reporting and Learning System (NRLS). |

The following table outlines the progress made to date against the key objectives for the learning from incidents quality priority:

| Objective | Progress |
|---|---|
| **Achieved:**<br>Reducing the number of Never Events on the previous year | A number of actions have taken place to support the reduction in the number of never events being reported including but not limited to:<br>• An action and improvement plan for Theatres commenced following the last CQC report released in March 2023;<br>• Regular newsletter produced to share learning from patient safety incidents;<br>• Increased reporting of near miss never events being reported.<br>**NB** The National Patient Safety Team have launched a public consultation on the future of the Never Events Framework. The Care Quality Commission (CQC) and Health Services Safety Investigations Body (HSSIB), as well as a series of focus groups with relevant experts, has highlighted that for several types and sub types of Never Events, the protective barriers are not strong enough and called for the Never Event framework to be reviewed. |
| **Working towards:**<br>Increasing the number of no harm and near miss incidents being reported | The following chart demonstrates the number of harm free incidents reported per 1,000 bed days between April 2022 and February 2024 (17,195 in 2023/24 v 15,241 in 2022/23):<br>x-Chart Harm free Patient Incidents p1000bd<br>Awareness sessions were held in October 2023 discussing the importance of reporting no harm and near miss incidents. These sessions helped to further increase understanding that recording patient safety events whether they result in harm or not, also provides vital insight into what can go wrong in healthcare and the reasons why and how this is in line with the national LFPSE.<br>Following the release of PSIRF in April 2023, the number of no harm incidents reported has shown signs of increasing with 7 months out 11 reporting no harm |

| Objective | Progress |
|---|---|
| | incidents above the median highlighting the importance of regular communication highlighting best practice.<br><br>Further awareness sessions alongside a communication package will be implemented following the changes to the Datix reporting form in line with LFPSE. |
| **Working towards:**<br><br>Increase excellence reporting | Staff are able to report learning from Excellence via Greatix[1] reporting supports capturing positive events and improve safety by sharing and spreading the excellent work that happens at the trust. During 23/24, **9** Greatix submissions were received of which only **3** met the criteria with the remaining **6** highlighting moments of magic. Moving forward, a relaunch of the Greatix system is required to increase reporting from excellence as well as increasing the number of celebration events to display and share learning from excellence.<br><br>Moving forward, following updates to the Datix incident reporting in line with LFPSE, this will provide further opportunities for sharing learning from excellence. |
| **Working towards:**<br><br>Improving the quality and timeliness of investigations with the involvement patients and/or their families | As of 1 April 2023, the Trust began the transition to PSIRF with **29** ongoing Serious Incident (SI) investigations; these were investigated whilst the Trust was adapting to the new way of responding to patient safety incidents. All outstanding SI investigations were completed by November 2023. The aim is to complete all outstanding SI actions by March 2024 with a closing report submitted to ICB shortly after.<br><br>PSIRF is centred on the involvement of patients and during the transitional period and beyond, investigations are actively involving patients in Patient Safety Incident Investigations (PSII) where the want for involvement has been confirmed.<br><br>The Trust has a response plan (PSIRP) which outlines the different response methods and tools available for responding to patient safety incidents for the purpose of learning and improving patient safety.<br><br>The Trust presented to the regional Yorkshire and Humber Collaborative PSIRF Learning Community to share the process that was undertaken whilst developing the Trust safety profile, the themes that emerged and how this informed the Trust PSIRP. They shared assurances that were provided to the Board, plans for proactively seeking assurance and reflections on the journey to date.<br><br>Feedback from the Learning Community was very positive and it led to more interest with other Trusts asking for further information about our journey; the Trust held an 'open event' to help other providers which was well received.<br><br>Moving forwards, further work is required for patient involvement in After Action Reviews (AARs) and low-level investigations. |
| **Working towards:**<br><br>Increasing the number of AARs and Thematic | As part of implementing PSIRF, our response plan includes AAR and thematic reviews as a learning response.<br><br>The Patient Safety Team (PST) have provided training on how to undertake an AAR and since April 2023, the PST have facilitated **30** AARs with more having |

[1]Greatix - a Greatix is a nomination form that any member of staff can submit in recognition of a colleague or team. Submitting a Greatix enables us to capture positive events and improve safety by sharing and spreading the excellent work that happens at the trust. It is important to identify areas of good practice (as well as when things do not go so well which are reported on Datix) and ensure we create opportunities for learning.

| Objective | Progress |
|---|---|
| Reviews undertaken | been undertaken within the Health Groups. The learning is shared across the Trust via governance meetings, newsletters and one page learning responses summarising what had happened, what went well and key findings and learning.<br><br>Any incidents reporting a fall are responded to immediately with a swarm. The purpose of the swarm is to collect information needed to learn from falls. The data collected is then used to identify patterns associated with inpatient falls and inform after-action reviews. The swarm also aims to identify immediate actions required to reduce further falls and be a mechanism to provide support to the staff involved in a fall incident.<br><br>The Patient Safety Team have completed **4** Thematic Reviews for TAVI, stroke, radiotherapy and radiology and a further **6** are currently underway for VTE, falls, hypoglycaemia, sepsis, ED, transfer care concerns and ophthalmology. A thematic review is useful in understanding common links, themes, or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety as well as identifying areas for further improvement. |
| **Working towards:**<br><br>Increasing the number of Learning Response Leads | Training within the Trust around Human Factors Train the Trainer training and PSIRF, has been led and delivered by MedLed. To date, **50** members of staff have undergone PSRIF training and **30** members of staff have received Human Factors train the trainer training.<br><br>The training helps with understanding human factors and a systems thinking approach when investigating PSII. This approach also supports with building and nurturing a Just Culture within the organisation.<br><br>To benchmark staff perceptions of the organisation's Just Culture, a baseline was established using survey results from March 23 to May 23. A follow-up survey in April 2024 will evaluate improvements post PSIRF launch and incident reporting changes. |
| **Achieved:**<br><br>Implementation of Patient Safety Partners (PSPs) within the organisation | There are **4** Patient Safety Partners (PSPs), which have been recruited within the Trust, **2** of which are Maternity PSPs. Recruitment of PSPs within the Trust will continue alongside plans to develop and increase co-production with lived experience partners to drive improvement within the Trust. |
| **Not achieved:** Reviewing the DATIX (incident reporting tool) incident reporting form to align with the LFPSE service | Currently, the Trust is non-compliant with LFPSE due to delays with upgrades to the Datix system in house, which was a national issue. Datix was upgraded in April 2024 which has removed the system barrier to going live and the Trust's transition is planned for late May 2024. Concerns around non-compliance with LFPSE and Datix were escalated to the Quality Committee in Common in 2023 and included as a risk on the corporate risk register. |

**Going forward**

A number of areas have been identified to further improve the organisations learning from incidents:

- To undertake timely learning responses for incidents resulting in patient harm

- Safety Huddles
- After Action Reviews (AARs)
- Table Top Reviews

- To share learning from the above learning responses in 'one page learning responses' published on the Trust intranet for Trust wide learning and via the governance reporting structure;
- To raise the understanding of systems and human factors thinking and how it impacts on patient safety;
- To raise the understanding of psychological safety and encourage staff to speak up about and report their concerns regarding patient safety;
- To involve the staff affected by patient safety incidents in learning responses in a restorative manner and including them in AARs ;
- We will ensure that patients and their families are involved in and contribute to learning and quality improvement for PSIIs;
- We will work in collaboration with system partners for shared learning; and
- To host the 3rd Trust Patient Safety Conference on World Patient Safety Day in September 2024 inviting internal and external stakeholders.

# Safer Care: Sepsis

### Why this was important

The Trust is committed to improving outcomes in relation to the early identification of sepsis and treatment, through culture through education, pathways, sepsis bundles, audits, targets/KPIs and awareness.

### What did we aim to achieve?

The aims from the quality priority centred on the following:

- Improve the identification and management of patients with Sepsis;
- Improved compliance of the Sepsis Six[2]; and
- Improve the outcome of patients with Sepsis.

### Objectives of the project

The objectives of the project included:

- Improve compliance with administering antibiotics within appropriate timescales for patients with sepsis;
- Increase compliance rates for the utilisation of the electronic 'Infection and Sepsis Screening and Management Pathway' through to completion of part 2, within 2 hours of admission with particular attention to encouraging doctors/ACPs to use the tool in initial assessment of patients with NEWS2 score 5+ (or 3 in one parameter)/ sepsis red flag/ signs or symptoms of infection;
- Support Junior Doctors with undertaking smaller improvement projects in relation to sepsis management and treatment at a local level; and
- Review previous improvement projects relating to sepsis to understand what worked well and adopt/rollout successes to other areas within the Trust.

### Benefits of the project

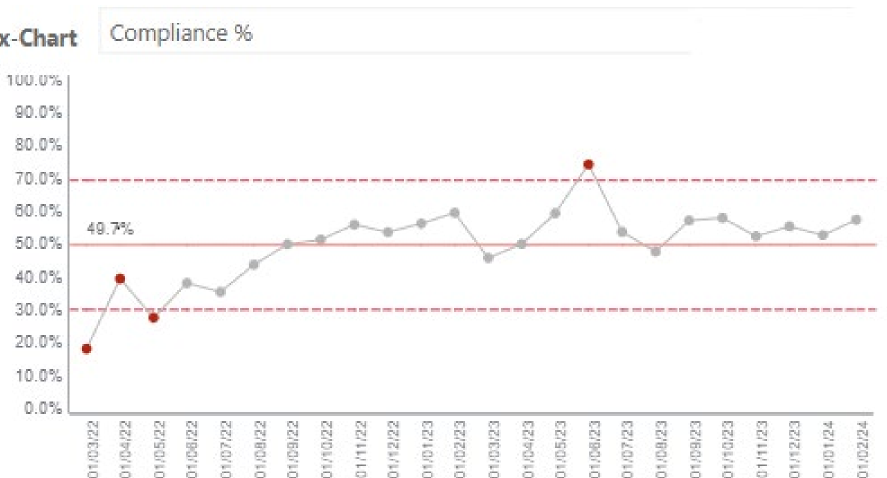
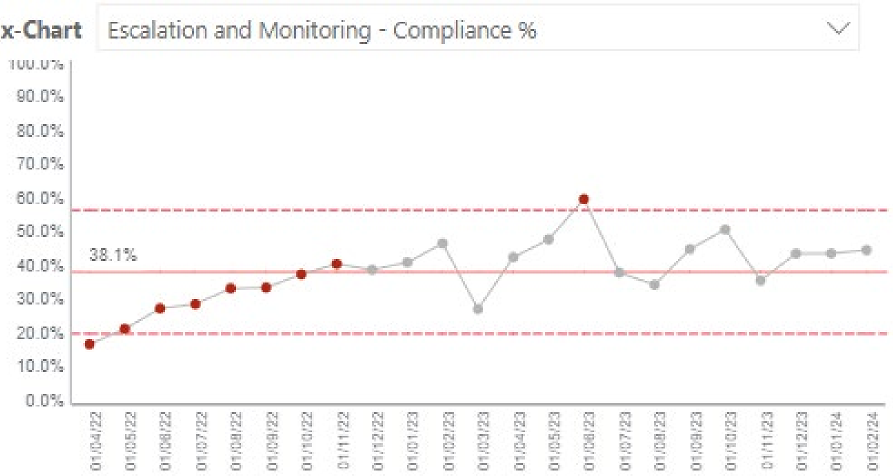
The identified benefits from implementation of the project included:

- **Patient Experience:** Patients will receive the appropriate level of care in a timely manner to support optimised recovery.
- **Quality Experience:** Timely interventions and treatments provided.
- **Staff Benefits:** Staff will have improved knowledge and understanding of Sepsis and the required treatment and timescales.
- **Organisational Benefits:** Reputational benefits, improved care pathways for patients, reduction in mortality outlier status.

### How did we perform?

A number of Key Performance Indicators (KPIs) were used to measure progress against the quality priority for learning from incidents and the following table outlines the progress made throughout 23/24:

[2] Sepsis six - a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring to be commenced within one hour to reduce mortality in patients with Sepsis.

| KPI | Progress |
|---|---|
| **Ongoing**<br><br>Improved compliance with the standards outlined on the Sepsis Audit dashboard. | Audits are regularly undertaken with support from Junior Doctors within the Trust, which then supports quality improvement. The audits help to increase knowledge around sepsis as well as increasing awareness with the challenges around sepsis management. From review of the audit data, this supports with identifying areas for improvement.<br><br>Overall compliance with the sepsis standards has shown signs of improvement since 1 April 2022 with performance above 50% sustained in 2023/24 as demonstrated by the below SPC chart:<br><br><br><br><br>Further work is required to improve compliance with individual sepsis standards including:<br><br>• Escalation and monitoring;<br>• Investigation; and<br>• Management.<br><br>Improvements in these standards will have a significant impact on positive outcomes for patients diagnosed with sepsis.<br><br>Currently, compliance for escalation and monitoring patients with sepsis is low with an average of **38%** compliance rate over the period since 1 April 2022 as demonstrated by the below SPC chart:<br><br><br><br><br>A number of quality improvement projects are underway to improve escalation and monitoring compliance including, Escalation and assessment of patients with NEWS 5+ (or 3 in 1 parameter) on C7 and sepsis recognition in the ED: |

| KPI | Progress |
| --- | --- |
| | Compliance for investigation for patients with sepsis has shown sustained improvement with an average of **52%** compliance rate since 1 April 2022 and sustained above 50% in 2023/24 as demonstrated by the below SPC chart:<br><br>A number of quality improvement projects are underway to support improvement with investigation compliance including, Improving compliance with blood culture sampling and processing and improving the search for source of sepsis in ED<br><br>Compliance for management of patients with sepsis is low with an average of **64%** over the period since 1 April 2022 which has declined in 2023/24 as demonstrated by the below SPC chart:<br><br>A number of quality improvement projects are underway to support improvement with management compliance including, improving IV antibiotic administration times in Oncology and Haematology wards and reducing antibiotics administration time in ED. |
| **Ongoing**<br><br>Reduction in patient deaths with a primary diagnosis of Sepsis | Following the CQC Inspection in November 2022, HUTH commenced monthly ED Audits. These include a snap shots in the recognition of sepsis and escalation of patients where required. The audits have shown improvements and sustained treatment.<br><br>Post sepsis follow up clinics are in place to encourage sepsis survivors who develop recurrent signs of sepsis in the community, to seek early and appropriate healthcare intervention. The clinics also support sepsis survivors to undertake infection prevention measures, such as, vaccinations, to avoid recurrent sepsis. |

The following table outlines the progress made to date against the key objectives for the quality priority:

| Objective | Progress |
|---|---|
| **Ongoing:**<br><br>Improved compliance with administering antibiotics within appropriate timescales for patients with sepsis | The Emergency Department Sepsis Quality Improvement Project saw the implementation of a part time sepsis nurse, escalation nurses and a High Acuity Bay (HAB). A significant improvement was seen in response to these actions; however, the improvements were not sustained after an increase in demand within ED meant the HAB had to be repurposed.<br><br>The Acute Assessment Unit are undertaking a quality improvement project to improve stat IV antibiotic times. The below SPC chart demonstrates improvements had been made between February 24 and March 24:<br><br>The data continues to be monitored to understand where changes have been made, if this has resulted in continued and sustained improvement or whether further changes need to be made.<br><br>A number of additional wards and specialities are undertaking locally led improvement projects to support with timely administration of antibiotics. These locally led projects explore the barriers that are specific to those areas and work with staff to identify what change ideas can be implemented that will support with continued improvement. |
| **Ongoing:**<br><br>Increase compliance rates for the utilisation of the electronic 'Infection and Sepsis Screening and Management Pathway' through to completion, within 2 hours of admission with particular attention to encouraging doctors/ACPs to use the tool in initial assessment of patients with NEWS2 score 5+ (or 3 in one parameter)/ sepsis red flag/ signs or symptoms of infection | Progress is being made with the electronic sepsis pathway with further work underway to improve access to electronic data with both the electronic paediatric sepsis pathway and the revised electronic sepsis pathway due to launch in May 2024.<br><br>Currently, we are unable to monitor compliance with the use of the electronic sepsis pathway, however, it is anticipated that following the release of the new electronic sepsis pathways, we will be able to monitor compliance moving forward.<br><br>**NB:** There have been significant changes to NICE Guidance and further review and revision will be required in line with the new guidance. |
| **Ongoing:**<br><br>Support Junior Doctors to undertake smaller improvement projects in | The following list details some of the sepsis related Quality Improvement Projects lead by junior doctors with support from the Sepsis Specialist Nursing team:<br><br>• Escalation of the deteriorating patient on the Acute Medical Unit (AMU);<br>• Mid-stream urine samples; |

| Objective | Progress |
| --- | --- |
| relation to sepsis management and treatment at a local level | • Reducing IV STAT antibiotic administration times on AMU;<br>• Improving compliance with blood culture sampling and processing;<br>• Improving the search for source of sepsis at Hull Royal Infirmary Emergency Department (ED);<br>• Sepsis - Escalation and assessment of patients with NEWS 5+ (or 3 in 1 parameter) on C7 (Infectious Diseases ward);<br>• Sepsis: Improving IV antibiotic administration times in Oncology and Haematology wards;<br>• Sepsis recognition in the ED;<br>• Reducing STAT IV antibiotics administration time in the Emergency Department; and<br>• Improving the hospital experience for patients diagnosed with Sepsis. |
| **Ongoing:**<br>Review previous improvement projects relating to sepsis to understand what worked well and adopt/rollout successes to other areas within the Trust | The Sepsis Specialist Nursing team provide support for sepsis related quality improvement projects throughout the organisation.<br>Previous improvement projects are continually reviewed to understand what has worked and what could be adopted elsewhere as well as learning from projects that have not been successful to identify what could be done differently. |
| **Ongoing:**<br>Improve the outcome of patients with Sepsis. | Further improvements required with timely patient monitoring of vital signs to support appropriate management and timely escalation of patients.<br>Continued communication, training, and resources (electronic sepsis pathway) to ensure accurate recognition of sepsis.<br>Further improvements required for timely antibiotics. There has been good compliance with prescribing antibiotics following the release of Micro-Guide and reaching almost 80% compliance rates with prescribing the correct antibiotics for the source of infection.<br>Identifying the source of infection at an early stage increases chances of survival and potential reduce the chances of patients of infection related readmission within 30 days.<br>Currently developing a leaflet for patients previously admitted with sepsis or discharged with infection are provided with adequate safety netting advice to encourage patients to seek medical help at an appropriate time as opposed to presenting to hospitals in the later stages of sepsis. Patients will receive the leaflet automatically via text on discharge. |

### Going forward

Going forward, Sepsis has been agreed as a quality priority as part of the 24/25 Quality Accounts. Please see section 3.1 for further information.

From 1 May 2024 the Associate Chief Medical Officer for Quality and Safety will be dedicating time to drive further improvements in relation to sepsis and the deteriorating patient.

# Safer Care: Medication Errors

**Why was this important**

Medicines optimisation describes a patient-focused approach to getting the best from the investment in and use of medicines. This is holistically achieved from an enhanced level of patient centred care and partnerships between clinical professionals, relatives and carers and patients. Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time.

**What did we aim to achieve?**

The aims from the quality priority focused on patients and their experiences, helping patients to:

- Improve their health outcomes;
- Improve medicines safety;
- Take medication correctly;
- Avoid taking unnecessary medication; and
- Reduce the wastage of medicines.

**Objectives of the project**

The objectives of the project included:

- The Trust will continue to include audits/improvement work on the safe and secure handling of medicines, including controlled drugs and omitted doses and undertake quality improvement projects as appropriate.
- Significant medication incidents will continue to be reported using DATIX and escalated as appropriate.
- Medicines reconciliation will be monitored.
- Medication cost reduction schemes will be risk assessed for service quality.
- The Drug Policy will be reviewed by a Multidisciplinary Team to ensure its fitness for purpose lead by the Trust Medication Safety Officer.
- The Medication Safety Officer role will continue to support patient safety improvement in the Trust and support national work on medication safety.
- The Trust will work with others to ensure medication safety across the interface into other health care sectors is optimised.
- The Trust has e-prescribing for chemotherapy and in some areas for in-patients and discharge medication, the programme was rolled out to the adult wards within Hull Royal Infirmary in 2022. The successful roll out of the programme will be key to improving patient safety.
- The Department of Pharmacy will work with the 'Scan4Safety' project and support work where it links with the safe use of medicines.
- The Trust will plan and work towards compliance with national initiatives including Dictionary of Medicines and Devices (DMandD).
- The implementation of the New Medicines Service will be rolled out across the trust in line with the 2022/23 CQUIN, which will improve discharge communication with community pharmacies and reduce readmission rates.

### Benefits of the project

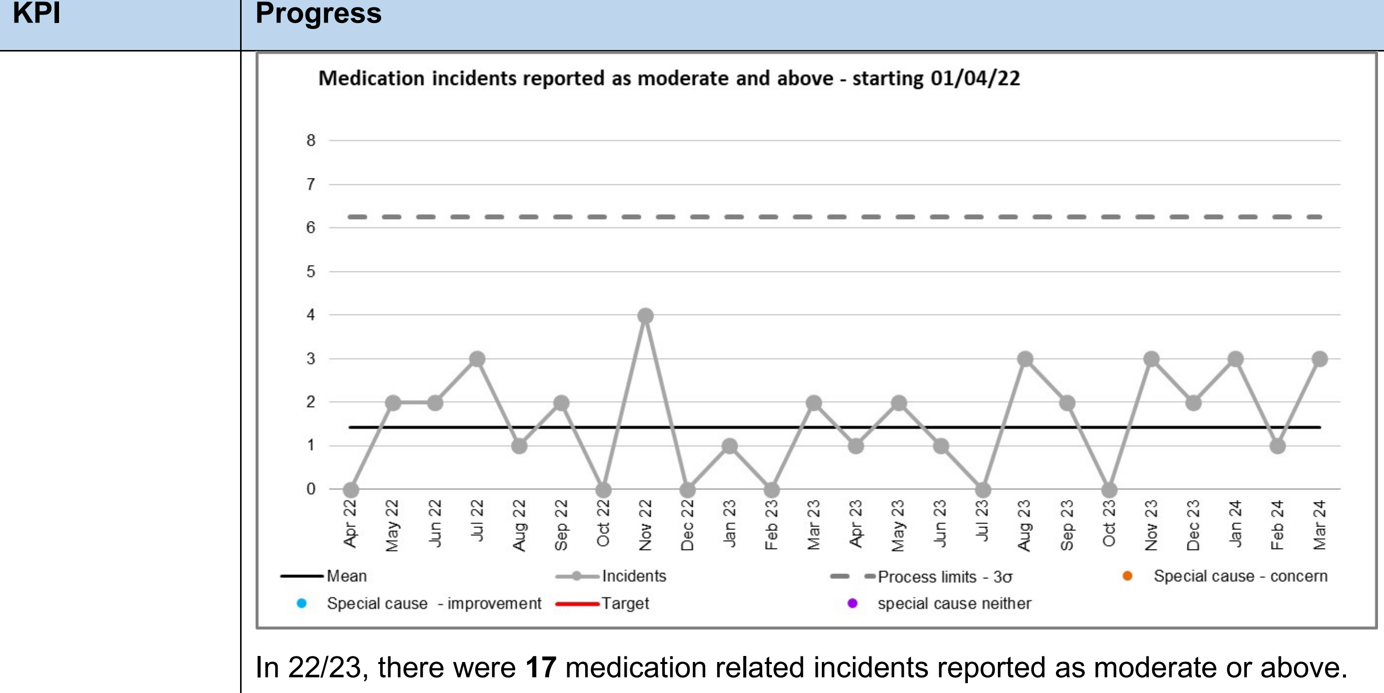
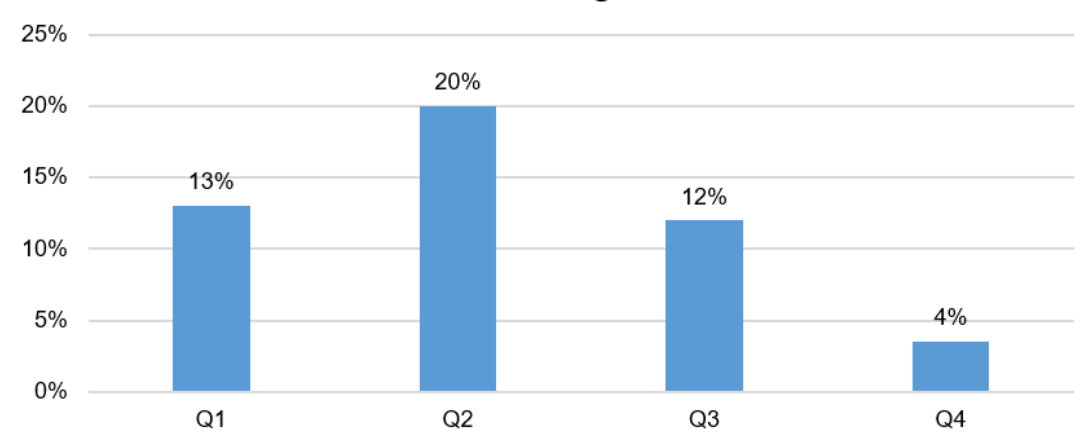
The identified benefits from implementation of the project included:

- **Patient Experience:** Patients and carers will be involved in decisions made about their medicines and supported to take their medicines as intended. We know that a better patient experience results in better clinical outcomes.
- **Quality Experience:** Maximised patient safety and experience around medication issues.
- **Staff Benefits:** The Trust will ensure workforce planning, development and education and training support to deliver optimal use of medicines. Services will be delivered by competent and well trained staff.
- **Organisational Benefits:** The Trust will support getting the best value out of medicines and Pharmacy.

**How did we perform?**

A number of Key Performance Indicators (KPIs) were used to measure progress against the quality priority for learning from medication errors and the following table outlines the progress made throughout 23/24:

| KPI | Progress |
| --- | --- |
| **Achieved:**<br>Stop medication related never events within HUTH | During 22/23, **1** medication related never event had been reported. There has been a **100%** reduction in the number of medication related never events reported so far in 23/24 (**0**).<br>The previous 2022/23 event involved an error in administering strong potassium. Much work has been undertaken following the investigation, including redesign and rollout of new theatre controlled drugs registers, and revision of the second checker process within theatres for injectable medicines.<br>**NB:** The National Patient Safety Team have launched a public consultation on the future of the Never Events Framework. The Care Quality Commission (CQC) and Health Services Safety Investigations Body (HSSIB), as well as a series of focus groups with relevant experts, has highlighted that for several types and sub types of Never Events, the protective barriers are not strong enough and called for the Never Event framework to be reviewed. |
| **Not achieved:**<br>Reduction in significant and major harm medication related incidents on DATIX | The following SPC chart demonstrates the number of medication related incidents reported as moderate or above over time: |

| KPI | Progress |
| --- | --- |
| | <br><br>In 22/23, there were **17** medication related incidents reported as moderate or above. There has been an increase of **24%** (**21**) medication related incidents reported as moderate above during 23/24. Whilst this reflects an increase during 2023/24, this has coincided with efforts to increase reporting to ensure all incidents are captured and where necessary taken action to learn from them. |
| **Achieved:**<br>Improvement in medication related CQUIN – Discharge medicines service (DMS) and IV to Oral switch for antibiotics | CQUIN 03 centres on the prompt switching of intravenous (IV) antimicrobial treatment to the oral route as soon as patients meet the switch criteria. The CQUIN target is to achieve **40%** (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.<br>The following graph demonstrates the progress for 2023/24:<br><br><br>The Trust has met the standards of this CQUIN for all four quarters in 23/24. |
| **Achieved:**<br><br>Embed QI programmes for | A medicines quality improvement group is held on a monthly basis chaired by the Chief Pharmacist for the Trust to support and embed quality improvement for medicines optimisation. The following illustrates a number of projects that have taken place and/or ongoing to embed QI for medicines optimisation: |

| KPI | Progress |
|---|---|
| medicines optimisation | • Medical Gas/Oxygen task and finish group;<br>• Reducing duplication/waste in medication;<br>• Improving flow within the dispensaries;<br>• Dialysate fluid work with procurement to reduce waste and improve storage safety;<br>• Scan for ID project to improve identification of patients;<br>• Neonatal workstream – reduction in interruptions to improve patient safety<br>• Nicotine advice referral service improvements;<br>• IV to oral switch of paracetamol during shortages;<br>• Electronic keys for controlled drugs (and others) – looking to roll out across the Trust pending funding;<br>• Druggles – spreading out to maternity;<br>• CQC improvement in theatres and Emergency Department (ED) and recording of controlled drugs and updates to the controlled drug registers;<br>• Implementation of Electronic Prescribing and Medicines Administration (EPMA);<br>• IV pumps and drug libraries work. Antimicrobial resistance task and finish group;<br>• Cotrimoxazole hard stop on ePMA;<br>• Task and finish group set up to action Hyperkalaemia/Calcium gluconate NPSA along with review of Trust Electrolyte/Hyperkalaemia Guidelines and supporting order set setup on EPMA; and<br>• Insulin task and finish group commenced in February 2024. |

The following table outlines the progress made to date against the key objectives for the quality priority:

| Objective | Progress |
|---|---|
| **Ongoing:**<br>Continue including audits/improvement work on the safe and secure handling of medicines, including controlled drugs and omitted doses | • As demonstrated, the embedding of QI programmes in relation to medicines optimisation showcases the continued work from Pharmacy and services within the Trust to continually learn and improve on the safe and secure handling of medicines including controlled drugs and omitted doses.<br>• Trust Controlled Drug Accountable Officer (CDAO - the Chief Pharmacist) chairs the Trusts CDAO monthly meeting to ensure oversite and audit of Controlled Drugs usage. Chief Pharmacists attend the Controlled Drug Local Intelligence Network (CDLIN) on a quarterly basis.<br>• Pharmacy involvement with the implementation of PSIRF and development of safety actions in relation to medicines. |
| **Ongoing:**<br>Significant medication incidents will continue to be reported using DATIX and escalated as appropriate | • Insulin working group commenced Feb 24 to review learning from insulin medication related incidents and determine areas for improvement.<br>• Trust Medical Safety Office (MSO) attend the monthly national MSO webinar, to share learning from incidents and updates. |

| Objective | Progress |
| --- | --- |
| | • Trust MSO attends the Yorkshire regional MSO webinar 2-3 monthly, to share learning from incidents and updates. |
| **Ongoing:**<br>Medication cost reduction schemes will be risk assessed for service quality. | A number of improvement projects are ongoing to support reduction in costs for medicines optimisation. Details of the some of the improvement programmes include but not limited to:<br>• Reducing duplication/waste in medication;<br>• IV to oral switch of paracetamol during shortages;<br>• Improving flow within the dispensaries;<br>• Reducing waste resulting from inappropriate fridge storage;<br>• Dialysate fluid work with procurement to reduce waste and improve storage safety – approx. **£3,500** has been saved to date;<br>• Biosimilar switches of medicines – approx. **£100,000** has been saved to date and forecasted saving of **£250,000** for 24/25; and<br>• Fragmin to enoxaparin switch has saved approx. **£300,000** per annum.<br>**NB:** Inflation and medicine supply issues/shortages continues to impact costs of medication, work is ongoing to identify areas for further cost improvement, ensuring patient safety is maintained at all times. |
| **Achieved:**<br>The Drug Policy will be reviewed by a Multidisciplinary Team to ensure its fitness for purpose lead by the Trust MSO | Following a review by the MSO and appropriate governance committees, the drugs policy has been updated and approved. |
| **Ongoing:**<br>The MSO role will continue to support patient safety improvement in the Trust and support national work on medication safety | • In the 2023 year, **121** Medicines Supply Notifications (MSNs) were received. Pharmacy managed these medicines shortages in conjunction with clinical multidisciplinary teams.<br>• MHRA "Drug Alerts" were successfully managed by Pharmacy. In the 2022 year, **52** drug alerts were received and actioned appropriately, in addition to **4** NPSAs that related to medicines supplies. In 2023, **44** MHRA Drug alerts and **1** NPSA related to medicines supplies were received and successfully managed.<br>• Exploring use of electronic medication cupboards<br>• Valproate and pregnancy safety work – implementation of the national patient safety alert and new regulatory measures:<br>  ○ CAS-ViewAlert (mhra.gov.uk)<br>  ○ Valproate safety measures - GOV.UK (www.gov.uk) |
| **Ongoing:**<br>The Trust will work with others to ensure medication safety across | • Trust MSO attends the monthly national MSO webinar, to share learning from errors and updates.<br>• Trust MSO attends the Yorkshire regional MSO webinar 2-3 monthly, to share learning from errors and updates. |

| Objective | Progress |
|---|---|
| the interface into other health care sectors is optimised | |
| **Completed:**<br>The Trust has e-prescribing for chemotherapy and in some areas for in-patients and discharge medication, the successful roll out of this programme will be key to improving patient safety | EPMA for Chemotherapy is operational on the ARIA system. |
| **Working towards:**<br>The Department of Pharmacy will work with the 'Scan4Safety' project and support work where it links with the safe use of medicines. | Pharmacy Leadership Team have met with the Scan 4 Safety team to scope out requirements. |
| **Completed:**<br>The Trust will plan and work towards compliance with national initiatives including Dictionary of Medicines and Devices | EPMA and ASCRIBE pharmacy computer systems are fully compliant with the exception of specials and unlicensed items. |
| **Achieved:**<br>Implementation of the New Medicines Service will be rolled out across the trust to improve discharge communication with community pharmacies and reduce readmission rates | The CQUIN has been achieved and systems are in place. |

### Going forward

Going forward, medication safety has been agreed as a quality priority as part of the 24/25 Quality Accounts. Please see section 3.1 for further information.

# Focused: Improved care for patients with Mental Health needs in the Emergency Department

**Why was this important**

Studies have shown that poor mental health can significantly affect physical heath, increasing the amount of intervention that is required.

Whilst our Trust is not a specialist mental health provider, it is vital that we have a clear and robust mental health strategy in place to ensure that patients with existing and new mental health needs have those needs met whilst in our care.

**What did we aim to achieve?**

The aims from the quality priority centred on the following:

- Continued implementation of the triage process for patients attending ED to make they have a mental health triage with a Nurse on arrival and appropriate risk assessments undertaken;
- Provide safe therapeutic environments for mental health, learning disabilities and patients with autism which conform to national standards within ED;
- Work with external partners making sure people experiencing a mental health crisis are able to access meaningful alternatives to ED; and
- Develop a patient survey to collect feedback and inform further work required.

**Objectives of the project**

The objectives of the project included:

- Reduction of waiting times using the ED Flowchart for patients with no physical health concerns presenting with mental health illness;
- Increased partnership working with local services to improve provision of Mental Health Support ensuring patients are attending the Emergency Department for the right level of support; and
- Staff in the Emergency Department are supported through training to provide safe therapeutic environments for patients with mental health needs.

**Benefits of the project**

The identified benefits from implementation of the project included:

- **Patient Experience:** Patient receive the level of support from the Emergency Department required when experiencing a mental health crisis.
- **Quality Experience:** Timely interventions and treatments provided.
- **Staff Benefits:** Staff will have improved understanding of therapeutic training and de-escalation techniques and improved knowledge of mental health illness. Reduction in violence and aggression.
- **Organisational Benefits:** Reputational benefits, improved pathways for patients, reduction in patient and staff incidents of violence and aggression.  Improved collaborative working with external partners

**How did we perform?**

A number of Key Performance Indicators (KPIs) were outlined to measure progress against the quality priorities. The following table outlines progress to date:

| KPI | Progress |
|---|---|
| **Working Towards:**<br>Monitor complete and accurate completion of assessments | Evidence of appropriate physical health assessment, relevant investigation and treatment carried out by the ED clinician appropriate to patient presentation in 81.6% |
| **Ongoing:**<br>Proportion of patients who had a complete mental health triage with risk assessment within 15 and within 30 minutes of arrival | Prior to January 2023, there was no documented evidence that mental health triage was taking place. Compliance has since improved following the rollout of the risk assessment tool with compliance consistently above the average.<br>**% of patients with a completed mental health triage - starting 01/01/23**<br>100.0% 90.0% 80.0% 70.0% 60.0% 50.0% 40.0% 30.0% 20.0% 10.0% 0.0%<br>Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24<br>Mean; Incidents; Process limits - 3σ; Special cause - concern; Special cause - improvement; Target; special cause neither<br>Further improvements are required to support patients receiving a mental health triage risk assessment within 15 or even 30 minutes of arrival. |
| **Working Towards:**<br>Performance of a parallel mental health and ED assessment | There was evidence of parallel assessment in 64.2% |
| **Working Towards:**<br>Proportion of medium or high-risk patients having an appropriate level of observation | This was hard to evidence due to a lack of documentation but there was evidence of compliance in only 36%<br>The Trust undertake monthly assurance visits within external partners and document the departments mental health patients on each visit and ensure that they are in the correct environment and observations. |

| KPI | Progress |
| --- | --- |
| | |
| **Working Towards:**<br>Proportion of patients who had a risk assessment by an ED clinician of risk of suicide and further self-harm | 64% of patients had a risk assessment; this reflects the frequency with which the risk assessment is documented. It is possible that improved documentation will adequately reflect actual practice. |
| **Ongoing:**<br>Evidence of compassionate and practical care. Service user satisfaction from experience | Evidence of appropriate physical health assessment, relevant investigation and treatment carried out by the ED clinician appropriate to patient presentation in 81.6%<br>There are a mixture of responses from surveys and from patient feedback. Compassionate care and praise for staff has been highlighted but there is room for improvement when providing privacy during triage. Unknown wait times are also mentioned as a problem as is the poor selection of food. |

The following table outlines the progress made to date against the key objectives for the quality priority:

| Objective | Progress |
| --- | --- |
| **Ongoing:**<br>Continue implementing the triage process for patients attending ED to make they have a mental health triage with a Nurse on arrival and appropriate risk assessments undertaken | The ED have digitalised all assessments and therefore are now able to track all completed and outstanding assessments for patients including mental health and is monitored on a live dashboard, which is overseen by the matrons. |
| **Completed:**<br>Provide safe therapeutic environments for mental health, learning disabilities and patients with autism which conform to national standards within ED | There have been allocated spaces within in ED that have modified to conform to national standards within ED. These include specific rooms in both ECA and majors. An additional space has also been designed and staff with mental health staff within the ED.<br>Feedback from the CQC in April 2024 was positive on the Trust's work to provide safe mental health rooms within ED. |
| **Ongoing:**<br>Work with external partners making sure people experiencing a mental | The ED team meet frequently with Humber Foundation NHS Teaching Trust to discuss provision within ED and locally for mental health patients to promote community crisis services. |

| Objective | Progress |
|---|---|
| health crisis are able to access meaningful alternatives to ED | |
| **Working Towards:**<br>Develop a patient survey to collect feedback and inform further work required. | This has been developed and feedback is being collected. |

**Going forward**

A number of areas have been identified to further improve mental health triage in ED including:

- There is now provision of spare clothing for those who have wet or muddy clothing or those who have had clothing cut off.
- De-escalation Management & Intervention (DMI) Training has been delivered to the first few cohorts of ED staff and dates are booked throughout 2024.
- Training has been delivered to the multi-disciplinary ED team on unmet needs in high-impact service users.
- Cubicle 5 in Majors has been repurposed to be a safe environment for those presenting with mental health emergencies.
- There is now a bespoke area on site designed for the assessment and treatment of those with mental health emergencies. Appropriate patients can now be streamed to this area, which is run by Humber Teaching NHS Foundation Trust.

# Effective and Learning: Learning from Deaths

**Why was this important**

For many people, death under the care of the NHS is an expected outcome and a majority of patients experience excellent care from the NHS in the months or years leading up to their death. However, some patients experience poor quality provision of care from a range of contributory factors, including but not limited to poor leadership and system-wide failures.

Staff in the Trust work determinedly under ever-increasing pressures to deliver safe and high-quality patient centred care. When mistakes happen, as an organisation, we have a duty of care to understand where problems in care may have contributed to a patient's death, to learn lessons in order to prevent recurrence as well as identifying, sharing and celebrating good practices.

**What did we aim to achieve?**

The aims from the quality priority centred on the following:

- Reviews and investigations shared for continued learning and improvement of patient care;
- Collaborative reviews undertaken;
- Effective and cohesive collaboration with the Trusts Medical Examiner's Office; and
- Further development of Structured Judgment Reviews to respond to the Trust clinical needs.

**Objectives of the project**

The objectives of the project included:

- Deaths that are of concern are appropriately escalated and reviewed in line with Trust policy;
- Learning is identified, shared and implemented appropriately;
- Seek opportunities to work a broad range of stakeholders;
- Improve and amend the Structured Judgement Review tool to allow for a greater depth of review and learning;
- To improve and develop feedback mechanisms across the Trust; and
- Undertake an internal quality control audit.

**Benefits of the project**

The identified benefits from implementation of the project included:

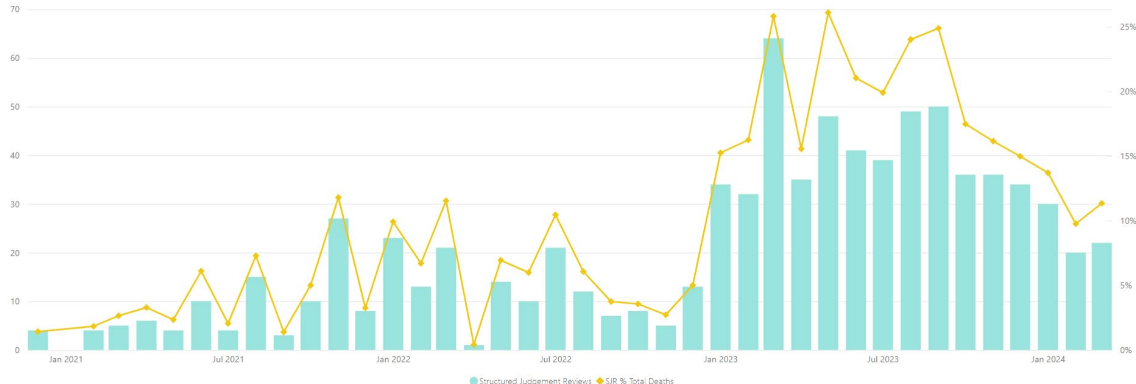
- **Patient Experience:** Learning from deaths supports continued improvement for patient experience
- **Quality Experience:** Learning from deaths supports continued improvement for services
- **Staff Benefits:** Provision of high quality care and improved education from learning from deaths
- **Organisational Benefits:** Support the patient safety strategy.

**How did we perform?**

A number of Key Performance Indicators (KPIs) were outlined to measure progress against the quality priorities.

The following table outlines progress to date:

| KPI | Progress |
| --- | --- |
| **Not achieved:** Achieve below the national average of 100 against the Trust Hospital Standardised Mortality Ratio (HSMR) | The run chart shown above demonstrates the HSMR data.<br>The latest data available (up to January 2024) for the rolling average is currently 116.08.<br>Further work is required to meet the national average of 100 for HSMR.<br>As part of the 24/25 Quality Priorities, focus will be on the deteriorating patient and sepsis – this will support with driving improvements patient outcomes and reduce the current average against SHMI to below the national average. |
| **Not achieved** Maintain the national average and aim to achieve below the national average of 1.0 against the Trust SHMI | The Summary Hospital-level Mortality Indicator (SHMI) provides data on mortality rates within individual healthcare trusts across the NHS in England. It calculates the ratio of actual patient deaths following hospitalisation at a trust to the expected number of deaths based on average national figures and patient characteristics.<br>The run chart shown below, demonstrates the SHMI data:<br>The Trust had seen a reduction in its SHMI data from April 2021 through to May 2023. This was driven by reductions particularly in respect of sepsis and pneumonia diagnosis conditions, although with significant improvement still required through our sepsis improvement programmes.<br>Of the conditions for which a SHMI is calculated by NHS Digital, HUTH is identified as being higher than expected for the below conditions in the most recent published data (12 months to December 2023 published in May 2024):<br>• Septicaemia;<br>• Fracture of neck of femur (hip); and<br>• Secondary malignancies. |

| KPI | Progress |
|---|---|
| | Of the two sites forming HUTH, the SHMI for Hull Royal has continued to reduce during 2023/24. However, there is a notable and clear change in the calculated SHMI for Castle Hill Hospital, reflective of both an increase in the actual number of deaths and a decrease in the number of expected deaths. This is driving the change for HUTH overall. There hasn't been a noticeable increase in the volume of activity (spells) included in the SHMI data for CHH in recent SHMI reporting periods.<br><br>There are several drivers that may have caused this change which are subject to in depth investigation, including:<br>• Consolidation of oncology/haematology services at CHH. This means that more patients from a much wider geographical area are being referred to CHH to utilise the Queen's Centre specialisms.<br>• Patients with cancer requiring emergency assessment now admitted at CHH rather than HRI. In addition we have made some changes to the coding of patients which has had an impact in comparison to previous data.<br>• Alterations made to the arrangements for treatment of cardiac patients.<br><br>As part of the 24/25 Quality Priorities, focus will be on the deteriorating patient and sepsis – this will support with driving improvements patient outcomes and reduce the current average against SHMI to below the national average.<br><br>The Trust has a quality improvement programme to reduce falls which was initiated in 2023 and will continue into 24/25. The number of inpatient falls resulting in fracture of neck of femur has reduced by 50% since the focused improvement work was initiated. |
| **Achieved:**<br><br>Achieve 15% completion rate of Structured Judgement Reviews | Over the course of 23/24, we have been able to achieve **15%** or above completion rate for SJR as demonstrated by the below graph:<br><br>There has been positive engagement with SJRs, which is an essential tool for assessing care given, identifying gaps in care and areas of good practice that can be shared across the organisation.<br><br>A working group was established in response to concerns raised regarding fluid balancing, which were prompted by findings from several SJRs. A series of actions were identified, including the implementation of digital platforms for monitoring fluid balance and providing support and training for fluid balance management.<br><br>Regular SJRs for patients who died with a Learning Disability, have enabled the Trust to identify potential gaps in care relating to best interest meetings and proper documentation of learning disabilities within case-notes. |

| KPI | Progress |
| --- | --- |
| **Working towards:**<br>Standardise the outcomes to the central team from the Mortality and Morbidity meetings held | A digital online platform (AMaT – Audit Management and Tracking) was funded in October 2023 supporting a number of functions across the Trust including clinical audit, NICE guidance and quality improvement.<br><br>The platform also has a mortality and morbidity module. This module will support clinical teams to record and review the care and treatment of patients in relation to mortality and morbidity. Furthermore, staff will be able to:<br>• Undertake speciality and multi-disciplinary reviews;<br>• Create presentations and monitor peer review;<br>• Record meetings and discussions;<br>• Have an instant overview of quality of care scores and progress;<br>• Link to risks and record learning points;<br>• Create and monitor actions for learning and improvement; and<br>• Record complex morbidity cases for learning.<br><br>Discussions are underway to integrate Lorenzo PAS with AMaT to support with data accuracy and increase clinical interaction with the system to standardise meetings held and share learning. |

The following table outlines the progress made to date against the key objectives for the quality priority:

| Objective | Progress |
| --- | --- |
| **Ongoing:**<br>Deaths that are of concern are appropriately escalated and reviewed in line with Trust policy | Significant improvement made with reviewing deaths and any death highlighted as a cause for concern, are then escalated accordingly.<br>Further work is required to triangulate information and provide assurances that actions are undertaken where appropriate. This will be supported by the ongoing work to standardise the outcomes from mortality and morbidity reviews. |
| **Ongoing:**<br>Learning is identified, shared and implemented appropriately | Further work is required to triangulate information and provide assurances that actions are undertaken where appropriate. This will be supported by the ongoing work to standardise the outcomes from mortality and morbidity reviews. |
| **Ongoing:**<br>Seek opportunities to work a broad range of stakeholders | Collaborative working with Yorkshire Ambulance Service to review learning from mortality, morbidity and highlighted cases by either party, these meetings take place on a monthly basis and with the ICB also in attendance, next steps are to include GP practices as part of the wider learning process and a broader depth of understanding where improvements maybe required. |
| **Ongoing:**<br>Improve and amend the Structured Judgement Review tool to allow for a greater depth of review and learning | There has been a shift towards identifying cases where a death was more likely than not due to problems in care, rather than using the terminology of avoidable or unavoidable death. The |

| Objective | Progress |
| --- | --- |
| | changes have been made to support staff to learn and improve rather than apportioning blame.<br><br>Bespoke review forms are also developed to support learning at speciality level – this enables meaningful actions to be implemented to ensure continuous improvement. |
| **Working towards:**<br><br>To improve and develop feedback mechanisms across the Trusts | Further work is required to triangulate information and provide assurances that actions are undertaken where appropriate. This will be supported by the ongoing work to standardise the outcomes from mortality and morbidity reviews. |
| **Ongoing:**<br><br>Undertake an internal quality control audit | Quarterly audits are undertaken with ten SJRs reviewed to provide assurances that the SJRs are investigated in line with Trust policy. Any concerns or issues highlighted are escalated accordingly. |

**Going forward**

A number of areas have been identified to further improve learning from deaths including:

- The development of the digital solution for encompassing SJRs and mortality and morbidity reviews whilst standardising the process across the organisation.
- Terms of reference for speciality mortality and morbidity meetings to outline the expectations of mortality and morbidity reviews meetings taking place – this will further support with standardisation across the organisation.
- Support services with higher than expected SHMI to identify areas for improvement.
- Formation of a central team of clinicians to support with reviews where potential concerns have been identified to maximise learning opportunities and provide robust escalation.

Learning from deaths will continue with collaborative working North Lincolnshire and Goole Hospitals NHS Trust.

# 2.2 Performance against other Quality and Safety Indicators

This section covers:


- 2.2.1 Patient Safety Incidents
- 2.2.2 Serious Incidents and Never Events
- 2.2.3 Patient Safety Alert compliance
- 2.2.4 NHS staff survey results and Cultural Transformation
- 2.2.5 Whistleblowing
- 2.2.6 Freedom to Speak Up
- 2.2.7 Duty of Candour

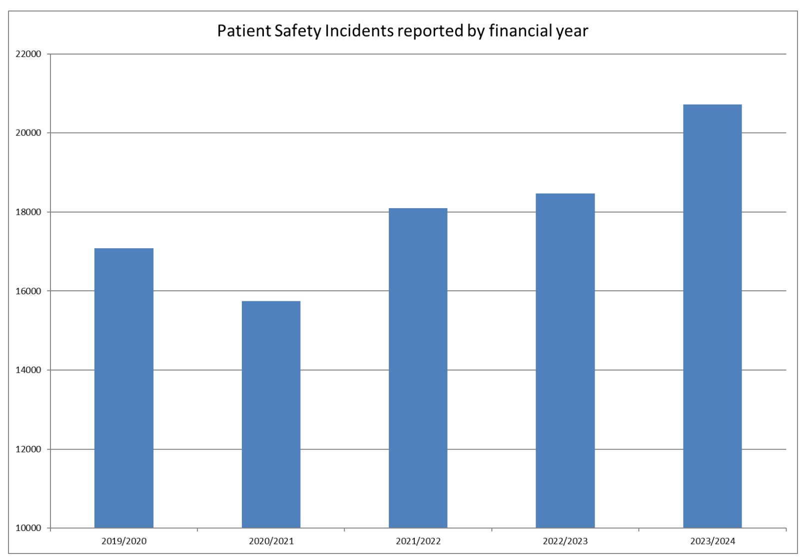
# 2.2.1 Patient Safety Incidents

## What is a patient safety incident

Patient safety incidents are any unintended or unexpected incident, which could have, or did, lead to harm for one or more patients receiving healthcare. The Trust encourages incident reporting and believes that a strong incident reporting culture (i.e. a high level of incident reporting), is a sign of a good patient safety culture and provides an opportunity to learn, prevent reoccurrence and improve patient safety.

## Patient Safety Incidents reported by the Trust

The total number of patient safety incident reported from 1 April 2023 to 31 March 2024 (20,722) is displayed in the graph below with comparison against previous year's data:



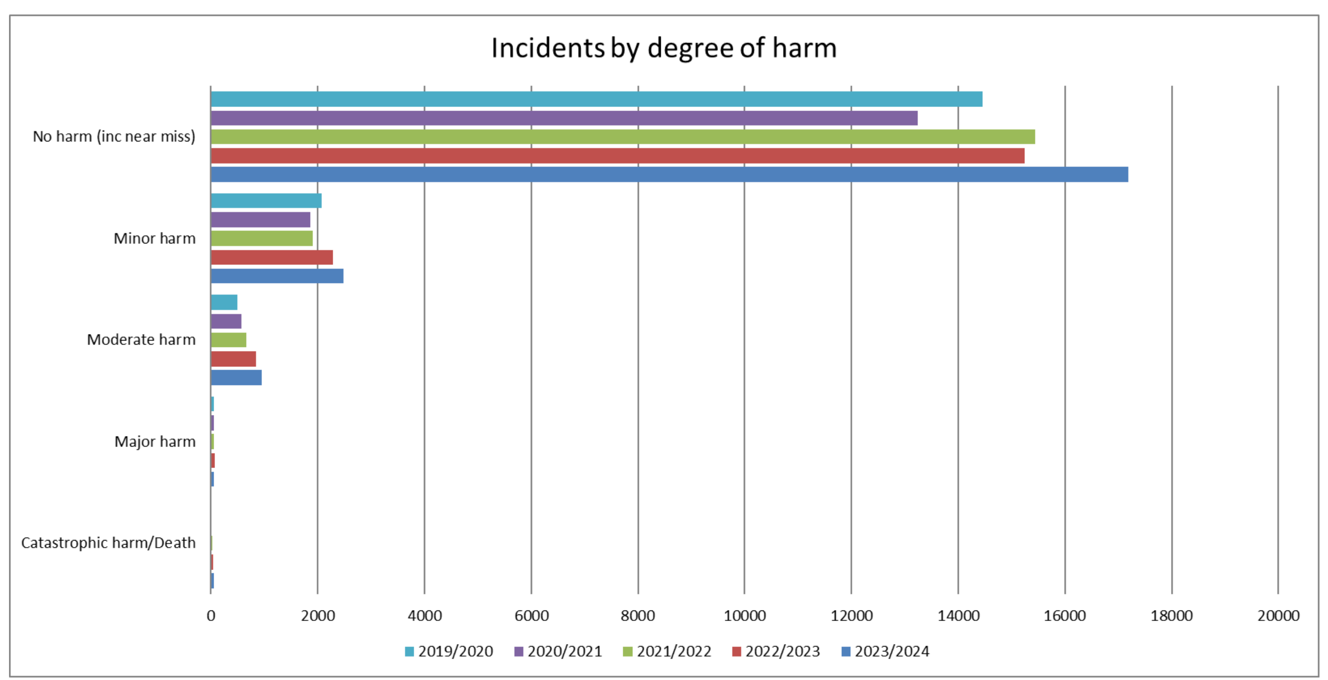

The patient safety incidents when reviewed against bed occupancy for 2023/24 is shown in the table below

| Number of incidents reported | Bed occupancy | Incidents per 1,000 bed days | Incidents reporting an Injury/harm | Incidents reporting a Near Miss | Incidents reporting No Injury/harm |
|---|---|---|---|---|---|
| 20,722 | 435,492 | 47.58 | 3,533 | 2,129 | 15,060 |
| | | As a percentage | 17% | 10% | 73% |
| | | 2022/23 comparison | 18% | 9% | 73% |

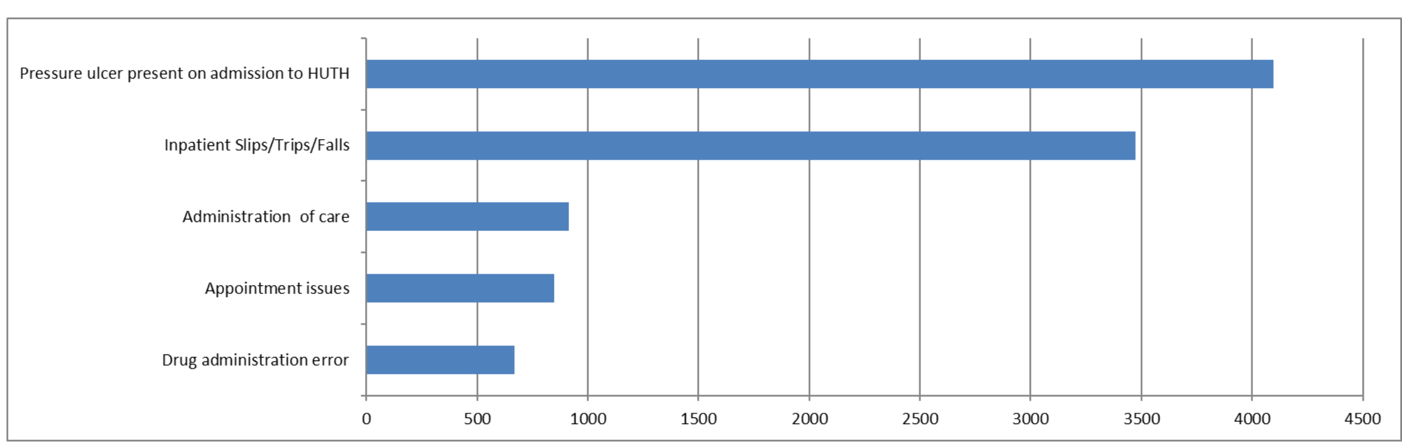
The Trust encourages incident reporting, and recognises that a good incident reporting rate is a sign of a healthy patient safety culture and provides insight into patient safety. Despite the increase in patient safety incidents being reported, 83% were events which resulted in 'no harm' or a 'near miss'. The observed high reporting of 'no harm' incidents is recognised as a positive safety culture and demonstrates 'high volume, low harm' reporting culture.

The Trust monitors its levels of harm within the former Health Groups and the Quality Governance and Assurance Directorate, and levels of harm may be adjusted, either increased or decreased, according to information known about the event upon investigation.

The graph below shows the Trust's incidents by degree of harm during 2023/24 with comparison against previous years:




The graph below demonstrates the top 5 reported incident themes during 2023/24:




These top 5 are consistent with those reported in 2022/23. However, for 4 of the 5 categories, the number has reduced following targeted improvement work. However, the number of pressure ulcer incidents has increased in 2023/24 as we have targeted improved reporting in this space.

In August 2022, the National Patient Safety Team (NHSE/I) published the Patient Safety Incident Response Framework (PSIRF), which outlined how Trusts move towards a proactive approach to learning from patient safety incidents. The focus of PSIRF is on learning and improvement, with fewer full investigations being the exception as opposed to the rule, to focus on quality rather than quantity of patient safety investigations and utilising different models of investigation.

During quarters 3 and 4 of 2022/23, a PSIRF steering group undertook preparatory work in response to the PSIRF and developed a Patient Safety Incident Response Plan (PSIRP), which sets out how the Trust intends to respond to patient safety incidents in line with the new framework from April 2023. The PSIRP outlines different investigation and learning response methods to National Priorities requiring mandatory responses (e.g. Never Events) and local responses to patient safety incidents.

# 2.2.2 Serious Incidents and Never Events

In April 2023, the Trust became an early adopter and started the transition to responding to patient safety incidents in line with the National Patient Safety Incident Response Framework (PSIRF), which was published in August 2022. The PSIRF outlines how Trusts move towards a proactive approach to learning from patient safety incidents. The focus of PSIRF is on learning and improvement, with fewer full investigations being the exception as opposed to the rule, to focus on quality rather than quantity of patient safety investigations and utilising different models of investigation.

In response to the PSIRF the trust developed a Patient Safety Incident Response Plan (PSIRP), which sets out how the Trust responds to patient safety incidents. The PSIRP outlines different investigation and learning response methods to National Priorities requiring mandatory responses (e.g. Never Events) and local responses to patient safety incidents. Never Events are patient safety incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

The Trust presented to the regional Yorkshire and Humber Collaborative PSIRF Learning Community to share the process that was undertaken whilst developing the Trust safety profile, the themes that emerged and how this informed the Trust PSIRP. They shared assurances that were provided to the Board, plans for proactively seeking assurance and reflections on the journey to date.

Feedback from the Learning Community was very positive and it led to more interest with other Trusts asking for further information about our journey; the Trust held an 'open event' to help other providers which was well received.

Patient safety incidents that meet the national priorities including Never Events and '*deaths clinically assessed as more likely than not due to problems in care'* are investigated as a Patient Safety Incident Investigation (PSII). PSIIs apply a system-based approach to learning to understand how work systems and human factors can influence processes which in turn shapes outcomes resulting in patient safety incidents.

PSII Learning Response Leads ensure that the four key aims of the PSIRF are integrated into the PSII and are reflected within the report:

- compassionate engagement and involvement of those affected by patient safety incidents;
- application of a range of system-based approaches to learning from patient safety incidents;
- considered and proportionate responses to patient safety incidents and safety issues; and
- supportive oversight focused on strengthening response system functioning and improvement.

As well as PSIIs the Trust utilises other methods of learning responses such as After Action Reviews (AARs), Walkthrough Analysis (table tops) and Thematic reviews. The learning responses from these investigation methods are shared throughout the Trust through the governance structures and are publicised on the Trust intranet

### Never Events, SIs and PSIIs investigated by the Trust:

Whilst the Trust began the transition to the PSIRF in 2023/24 there were still 29 investigations still open for investigation that had been declared in line with the Serious Incident Framework (SIF, 2015). These investigations continued and were completed during the transition to PSIRF.

The Trust investigated one Never Events in 2023/24; a decrease on the number investigated in 2022/23 (7).

The Never Event was in relation to a 'Wrong Site Surgery' involving the administration of a root nerve block. The Never Event was investigated by means of a simulation exercise to recreate the procedure to identify system errors.

An improvement action plan was initiated in response to this event which continues to be delivered into 2024/25.

During 2023/24, in addition to the 29 investigations under the Serious Incident Framework, there were 16 investigations identified to be investigated as PSIIs.

| Learning response method | 2022/23 | 2023/24 |
|---|---|---|
| Never Event investigations completed | 7 | 1 |
| Serious Incidents (SI) investigations completed (framework applicable to April 2023) | 123 | 29 |
| Patient Safety Incident Investigations (PSII) completed (framework applicable from April 2023) | N/A | 16 |
| After Action Reviews/Walkthrough Analysis facilitated (framework applicable from April 2023) | N/A | 40 |
| Thematic Reviews (framework applicable from April 2023) | N/A | 4 |

During 2023/24, each patient safety incident that has resulted in harm to the patient has been discussed at the Weekly Patient Safety Summit (WPSS). This enabled early identification of immediate actions and learning from the incidents to be discussed at a Trust wide level and for agreement on the type of learning response required to ensure that proportionate investigations were undertaken.

The Patient Safety Team facilitated the majority of the different learning responses (AARs) however a training programme has also been delivered across the Trust to nursing staff providing them with the skills required to facilitate AARs at ward and specialty level.

The Trust continues to be open and honest when a patient safety incident has occurred, to ensure that they are fully investigated, with appropriate actions taken as a result. The Trust is committed to providing the best care to our patients and our responses patient safety incidents focuses on the learning and actions arising from the investigations to improve the patient safety culture within the organisation.

Patients and their representatives are invited to ask questions to the investigation panel and to agree the terms of reference of the investigation to ensure that a full holistic picture of the consequences of the incident are considered during the investigation, not just how the incident has impacted on the Trust.

A Learning from Patient Safety Incidents Oversight Group meets on a weekly basis to oversee the completion of investigations and learning responses providing additional scrutiny and assurance that key factors identified are addressed by the actions. The Oversight Group is also responsible for reviewing themes and trends arising from investigations and aligning them to quality improvement projects that are being undertaken within the Trust.

# 2.2.3 Patient Safety Alerts Compliance

**What is meant by Patient Safety Alerts**

Patient safety alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients. These alerts are issued by NHS Improvement through the Central Alerting System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages, and useful safety information to the NHS and other healthcare organisations.

Patient safety alerts are developed with input, advice, and guidance from the National Patient Safety Response Advisory Panel, which assembles frontline healthcare staff, patients and their families, safety experts, royal colleges, and other professional and national bodies. The panel discusses and advises on approaches to respond to patient safety issues through the publication of alerts which are identified through the clinical review of incidents reported to the NRLS and Strategic Executive Information System by NHS Trust and other health care providers and also from concerns raised by members of the public. Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider program of work. Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety.

Coordination of patient safety alerts is carried out by the Patient Safety Team who work with various Trust departments and Health Groups to facilitate compliance and monitor ongoing work or action plans used to address the issues raised

**Compliance for Patient Safety Alerts**

The patient safety team continues to undertake improvement work with a focus on enhancing compliance with and adherence to deadlines for National Patient Safety alerts.
A robust monitoring process has been put in place for all alerts received by the organization to ensure proactive identification and resolution of patient safety issues.

This approach has demonstrated additional learning and improvements from National Patient Safety Alerts, as well as preemptive actions taken for identified issues in advance of receiving a National Patient Safety Alert. To facilitate wider sharing of these alerts across the Trust, the patient safety team produces a monthly National Patient Safety Newsletter. Efforts are ongoing to promote the embedding of learning from National Patient Safety alerts across the Trust, in keeping with the Trust Quality Strategy 2022-2025 of Safe Care.

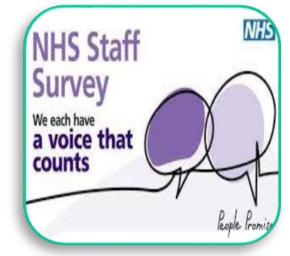
The table below demonstrates the alerts received from April 2023 to March 2024 and the Trust response:

| Reference | Title of Alert | Date Issued | Due Date | Completed Date | Trust Response |
|---|---|---|---|---|---|
| NatPSA/2023/004/ MHRA | Recall of Emerade auto injectors due to the potential for device failure | 09-May-23 | 12-May-23 | 12-May-23 | Action Completed |

| Reference | Title of Alert | Date Issued | Due Date | Completed Date | Trust Response |
|---|---|---|---|---|---|
| NatPSA/2023/005/ MHRA | Removal of Philips Health Systems V60 and V60 Plus ventilators from service - potential unexpected s ... | 18-May-23 | 02-Oct-23 | 03-Oct-23 | Action Completed |
| NatPSA/2023/006/ DHSC | Shortage of pyridostigmine 60mg tablets | 24-May-23 | 26-May-23 | 26-May-23 | Action Completed |
| NatPSA/2023/007/ MHRA | Potential risk of underdosing with calcium gluconate in severe hyperkalaemia | 27-Jun-23 | 01-Dec-23 | 23-Nov-23 | Action Completed |
| NatPSA/2023/008/ DHSC | Shortage of GLP-1 receptor agonists | 18-Jul-23 | 18-Oct-23 | 03-Oct-23 | Action Completed |
| NatPSA/2023/009/ OHID | Potent synthetic opioids implicated in heroin overdoses and deaths | 26-Jul-23 | 04-Aug-23 | 31-Jul-23 | Action Completed |
| NatPSA/2023/010/ MHRA | Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from ... | 31-Aug-23 | 01-Mar-24 | Ongoing | Ongoing – task and finish group in place to address actions working with system partners; the Trust bed stock is not compliant and alternatives are being sought |
| NatPSA/2023/011/ DHSC | Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and g ... | 27-Sep-23 | 11-Oct-23 | Not Applicable | Assessed - not relevant to organisations services |
| NatPSA/2023/012/ DHSC | Shortage of verteporfin 15mg powder for solution for injection | 28-Sep-23 | 20-Oct-23 | 19-Oct-23 | Action Completed |
| NatPSA/2023/013/ MHRA | Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new ... | 28-Nov-23 | Response Not Required | Response Not Required | Response Not Required |
| NatPSA/2023/015/ UKHSA | Potential contamination of some carbomer-containing lubricating eye products with Burkholderia cenoc ... | 07-Dec-23 | 17-Dec-23 | Not Applicable | Assessed - not relevant to organisations services |
| NatPSA/2023/014/ NHSPS | Identified safety risks with the Euroking maternity information system | 07-Dec-23 | 07-Jun-24 | Ongoing | Ongoing – actions being addressed by Trust Clinical Safety Officers |

| Reference | Title of Alert | Date Issued | Due Date | Completed Date | Trust Response |
|---|---|---|---|---|---|
| | | | | | and Digital Midwives |
| NatPSA/2023/016/ DHSC | Potential for inappropriate dosing of insulin when switching insulin degludec (Tresiba) products | 08-Dec-23 | 22-Dec-23 | 14-Dec-23 | Action Completed |
| NatPSA/2024/001/ DHSC | Shortage of GLP-1 receptor agonists (GLP-1 RA) update | 03-Jan-24 | 28-Mar-24 | 07-Mar-24 | Action Completed |
| NatPSA/2024/002/ NHSPS | Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks | 31-Jan-24 | 31-Jan-25 | Ongoing | Ongoing – a task and finish group has been set up to address the actions |
| NatPSA/2024/003/ DHSC | Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials | 26-Feb-24 | 08-Mar-24 | 04-Apr-24 | Action Completed |

# 2.2.4 NHS Staff Survey Results




**What is the NHS Staff Survey**

The NHS Staff Survey is one of the largest workforce surveys and has been conducted every year since 2003. All staff working in the NHS are invited to take part in the NHS Staff Survey. The survey offers a snapshot in time of how people experience their working lives and information is gathered at the same time each year. The survey captures a national picture alongside local detail, enabling organisations to understand what it is like for staff across different parts of the NHS and to support further improvements.

**Results of the 2023 Staff Survey for HUTH**

**Background**

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

The National Staff Survey ran between September and December 2023. Picker is commissioned by 62 Acute and Acute Community Trusts organisations to run their National Staff survey, including HUTH.

HUTH increased its **completion rate** from **37% to 50%** (4,620 staff responded compared to 3,160 last year).

The Picker report uses “positive score” as its primary unit of measurement. This allows organisations to compare results historically, and to other similar organisations on a question-by-question basis, for all questions that can be positively scored. HUTH has significantly improved on its overall positive score.

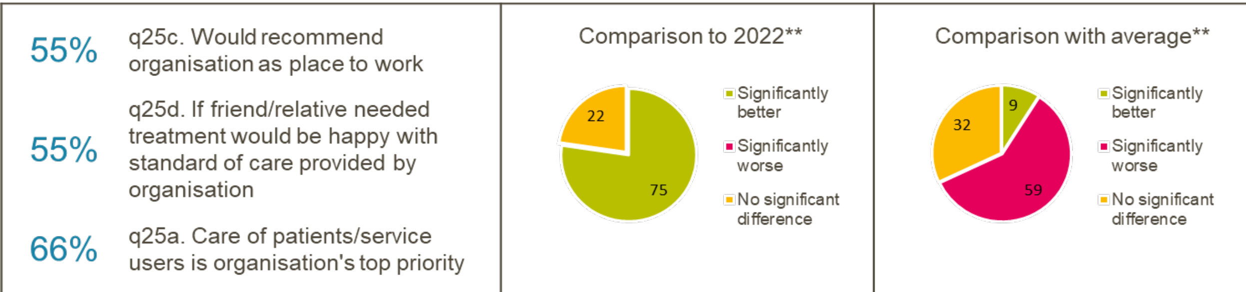
HUTH was the second most improved Picker Trust in 2023, moving from 59th/65 of the Picker league table for overall positive score to 48th/62 against the Picker average.

The National Staff Survey measures organisations against key themes, seven of which are based on the national People Promise indicators. Each indicator is a score out of 10.

HUTH has improved on all elements of the People Promise.

| | 2022 | **2023** | Change |
|---|---|---|---|
| People Promise element 1: We are compassionate and inclusive | 7.0 | **7.2** | +0.2 |
| People Promise element 2: We are recognised and rewarded | 5.5 | **5.9** | +0.4 |
| People Promise element 3: We each have a voice that counts | 6.4 | **6.5** | +0.1 |
| People Promise element 4: We are safe and healthy | 5.7 | **6.0** | +0.3 |
| People Promise element 5: We are always learning | 5.2 | **5.7** | +0.5 |
| People Promise element 6: We work flexibly | 5.6 | **6.0** | +0.4 |
| People Promise element 7: We are a team | 6.3 | **6.6** | +0.3 |
| Theme: Staff Engagement | 6.4 | **6.7** | +0.3 |
| Theme: Morale | 5.5 | **5.9** | +0.4 |

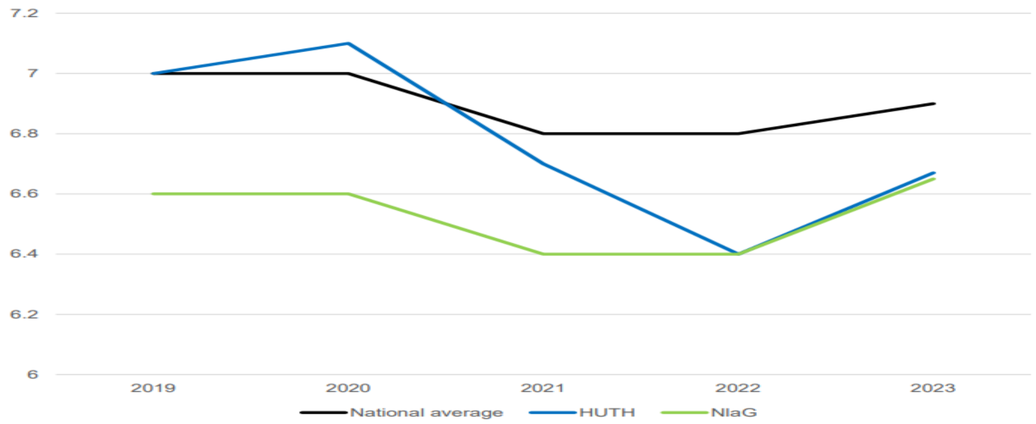
The table below shows comparison scores for HUTH in 2023.




**Staff Engagement**

One of the key measures in the National Staff Survey is that of staff engagement, which is seen as a strong indicator of cultural health in an organisation. HUTH has seen a significant improvement in staff engagement in the 2023 survey.

A chart showing staff engagement trend data for the past five years is below. HUTH shifted from a score of 6.4 in 2022 to a score of 6.7 in 2023. Whilst this remains below the national average, the Trust is seeking through its improvement journey to return to ahead of national average as it was prior to the pandemic.




Top five scores in the National Staff Survey vs Picker average:

| HUTH top 5 scores vs Picker average | HUTH | Picker Avg |
|---|---|---|
| q15. Organisation acts fairly: career progression | 60% | 57% |
| q24e. Able to access the right learning and development opportunities when I need to | 63% | 61% |
| q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work | 76% | 74% |
| q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours | 50% | 48% |
| q23a. Received appraisal in the past 12 months | 84% | 83% |

Bottom five scores in the National Staff Survey vs Picker average:

| HUTH bottom 5 scores vs Picker average | HUTH | Picker Avg |
|---|---|---|
| q25a. Care of patients/service users is organisation's top priority | 66% | 74% |
| q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation | 55% | 63% |
| q6b. Organisation is committed to helping balance work and home life | 42% | 49% |
| q25b. Organisation acts on concerns raised by patients/service users | 62% | 69% |
| q7b. Team members often meet to discuss the team's effectiveness | 55% | 61% |

Most improved scores:

| HUTH most improved scores | HUTH 2023 | HUTH 2022 |
|---|---|---|
| q3h. Have adequate materials, supplies and equipment to do my work | 59% | 51% |
| q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours | 50% | 42% |
| q23a. Received appraisal in the past 12 months | 84% | 77% |
| q8a. Teams within the organisation work well together to achieve objectives | 49% | 41% |
| q23b. Appraisal helped me improve how I do my job | 27% | 19% |

Most declined scores:

| HUTH most declined scores | HUTH 2023 | HUTH 2022 |
|---|---|---|
| q24a. Organisation offers me challenging work | 71% | 72% |
| q13d. Last experience of physical violence reported | 66% | 67% |

| | | |
|---|---|---|
| q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public | 93% | 93% |
| q7i. Feel a strong personal attachment to my team | 62% | 62% |

# 2.2.5 Whistleblowing

Whistleblowing In line with the NHS Constitution and Trust values, the Trust is committed to achieving the highest possible standards of quality, honesty, openness and accountability in all of our practices. An important aspect of accountability and openness is a mechanism to enable employees, workers and volunteers to voice their concerns in a responsible and effective manner and for them to feel valued for doing so.

Whistleblowing occurs 'when a worker raises a concern about dangerous or illegal activity that they are aware of through their work' (Public Concern at Work). A 'protected disclosure' is one where a worker must have a reasonable belief and in good faith believes that their disclosure is in the public interest.

Confidentiality is a fundamental term of every contract of employment, however, where an individual discovers information which they believe shows serious malpractice or wrongdoing within the Trust, this information should be disclosed without fear of reprisal.

To qualify for the protection (a 'qualified disclosure') afforded by The Public Interest Disclosure Act 1998, staff must have a reasonable belief that one or more of the following matters is either happening, has taken place or is likely to happen in the future:

- A criminal offence
- The breach of a legal obligation
- A miscarriage of justice
- A danger to the health and safety of any individual
- Damage to the environment
- Deliberate attempt to conceal any of the above

In addition to the legal framework, in 2010 the NHS Staff Council agreed that 'Employees in the NHS have a contractual right and duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risk they consider to be in the public interest'.

This change has been incorporated into the Terms and Conditions of Service Handbook for staff employees. The Francis Report 'Freedom to Speak Up – A review of whistleblowing in the NHS' published in February 2015, clearly indicated that NHS staff did not feel safe raising their concerns about patient care that was being delivered.

A key theme of the report was the requirement for openness, transparency and candour about matters of concern; the need for a 'just culture' as opposed to a 'no blame culture'. Sir Francis also recommended the introduction of a 'Freedom to Speak Up Guardian' post as an additional person staff can raise concerns with and at HUTH, Fran Moverley currently fulfils this role.

The Trust's 'How to Raise Concerns' (Whistleblowing) policy sets out that concerns may be raised via internal reporting processes, for example:

- DATIX (Incident Reporting tool)
- Line Manager
- Lead Clinician
- Matron
- Staff Side Representative
- Human Resources

- Occupational Health
- Chaplains
- Freedom to Speak Up Guardian
- Safeguarding Team

Concerns may also be raised to the next level of management; for example:

- A member of a Health Group Triumvirate
- A Deputy/Assistant Director
- A Divisional General Manager/Divisional Nurse/Clinical Director
- Heads of Service
- A Chief/Director
- The Chief Executive
- A Non-Executive Director (NED) – the Senior Independent Director in particular has a role to support staff who need to blow the whistle
- Freedom to Speak Up Guardian

If the member of staff feels unable to report at any of these levels for any reason, or feels their concerns have not been addressed adequately at an earlier level, they may choose to report their concerns externally. Concerns may be raised with an external regulatory body (which includes prescribed bodies or persons).

The Trust would urge staff to allow the Trust the opportunity to investigate and resolve the concerns prior to reporting externally if at all possible. If the investigation finds the allegation is unsubstantiated and all internal procedures have been exhausted, but the member of staff is not satisfied with the outcome, the Trust recognises the lawful rights of employees to make disclosures to prescribed persons.

In order to maintain the protection afforded by the Act, disclosure other than to the Trust must be made to prescribed bodies or persons and the Trust encourages staff to notify the Chief Executive of their intention to disclose their concerns externally. The Trust also encourages staff considering this course of action to seek advice from the Trust's Freedom to Speak up Guardian.

# 2.2.6 Freedom to Speak Up

All organisations that provide services under the NHS Standard Contract are required to appoint a Freedom to Speak Up Guardian (FTSUG).

The National Guardian's Office (NGO) train FTSUGs across the healthcare sector and raise the profile of speaking up at a national level. Both the FTSUG role and the NGO were created as a result of the recommendations in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).

FTSUGs provide dedicated confidential support to permanent and temporary staff, trainees, students and volunteers to encourage speaking up about workplace concerns and/or ideas for improvement. It can be difficult to know how to speak up and the FTSUG also plays a key role in signposting staff to the appropriate staff support services available at the Trust. The FTSUG role acts impartially and provides an option to raise concerns in a confidential manner.

Freedom to speak up supports the NHS People Promise which states:

"*We all feel safe and confident when expressing our views. If something concerns us, we speak up, knowing we will be listened to and supported. Our teams are safe spaces where we can work through issues that are worrying us. If we find a better way of doing something, we share it.*

*We use our voices to shape our roles, workplace, the NHS, and our communities, to improve the health and care of the nation. We take the time to really listen – beyond the words – to understand the hopes and fears that lie beneath them. We help one another through challenges, during times of change, and to make the most of new opportunities".*

The FTSUG role at HUTH is undertaken by the Head of Freedom to Speak Up, Frances Moverley. The role is supported by both an Executive Sponsor and a Non-Executive Director sponsor.

The FTSUG attends and reports directly to the formerly the Trust Board and from January 2024, the newly formed Group Trusts Boards-in-Common (held in public), the Workforce, Education and Culture Committees in Common and the Audit, Risk and Governance Committees in Common. This includes presenting a high level summary of the types of concerns being raised through this role, any learning and the proactive activities undertaken by the FTSUG to promote and raise awareness of speaking up.

The FTSUG has continued to focus on strengthening partnership working across the Trust, with staff support services and the Staff Network leadership teams. The Speak Up Champion Network continues to expand and at present, has 26 trained Speak Up Champions based across the Trust to support their colleagues and encourage speaking up.

As a result of continued engagement and promotion during 2023/24, the Trust has successfully increased the number of referrals to 201, a 101% increase from the 2022/2023 reporting year, which makes the Trust an above average reporter when compared nationally.

During 2023/2024 work continues on the actions within the improvement and strengths plan produced by the Board completing NHS England Self-reflection and Planning tool. In addition the Trust has in adopted the Freedom to Speak Up in the NHS national policy, as required by NHS England, and sets out how the Trust supports staff members to speak up about workplace concerns.

# 2.2.7 Duty of Candour

## What is Duty of Candour

The Care Quality Commission (CQC) introduced the Duty of Candour regulation in November 2015. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. Requirements include informing people about the incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

## How is the Trust Implementing Duty of Candour?

The Duty of Candour requires the provision of an apology, both verbal and written and feedback to the person affected, detailing the findings of the investigation and what actions are to be taken to avoid future occurrences of a similar nature. This requirement is detailed within the Trust's Being Open when Patients Are Harmed Policy (Duty of Candour) for staff to follow, which states that the ten principles of Being Open must be applied to any incident, complaint or claim occurring as a result of healthcare treatment within the Trust resulting in harm to the patient. This policy is also supported by the Datix incident investigation training which is available for all staff to complete.

Duty of Candour is monitored within the Trust's Quality Governance Department that ensures that responses to patients and their representatives, is sent in a timely manner, and to check the quality and content of letters, to ensure that information sent to patient and their representatives is open and honest. Compliance is monitored and reported to the Health Groups Governance meetings and Quality Committee for assurance and action.

## What is the Trust's compliance with Duty of Candour?

The CQC assessed the Trust most recently in March 2020 against the Duty of Candour requirements. The CQC found that staff were aware of their responsibilities under the Duty of Candour requirements and that the Trust is compliant with CQC Regulation 20: Duty of Candour.

The Trust expects that a verbal apology is given within 10 days of the incident occurring, that a written apology is also given within 10 days of the incident occurring, and that a written explanation of the incident is sent within 10 days of the completion of the incident investigation.

## Duty of Candour compliance

Each element of the duty of candour compliance is monitored for verbal and written apologies followed by written feedback provided following completion of investigations.

It is recognised that further assurances are necessary to ensure compliance rates meet 100% for incidents that have met the threshold where the application of Duty of Candour is required. A recent review of the systems and processes in place for Duty of Candour identified elements requiring improvements to address issues that affect the timescales in providing a written apology. This work will continue into 2024/25.

## 2.3 Statements of Assurance from the Board

This section covers:


- 2.3.1 Review of services
- 2.3.2 Participation in clinical audits
- 2.3.3 Participation in clinical research
- 2.3.4 Goals agreed with our commissioners/CQUIN
- 2.3.5 What others say about the Trust: CQC
- 2.3.6 Secondary Uses Service
- 2.3.7 Information Governance Toolkit
- 2.3.8 Payment by Results Clinical Coding Audit
- 2.3.9 Learning from Deaths Update
- 2.3.10 Reporting against core indicators - NHS Digital

# 2.3.1 Review of services

During 2023/24 the Hull University Teaching Hospitals NHS Trust provided and /or subcontracted a range of services within 7 service categories within the standard contract. The Trust has reviewed all the data available to them on the quality of care in the provision of these NHS services. The income generated by the NHS services reviewed in 2023/24 represents 100% of the total income generated from the provision of NHS services by the Hull University Teaching Hospitals NHS Trust for 2023/24.

# 2.3.2 Clinical audits

**What is a clinical audit?**

A clinical audit is a way to find out if healthcare is being provided in line with standards. This informs care providers and patients where services are doing well and where improvements could be made. The aim is to allow quality improvement to take place where it will be most effective and improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits can also be performed locally where healthcare is provided.

**Participation**

During 2023/24, 54 national clinical audits and 3 national confidential enquiries covered NHS services that Hull University Teaching Hospitals NHS provides.

During that period Hull University Teaching Hospitals NHS Trust participated in 94% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Hull University Teaching Hospitals NHS Trust was eligible to, and participated in during 2023/24 are listed below.

The national clinical audits and national confidential enquiries that Hull University Teaching Hospitals NHS Trust participated in, and for which data collection was completed during 2023/24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry is listed in the last column.

| Audit: | Participated | % of Cases Submitted |
|---|---|---|
| National Neonatal Audit Programme (NNAP) | ✓ | 100% |
| National Maternity and Perinatal Audit (NMPA) | ✓ | 100% |
| National Perinatal Mortality Review Tool (PMRT) | ✓ | 100% |
| National Paediatric Diabetes Audit (NPDA) | ✓ | 100% |
| National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) | ✓ | 100% |
| National Child Mortality Database | ✓ | 100% |
| Paediatric Intensive Care Audit (PICANet) | ✓ | 100% |
| Care of Older People (RCEM) | ✓ | 100% |
| Mental Health Self Harm (RCEM) | ✓ | 100% |
| National Emergency Laparotomy Audit (NELA) | ✓ | Ongoing |
| Society for Acute Medicine's Benchmarking Audit (SAMBA) | ✓ | 100% |
| Adult Critical Care (Case Mix Programme – ICNARC) | ✓ | 100% |
| National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)<br>a. Adult Asthma Secondary Care<br>b. Chronic Obstructive Pulmonary Disease Secondary Care<br>c. Paediatric Asthma Secondary Care | ✓<br>✓<br>✓ | Ongoing |
| National Audit of Care at the End of Life (NACEL) | ✓ | Ongoing |
| Audit of Blood Transfusion Against NICE Quality Standard 138 | ✓ | 100% |

| Audit: | Participated | % of Cases Submitted |
|---|---|---|
| Bedside Transfusion Audit | X | N/A |
| Serious Hazards of Transfusion UK National Haemovigilance Scheme | ✓ | 100% |
| Perioperative Quality Improvement Programme | X | N/A |
| National Acute Kidney Injury Audit | ✓ | Ongoing |
| UK Renal Registry Chronic Kidney Disease Audit | ✓ | Ongoing |
| National Diabetes Core Audit | ✓ | 100% |
| National Diabetes in Pregnancy Audit | ✓ | 100% |
| National Diabetes Footcare Audit | ✓ | 75% |
| National Diabetes Inpatient Safety Audit | ✓ | 100% |
| Improving Quality in Crohn's and Colitis (IQICC) / IBD Registry | X | Non-participation due to the cost of the software. The Registry is closing on 31 March 2024 |
| National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis | ✓ | Ongoing |
| UK Cystic Fibrosis Registry | ✓ | Ongoing |
| National Ophthalmology Database Audit | ✓ | Ongoing |
| National Audit of Dementia | ✓ | 100% |
| Adult Respiratory Support Audit | ✓ | 100% |
| National Joint Registry (NJR) | ✓ | Ongoing |
| National Audit of Percutaneous Coronary Interventions (PCI) | ✓ | 97% |
| National Vascular Registry | ✓ | Ongoing |
| Adult Cardiac Surgery Audit (ACS) | ✓ | 100% |
| Breast and Cosmetic Implant Registry | ✓ | Ongoing |
| Elective Surgery (National PROMs Programme) | ✓ | Ongoing |
| National Bariatric Surgery Registry | ✓ | Ongoing |
| National Obesity Audit (NOA) | ✓ | 100% |
| Myocardial Ischaemia National Audit Project (MINAP) | ✓ | 100% |
| National Heart Failure Audit | ✓ | Ongoing |
| Cardiac Rhythm Management (CRM) | ✓ | 100% |
| National Audit of Mitral Valve Leaflet Repairs (MVLR) | ✓ | 100% |
| UK Transcatheter Aortic Valve Implantation (TAVI) | ✓ | 100% |
| National Cardiac Arrest Audit (NCCA) | ✓ | 100% |
| Lung Cancer (National Lung Cancer Audit) | ✓ | 100% |
| Bowel Cancer (National Bowel Cancer Audit Programme) | ✓ | 100% |
| National Gastro-Intestinal Cancer Audit Programme (GICAP) | ✓ | 100% |
| National Prostate Cancer Audit | ✓ | 100% |
| Major Trauma (Trauma and Audit Research Network) | ✓ | The University of Manchester (UoM) switched off the TARN platform and allied resources, such as the TARN website, in June 2023 because of the cyber breach. The Trust continued to collect data locally using the nationally established dataset. |

| Audit: | Participated | % of Cases Submitted |
|---|---|---|
| | | |
| Falls and Fragility Fractures Audit Programme (FFFAP)<br>a. National Audit of Inpatient Falls<br>b. National Hip Fracture Database | ✓<br>✓ | Ongoing |
| Acute Stroke (Sentinel Stroke National Audit Programme - SSNAP) | ✓ | Ongoing |
| **National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study** | | |
| Endometriosis | ✓ | 50% |
| End of Life Care | ✓ | 100% |
| Juvenile Idiopathic Arthritis | ✓ | Ongoing |

The Trust was a positive outlier for 3 audit programmes between 1 April 2023 and 31 March 2024 as detailed below:

- National Neonatal Audit Programme (NNAP) The Trust was identified as outstanding for the audit measure – Two Year Follow-up, which the Trust was measured at 95.2% compared with the national average of 74.4%
- National Neonatal Audit Programme (NNAP) The Trust was identified as outstanding for the audit measure – Temperature, which the Trust was measured at 93.5% compared with the national average of 76.3%
- National Audit of Seizures and Epilepsies in Children and Young People. The Trust was identified as outstanding for the audit measure – ESN input, which the Trust was measured at 100% compared with the national average of 77%

### Actions

The reports of 19 national clinical audits were reviewed by Hull University Teaching Hospitals NHS Trust in 2023/24 and Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

| Audit | Proposed Actions |
|---|---|
| **National Emergency Laparotomy Audit (NELA)** | • The lack of a Care of the Elderly Specialist post was added to the Risk Register last year and taken forward by the Health Group team.<br>• To undertake an audit looking at patient delays to theatre due to the reduction in pre-operative input by Consultant Surgeons at Hull Royal Infirmary.<br>• To undertake an audit on unplanned admissions to Critical Care at Castle Hill Hospital.<br>• To review the unplanned returns to theatre (General Surgeons). |
| **National Chronic Obstructive Pulmonary Disease Audit (COPD) (National Asthma & COPD Audit Programme)** | • Funding has been made available for a new smoking cessation team at the Trust. This should help to address the indicators relating to smoking for both adult asthma and COPD.<br>• Spirometry tests are undertaken in primary care and therefore not routinely done on admission. This also means that results are not always available. Work is still ongoing to look at accessing spirometry results in primary care. |
| **National Lung Cancer Audit** | • To implement a new specialist multi-disciplinary team meeting for Non-small Cell Lung Cancer IIIA and IIIB patients |
| **National Audit of Percutaneous Coronary Interventions (PCI)** | • To complete an audit on intravascular ultrasound imaging during PCIs.<br>• To increase the number of same day discharges for elective PCIs. |
| **Myocardial Ischaemia National Audit** | • To speak to Consultants and junior doctors to ensure all medications are |

| Audit | Proposed Actions |
|---|---|
| **Project (MINAP)** | documented on the Immediate Discharge Letter.<br>• To speak to Consultants and Junior Doctors to ensure all echocardiograms are documented on the Immediate Discharge Letter. |
| **National Neonatal Audit Programme (NNAP)** | • To complete a QIP regarding parental first consultation and parental attendance on consultant ward rounds.<br>• To complete a QIP regarding own mothers milk feeding in babies.<br>• To review the neonatal staffing charter.<br>• To complete an audit against Saving Babies Lives CBV3 Standards for Caffeine and Volume Guided Ventilation use in Premature Infants Admitted to Hull NICU during the CNST Monitoring Period. |
| **National Joint Registry (NJR)** | • To review the casenotes of patients receiving hip revisions, to determine if they were discussed at a multi-disciplinary team meeting, prior to the revision surgery |
| **National Hip Fracture Database** | • To introduce the 'golden patient' where an identified patient goes first on the theatre list<br>• To add information regarding 'no pressure ulcer' and 'no reoperation' to discharge letters<br>• To discuss general anaesthetic and nerve block with the ICU Consultants, to determine how to improve compliance |
| **National Paediatric Diabetes Audit** | • To continue using technology to improve care of children with diabetes.<br>• To improve additional 4+ HbA1c measurement check.<br>• To commence getting all albuminuria samples done in clinic<br>• To ensure that all annual reviews are done in the first half of the year. This will ensure all Did Not Attend (DNA) patients are still seen within the year. |
| **National Prostate Cancer Audit** | • No further action required. |
| **National Oesophago-Gastric Cancer Audit** | • To continue undertaking more laparoscopic surgery as this reduces length of stay by up to two days.<br>• To continue with efforts to recruit further pathologists to help address the issue of low lymph node examinations. |
| **National Vascular Registry** | • To continue to pursue the plans for a hybrid theatre<br>• To continue to pursue the creation of anaesthetic pre-assessment sessions |
| **National Audit of End of Life Care** | • To improve recognition of dying through education.<br>• To develop an electronic care plan for dying patients in Nerve Centre and to include sections regarding discussions about anticipatory medications and side –effects.<br>• To ensure end of life training is included in induction training and priority training for staff who will be caring for patients at the end of life.<br>• To promote advance care planning discussions and sharing of advance care plans via the Electronic Palliative Care Coordination System (EPaCCS)<br>• To establish links with the medical examiners service to ensure that if requested, carer and family feedback can be obtained for subsequent round of audit. |
| **National Audit of Dementia** | • To introduce a Pain Assessment Tool for use across the Trust.<br>• To present a business case at the Nutritional Steering group to introduce a finger food menu across the Trust.<br>• To liaise with the Digital Team to convert the Delirium Screening and Pain Assessment tools to digital forms.<br>• To liaise with the Digital Team to ensure Delirium Screening and Pain Assessments are made mandatory screening questions.<br>• A3 laminated posters regarding pain assessment and general management of pain, the Abbey Pain Assessment Tool (including QR |

| Audit | Proposed Actions |
|---|---|
| | codes for the SOP, the record chart and guide to opioid prescribing) to be distributed to every ward and department across the Trust to be prominently displayed on the ward.<br>• To create credit card sized laminated guides which can be carried in ID badges regarding pain assessment tools and the basic analgesic ladder. 300 have been produced so far, to be distributed to staff on the wards and at the Link Nurse meetings.<br>• To request that Pain Assessment is made mandatory on Nervecentre with routine clinical observations for all patients. The team are currently working with the digital team to ensure that pain is featured in the list of categories in the clinical handover and also in the Nursing assessments<br>• To work with ICU to ensure that appropriate assessment is conducted for all patients, including those ventilated or sedated, with the possibility of developing a QR code for the on-line Critical Care Observation (CPOT) tool.<br>• To post a blog on the intranet explaining pain assessment scales and the types of tools which are used in the Trust.<br>• To arrange a Pain Link Nurse meeting, where pain assessment and specific training on the Abbey Pain Assessment tool, will feature.<br>• To complete a snapshot survey of staff knowledge regarding pain assessment to collect baseline data. This will be repeated to evaluate improvements |
| **National Audit of Bowel Cancer** | • To undertake a QIP to look at the number of patients having laparoscopic surgery attempted.<br>• To undertake a QIP on patients who have not seen a nurse specialist to understand why. |
| **ICNARC Case Mix Programme** | • Unit acquired blood infections - data is coded (by interpreting written clinical notes) and input by non-clinical staff. To improve data quality, medical staff to review this information.<br>• To improve data quality for unit acquired blood infections The Trust has re-enrolled in a Heath Protection Agency project where microbiologists state the source of the infection.<br>• To undertake infection control awareness training, promoting standards in terms of handwashing, changing gloves etc |
| **NCEPOD Community Acquired Pneumonia** | • Gap analysis underway |
| **NCEPOD Crohn's Disease** | • Gap analysis underway |
| **NCEPOD Testicular Torsion** | • Gap analysis underway |

The reports of local clinical audits were reviewed by the provider in 2023/24. For a full list of the proposed actions Hull University Teaching Hospitals NHS Trust intends to take following local audits reviewed during 2023/24, please see the Clinical Audit Annual Report. This can be requested via the Quality Accounts email address.

# 2.3.3 Clinical research

Clinical research is an arm of medical science that establishes the safety and effectiveness of Medication, Diagnostics products, Medical devices and Treatment regimes' which may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.

## Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Hull University Teaching Hospitals NHS Trust (HUTH) in 2023/24 that were recruited during that period to participate in research approved by a research ethics committee or Health Research Authority was **4,833**.

## Clinical Research Network – National Institute Health Research portfolio

There were **4,776** participants recruited onto **193** National Institute Health Research (NIHR) portfolio adopted studies. Specifically, we would like to highlight the following:

- Participant recruitment for 2023-24 achieved the target set by our clinical research network (Yorkshire and Humber) representing notable value for money and impact on the local community.
- Our overall portfolio recruitment for 2023-24 ranked the Trust sixth in Yorkshire and Humber.
- The Trusts commercial activity is also ranked second highest in the network with 54 studies (recruiting 351 participants) showing a commitment to delivering for the Life Sciences Industry post-pandemic.
- Respiratory Diseases was the top recruiting specialty in the Trust's portfolio with the 'Hull Lung Health' cohort study and a broad range of interventional drug studies.
- Notable activity areas to highlight based on recruitment figures include; Endocrinology, Respiratory and ENT (ranked 1st across Yorkshire and Humber), Renal and Hepatology (ranked 2nd across Yorkshire and Humber), Diabetes, Haematology, Cardiovascular, Surgery, (ranked 3rd across Yorkshire and Humber), Gastroenterology, Cancer, Infection, Trauma and Emergencies (ranked 4th across Yorkshire and Humber).
- The Trust continues to deliver a broad research portfolio with **193** active and open portfolio studies, ranked third highest in the network.
- In the annual Participant in Research Experience Survey (PRES) 98% of our research participants feel that they are fully prepared for their research experience by our research staff and feel valued when taking part in our research.100% of our research participants feel they are always treated with courtesy and respect by staff and 96% would take part in further research trials.

2023-24 has again illustrated the significance of the step-wise increase in Trust-led research undertaken nationally, which is providing the catalyst for the Trust's planned expansion of research capability and capacity. We have seen another year of the tireless efforts of all staff (research and non-research) in ensuring all possible opportunities to participate have been made available for our patients, staff and carers.

## Commercial Research Activity

The following table illustrates the commercial research activity as of 25th April 2024:

**Recruitment by Trust FY2324 (data cut 26/04/2024)**

**Recruitment**

| Trust | Recruitment |
|---|---|
| NIHR CRN: Yorks | 14,214 |
| Leeds Teaching | 899 |
| Hull University | 351 |
| Sheffield Teach | 311 |
| Bradford Teachi | 274 |
| Mid Yorkshire T | 55 |
| Calderdale and | 34 |
| Barnsley Hospit | 29 |
| Sheffield Child | 20 |
| York and Scarbo | 17 |
| Doncaster and B | 15 |
| Rotherham Donca | 11 |
| Harrogate and D | 8 |
| The Rotherham N | 2 |
| Humber Teaching | 1 |

**Recruiting Studies**

| Trust | Recruiting Studies |
|---|---|
| Leeds Teaching | 101 |
| Hull University | 54 |
| Sheffield Teach | 52 |
| Bradford Teachi | 34 |
| NIHR CRN: Yorks | 16 |
| Sheffield Child | 13 |
| Calderdale and | 8 |
| York and Scarbo | 8 |
| Doncaster and B | 7 |
| Mid Yorkshire T | 7 |
| Harrogate and D | 2 |
| Barnsley Hospit | 2 |
| Humber Teaching | 1 |
| Rotherham Donca | 1 |
| The Rotherham N | 1 |

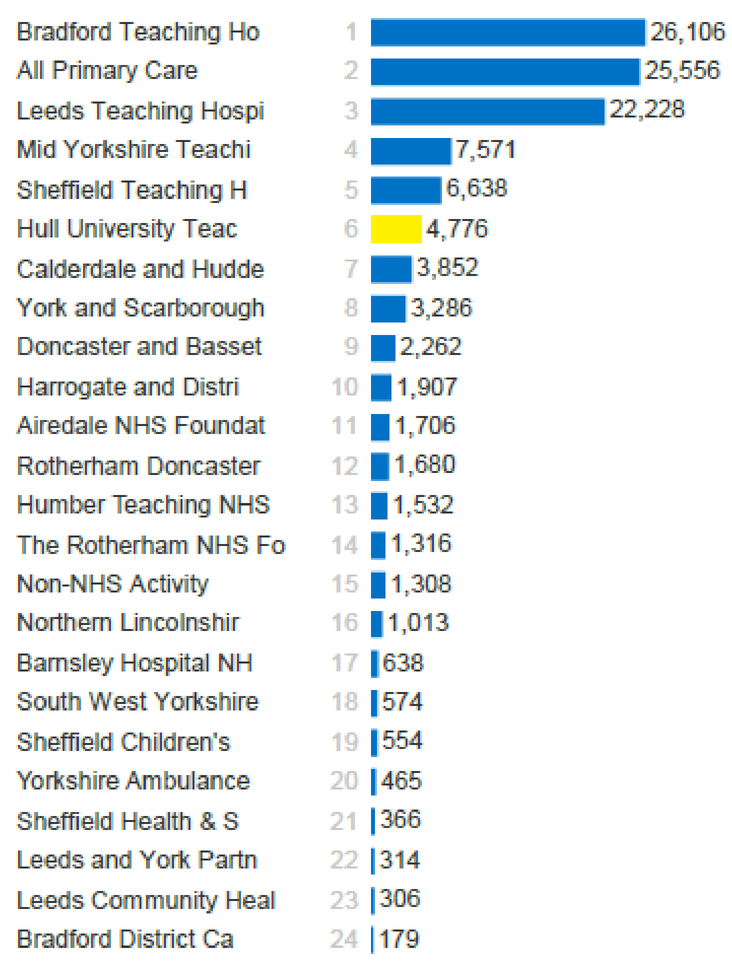
## Research Activity Performance Summary

The following tables detail the research activity performance as of 25th April 2024:

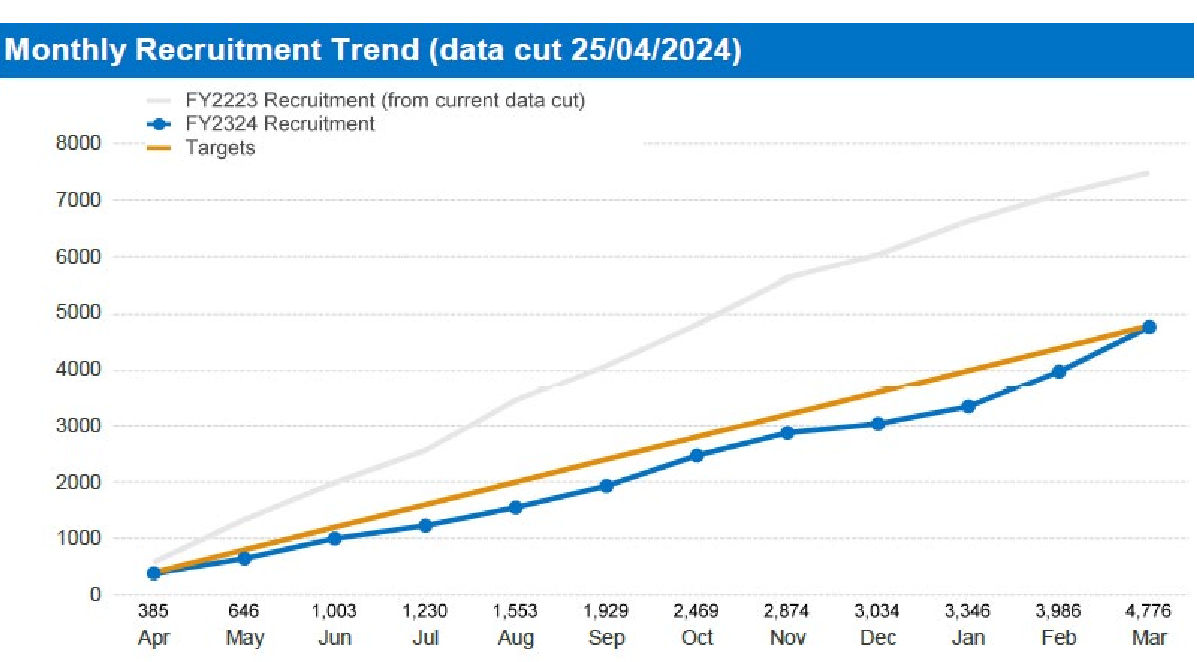
**Recruitment Summary FY2324 (data cut 25/04/2024)**

| | |
|---|---|
| **Recruitment** | Total: **4,776** |
| **Percentage of YTD Recruitment Targets *** | **100%** |
| **Percentage of Year End Recruitment Targets **** | **100%** |
| **Trust Share of LCRN Recruitment** | **4.1%** |
| **Commercial : Non-Commercial Recruitment Ratio** | **7% : 93%** |

## LCRN Recruitment FY2324 (data cut 25/04/2024)




## Monthly Recruitment Trend (data cut 25/04/2024)



**Recruitment by Specialty FY2324 (data cut 25/04/2024)**

**Recruitment**

| Specialty | Recruitment |
|---|---|
| Respiratory Dis | 1,110 |
| Renal Disorders | 481 |
| Ear, Nose and T | 472 |
| Ageing | 341 |
| Cardiovascular | 278 |
| Public Health | 243 |
| Cancer | 237 |
| Gastroenterolog | 233 |
| Surgery | 229 |
| Anaesthesia, Pe | 158 |
| Children | 133 |
| Metabolic and E | 129 |
| Trauma and Emer | 127 |
| Diabetes | 125 |
| Infection | 113 |
| Reproductive He | 66 |
| Hepatology | 61 |
| Critical Care | 55 |
| Musculoskeletal | 41 |
| Stroke | 25 |
| Genetics | 23 |
| Health Services | 22 |
| Neurological Di | 22 |
| Haematology | 16 |
| Dermatology | 15 |
| Primary Care | 11 |
| Ophthalmology | 8 |
| Mental Health | 2 |

**Recruiting Studies**

| Specialty | Recruiting Studies |
|---|---|
| Cancer | 41 |
| Respiratory Dis | 17 |
| Cardiovascular | 13 |
| Hepatology | 12 |
| Children | 11 |
| Trauma and Emer | 11 |
| Surgery | 10 |
| Metabolic and E | 9 |
| Gastroenterolog | 9 |
| Renal Disorders | 8 |
| Musculoskeletal | 7 |
| Critical Care | 6 |
| Diabetes | 6 |
| Infection | 5 |
| Health Services | 3 |
| Dermatology | 3 |
| Neurological Di | 3 |
| Ophthalmology | 3 |
| Stroke | 3 |
| Reproductive He | 3 |
| Ageing | 2 |
| Anaesthesia, Pe | 2 |
| Mental Health | 1 |
| Ear, Nose and T | 1 |
| Haematology | 1 |
| Primary Care | 1 |
| Genetics | 1 |
| Public Health | 1 |

## Celebrating Research Success in 2023-24

- **Establishing research programmes with the potential to positively impact our key performance and quality indicators –** February 2024 saw the launch of the Born and Bred (BaBi) in Hull and East Yorkshire study. Families across Hull and the East Riding are being invited to help shape a healthier generation by taking part in a unique study. The BaBi project is a significant study specifically looking at children's health in their early years. We want to connect up all the information which health, education, social care and other organisations hold about young children and families to try and identify patterns which could then drive improvements in the lives of the next generation and beyond. External support funding has been secured for this initial work and discussions are ongoing with maternity services and external partners (University of Hull and Hull City Council) about how we can maximise the benefits of this cohort work. A Research Midwife is taking a pivotal role in leading this work with over 200 participants recruited in the first eight weeks.
- **Northern Powerhouse Life Sciences Team –** HUTH RDI Team, in conjunction with the University of Hull and Hull City Council, had the pleasure of welcoming a delegation from the Northern Powerhouse (NPH). The NPH is the government's vision for a super-connected, globally-competitive northern economy with a flourishing private sector, a highly-skilled population, and world-renowned civic and business leadership. Through investment in research and development, the NPH is committed to supporting science and innovation in the North. The visit provided an opportunity to showcase a fraction of our research capabilities forged from our core academic partnerships with Hull York Medical School, the University of Hull and the Daisy Appeal with a tour of the CHH campus which included visits to the Daisy Laboratories outlining our collaborations on 'Lab on a Chip' microfluidics work and extensive wound healing research programmes; Ward 7 and the growing Infection Research Group vaccine and OMICS research capabilities and the Molecular Imaging Research Centre (MIRC), demonstrating our strong and unique proposition of access to on-site radiochemistry and cyclotron unit – allowing us to specialise in systemic diseases and drug development research. The NPH were truly impressed with our research offering to the Life Sciences Industry and has already promoted our capabilities to the extensive network of industry partners and contacts, ensuring our work can expand for the benefit of everyone.

- **Exploiting our research potential (OMICS Research) -** HUTH, in collaboration with the University of Hull, has been awarded a PromethION24 (approx. £400k), via the MRC World Class Labs funding scheme. This device uses nanopore DNA/RNA sequencing technology to sequence DNA/RNA in real-time and supports metagenomics, whole genome sequencing (WGS) and transcriptomics. Clinicians at HUTH are applying "omics" to a range of clinical samples, which has resulted in local expertise with an established bioinformatics pipeline at HUTH. Importantly, the technology will increase research participation opportunities for local patients, who live in an area with high disease burden.
- **Exploiting our research potential (Home-grown research) –** As our research activity and workforce capacity incrementally expand, our success in securing externally funded grant income from the NIHR continues. We can now boast to lead multi-centre national research in the areas of Vascular Surgery, Gastroenterology (IBD and Hepatology), Renal, Orthopaedics, Respiratory, Infection and Haematology and Cardiothoracic Surgery and Rehabilitation with over £1.6m of NIHR research funding in the last 12 months.
- **Global and European Firsts Commercial Research –** the achievement of Global and European first participants into trials is now considered an indicator within the NIHR Outcomes Framework (NOF) Economic Benefit domain, as it is a measure/indicator of the global competitiveness of the UK's research system. HUTH is proud of achieving multiple European and UK first trial participants in commercially led research (Endocrinology, Renal, Respiratory, Hepatology, Rheumatology, and Paediatrics).

## Progress on key Research, Development and Innovation (RDI) strategic priorities in 2023-24

- **Increasing research capacity in our workforce** – HUTH continued to work towards securing additional research capability and capacity. Areas supported by additional funding in 2023-24 include; Imaging, Pathology, Pharmacy, Paediatrics and Reproductive Health.

- **Research Workforce Strategy –** HUTH is currently supporting 7 staff through a pathway to obtain PhDs (4 nurses, 2 AHPs and 1 medic) including projects commencing in the areas of ultrasound services, plastic surgery/infection and wound management, physiotherapy and liver disease. 4 RDI funded Clinical Research Fellows have continued to work on the delivery of research programmes (including endometriosis, wound management, chronic endocrine conditions and artificial intelligence). 5 nursing staff have had successful applications to PG Cert Research Courses that commenced in September 2022.

- **Professorship promotions at UoH/HYMS –** in 2023-24 there have been several professorship promotions including Prof Gavin Barlow (Infection), Prof Dumbor Ngaage (Cardiothoracic Surgery) and Prof Mike Crooks and Prof Simon Hart (Respiratory). These will serve to enhance research activities and awareness in these core specialties and facilitate further building of critical mass.

- **Strategic Bid for NMAHP Research Engagement Initiative –** the Trust received CRN funding for a 2023-24 project to look at how best to engage NMAHP staff in Research. The deliverables from this work will include a nursing, midwifery and AHP research strategy that will form part of the wider Group research strategy, a peer-to-peer forum to signpost, support and mentor nursing and AHP staff on their early career research journeys as well as tools for how to get involved in delivering an designing research projects and seeking funding.

- **NIHR Capital Funding Bids –** HUTH successfully secured over £500k of capital funding for research equipment and associated building refurbishment costs. This bid will help enhance facilities and capabilities across several research areas including rehabilitation (CDP/IVR System Computerised Dynamic Posturography System), Diabetes and Endocrinology (Fibroscan), Gastroenterology and Hepatology (-80 Freezer, Incubator and GridION Mk1 CapEX sequencing device) and Vascular (Ultrasound and Shockwave machines).

- **Research communications and engagement strategy: HUTH RDI Newsletter –** a monthly update on research successes, publications, funding opportunities and career development pathways is helping to raise awareness of our research activities and is helping to encourage other staff to engage positively. A Group newsletter is planned in 2024-25 to ensure that the achievements of both NLaG and HUTH are promoted.

- **Exploiting our innovation potential**: As part of joint University of Hull (UoH) and Trust initiative, Aarthi Rajendran, commenced in post as 'Health Innovation Manager' in April 2022. Aarthi is crucial in identifying our collective innovation assets as well as pulling together the prioritisation of innovation projects that would harness the academic and clinical synergies of our partnerships. Projects and themes emerging over the last year include; 3D anatomical printing, virtual wards, rehabilitation, use of AI in clinical radiology and simulation training and mobile healthcare technology solutions.

- **Humber and North Yorkshire Integrated Care Board (ICB) –** As the largest provider Trust and most active research partner, HUTH is taking a proactive approach in shaping the establishment of a HNY ICB 'Research Collaborative' with a view to prioritising a formal governance pathway for joint research and innovation activities and identifying projects that can be jointly delivered for the mutual benefit of patients in our region. HUTH and NLaG have been representing the Group in Innovation, Research and Improvement System (IRIS) 'Communities of Practice' forums for research and innovation as we seek to influence the HNY ICB research strategy.

- **Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) –** in parallel to the provision of plans to ensure HUTH and NLAG clinical pathways and synergies are realised, the RDI Teams at both organisations are now implementing plans with regards to how we might pool resources, expand research programmes across both sites and streamline governance pathways. This work will also be critical to our respective and joint influence within the research and innovation strategies of the HNY ICB. Some of the short to longer term structural, operational and strategic work programmes that will be considered throughout 2024-25 under the Group Structure include:

    - A Group research leadership and management model (effective from 01/04/2024)
    - Development of a Group Research Strategy
    - Alignment of research governance, finance, engagement and promotion activities.
    - Increasing joint capability and capacity to maximise opportunities for patients (including 'home-grown' research for vulnerable patient cohorts).

- **University of Hull/HYMS –** Our portfolio of research is, in large part founded on partnerships between our local universities (Hull and York via HYMS) and those partnerships are stronger than ever. We offer a wide clinical base within with to study the conditions which most affect our communities. By working together with our core academic partners and patients, we can ensure we improve their health, while developing research that can be applied nationally and globally.

How our joint research is making a difference:

1. Unlocking the genetic code of blood cancer | Hull York Medical School (hyms.ac.uk) – Dr David Allsup's research means that treatment can be personalised based on a patient's genetic makeup.
2. Researchers revolutionise type 1 diabetes management with flash glucose technology | Hull York Medical School (hyms.ac.uk) – Led by Professor Thozhukat Sathyapalan and Dr Harshal Deshmukh, people with type 1 diabetes now have the Freestyle Libre device through the NHS to manage their diabetes effectively.
3. Addressing the silent killer: Revolutionising diabetic foot ulcer healing with shockwave therapy | Hull York Medical School (hyms.ac.uk) – Ms Louise Hitchman is making waves in improving diabetic foot ulcer healing - a stark marker of advance stage of the disease.
4. Research reveals the crucial role of the skin microbiome in wound healing and antimicrobial resistance | Hull York Medical School (hyms.ac.uk) – Research in laboratories in the Daisy Building at Castle Hill Hospital is paving the way in skin and wound healing.
5. Research trial aims to revolutionise antifungal treatment for patients with acute leukaemia | Hull York Medical School (hyms.ac.uk) – A study led by Professor Gavin Barlow will seek to identify the most effective to prevent and detect fungal infections in patients with acute leukaemia.
6. Revolutionising asthma care cuts blue inhaler reliance and carbon emissions | Hull York Medical School (hyms.ac.uk) – A project led by Professor Mike Crooks is improving appropriate use of inhalers, leading to a huge reduction in the use of blue SABA inhalers.
7. Trial investigates whether vacuum dressings accelerate healing of open surgical wounds | Hull York Medical School (hyms.ac.uk) – Professor Ian Chetter is leading a trial that could help patients suffering from open wounds.

- **BAME and Research Ready Communities initiatives** – work led by Jenny Ubi is looking at how best we can provide opportunities to engage BAME and socially deprived communities in research participation. Working alongside the NIHR Ethnic Minority Research Inclusion (EMRI) colleagues, Jenny is making a real impact in this area and is working closely with the commercial research companies to ensure BAME representation is increased. Trials activity is increasing as a direct result of this initiative.

# 2.3.4 Goals agreed with Integrated Care Board

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. The Integrated Care Board reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience, and improvements against outcomes.

**Use of the CQUIN payment framework**

A proportion of Hull University Teaching Hospitals NHS Trust income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

The financial value of CQUIN in 2023/24 is 1.25% of the annual contract value. The CQUIN financial incentive has been applied on the five most important indicators for each contract (5 main contract, 1 specialized commissioning contract) as agreed by commissioners.

It is anticipated that the CQUIN scheme for 2024/25 will not be mandated and will be a change from the previous contract requirements. There will be no central data collection by NHS England, under their current plans. The ICB may request local mandated reporting to continue. Specialised commissioning have advised that they do not plan for their CQUINs to continue.

The CQUIN scheme for 23/24 was:

- **CQUIN01: Flu vaccinations for frontline healthcare workers**
  Achieving 80% uptake of flu vaccinations by frontline staff with patient contact
- **CQUIN02: Supporting patients to drink, eat and mobilise (DrEaM) after surgery**
  Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.
- **CQUIN03: Prompt switching of intravenous to oral antibiotic**
  Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.
- **CQUIN04: Compliance with timed diagnostic pathways for cancer services**
  Achieving 55% of referrals for suspected prostate, colorectal, lung, oesophagogastric, head & neck and gynaecological cancers meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways
- **CQUIN05: Identification and response to frailty in emergency departments**
  Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.
- **CQUIN06: Timely communication of changes to medicines to community**
  Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.
- **CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions**
  Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes

- **CQUIN08 Achievement of revascularisation standards for lower limb Ischaemia**
  Following guidance published by the Vascular Society, to reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia, and in turn to reduce length of stay, in-hospital mortality rates, readmissions and amputation rates.
- **CQUIN09 Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres**
  The percentage of patients commencing treatment within 4 weeks of referral to ODN
- **CQUIN10: Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway**
  Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-2) referred for treatment with curative intent, as per the NICE QS17 recommendation.
- **CQUIN11: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery**
  The level of patient satisfaction with shared decision making conversations – as measured by patient scores on internationally validated patient questionnaires – at key decision points in specialised pathways
- **CQUIN12: Assessment and documentation of pressure ulcer risk**
  Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.

The table below outlines the CQUINs achieved for 2023/24:

| Key | |
|---|---|
| Green | Maximum target achieved or exceeded |
| Amber | Minimum target achieved |
| Red | Target not achieved |

| | Min | Max | Q1 | Q2 | Q3 | Q4 | Full Year performance |
|---|---|---|---|---|---|---|---|
| **CQUIN01:** Flu vaccinations for frontline healthcare workers | 75% | 80% | N/A | N/A | 40% | 54% | 54% |
| **CQUIN02:** Supporting patients to drink, eat and mobilise (DrEaM) after surgery | 70% | 80% | 90% | 69% | 76% | 84% | 80% |
| **CQUIN03:** Prompt switching of intravenous to oral antibiotic (Target: Lower is better) | 60% | 40% | 13% | 20% | 12% | 23% | 17% |
| **CQUIN04:** Compliance with timed diagnostic pathways for cancer services | 35% | 55% | 32% | 38% | 40% | 43% | 38% |
| **CQUIN05:** Identification and response to frailty in emergency departments | 10% | 30% | 58% | 48% | 33% | 36% | 44% |
| **CQUIN06:** Timely communication of changes to medicines to community pharmacists | 0.5% | 1.5% | 2.34% | 3.39% | 4.15% | 3.51% | 3.35% |
| **CQUIN07:** Recording of and response to NEWS2 score for unplanned critical care admissions | 10% | 30% | 61.5% | 75.86% | 73.08% | 59.0% | 67.36% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **CQUIN08:** Achievement of revascularisation standards for lower limb Ischaemia | **45%** | **65%** | **72.%** | **57%** | **83%** | **TBC in June** | **TBC in June** |
| **CQUIN09:** Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres | **60%** | **75%** | **N/A** | **TBC** | **N/A** | **TBC in June** | **TBC in June** |
| **CQUIN10:** Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway | **80%** | **85%** | **92.86%** | **100%** | **93.5%** | **100%** | **96.6%** |
| **CQUIN11:** Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery | **65%** | **75%** | **N/A** | **73%** | **N/A** | **72%** | **73%** |
| **CQUIN12:** Assessment and documentation of pressure ulcer risk | **70%** | **85%** | **24%** | **22%** | **50%** | **65%** | **40%** |

Unfortunately, the Trust did not meet the minimum threshold for CQUIN12 to be able to evidence achievement of 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks. Whilst our performance improved during the course of the year, with 65% compliance in Quarter 4, we did not meet the minimum threshold. The Tissue Viability team have regular meetings with wards an action plan is in place progress has been made, with ongoing work with the digital team to improve collection of information.

The Trust met the minimum thresholds for CQUIN 4 and CQUIN 11. The Trust notes its efforts for flu vaccinations did not meet the minimum threshold, but delivered above the regional and national average. It is positive that for two areas where the Trust did not pass the CQUIN threshold in 2022/23, these have been met in 2023/24 for:

**CQUIN02:** Supporting patients to drink, eat and mobilise (DrEaM) after surgery; and

**CQUIN07:** Recording of and response to NEWS2 score for unplanned critical care admissions.

Increasingly as the Trust's data capabilities have been enhanced, including electronic patient records, we will be able to draw this information from source as opposed to rely on manual records. Our systems now have inbuilt prompts which enforce our recording of patients drinking, eating and mobilising post surgery.

# 2.3.5 What others say about the Trust: Care Quality Commission

**About the Care Quality Commission**

The Care Quality Commission (CQC) regulates and inspects health and social care services in England. They check that services meet the Health and Social Care Act 2008 ('the Act') and the CQC Fundamental Standards. If they feel that an organisation provides good, safe care the CQC registers it without conditions. The CQC provides assurance to the public and commissioners about the quality of care through a continuous monitoring of a Trust's performance across a whole range of core services.

The CQC Operating Model was revised and in June 2017 the CQC confirmed they will focus on eight core services and four additional services. The additional services may be inspected depending on the level of activity and risk.

**The eight core services are:**

- Urgent and Emergency Services
- Medical Care
- Surgery
- Critical Care
- Maternity
- Services for Children and Young People
- End of Life Care
- Outpatients

**The four additional services are:**

- Gynaecology
- Diagnostic Imaging
- Rehabilitation
- Spinal Injuries

**Statement of compliance with the Care Quality Commission**

Hull University Teaching Hospitals NHS Trust is required to register with the CQC and in 2023/24 our registration status had two additional conditions on its registration under a Section 31 Notice in Maternity Services. The CQC has not undertaken enforcement action during the period.

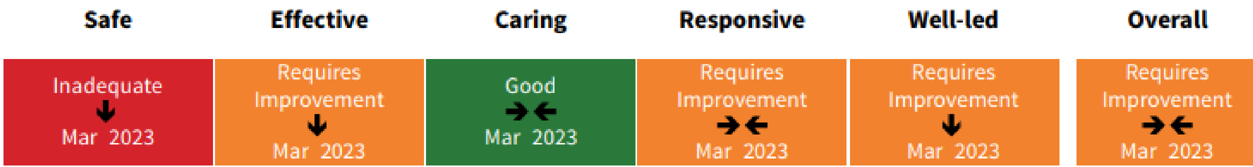
The conditions on registration for maternity services require the Trust to:

i. implement an effective system for managing and responding to patient risk to ensure all mothers and babies who attend Hull Royal Infirmary are cared for in a safe and effective manner and in line with national guidance. The registered provider must operate an effective clinical escalation system to ensure every woman attending the hospital are triaged, assessed, and streamlined in a timely manner by appropriately skilled and qualified staff;
ii. implement an effective risk and governance system, with individual prompts covering oversight, incident management and shared learning.

The Trust responded to the Section 31 notice for Maternity Services and provided an action plan to address concerns. Progress is submitted to the CQC monthly and monitored also by the ICB and NHSE monthly. Further update to our progress in maternity is documented on **page 79.**

Hull University Teaching Hospitals NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

## Current CQC ratings



Ratings for the whole trust

| Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|
| Inadequate ↓ Mar 2023 | Requires Improvement ↓ Mar 2023 | Good →← Mar 2023 | Requires Improvement →← Mar 2023 | Requires Improvement ↓ Mar 2023 | Requires Improvement →← Mar 2023 |

The CQC inspected Hull University Teaching Hospitals NHS Trust during 2022/23. The inspection was undertaken in November 2022 of Urgent and Emergency Services, Surgery and Medicine.  The Well-led inspection was undertaken in December 2022. The Trust's overall rating remains as 'Requires Improvement'.  The report was published in March 2023.

Several significant changes were published in the report with the Trust receiving 'Inadequate' ratings for Urgent and Emergency Services in the Safe, Effective, Responsive and Well-Led domains. Surgery also received at 'Inadequate' rating for the Safe domain. In addition, Surgery and Medical care was downgraded to reflect "Requires Improvement" ratings for the Effective, Responsive and Well-Led domains.

The following details the ratings against each of the core services that take place at individual sites including the Maternity visit which was reported on 9 August 2024:

Hull Royal Infirmary

Overall rating: Inadequate (Inadequate / Requires improvement / Good / Outstanding)

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement | Requires Improvement |
| Services for children & young people | Requires Improvement | Good | Good | Good | Good | Good |
| Critical care | Good | Good | Good | Good | Requires Improvement | Good |
| End of life care | Good | Good | Good | Good | Good | Good |
| Maternity | Inadequate | Good | Good | Good | Inadequate | Inadequate |
| Outpatients | Good | Not rated | Good | Requires Improvement | Good | Good |
| Surgery | Inadequate | Requires Improvement | Good | Requires Improvement | Requires Improvement | Requires Improvement |
| Urgent and emergency services | Inadequate | Inadequate | Requires Improvement | Inadequate | Inadequate | Inadequate |

Castle Hill Hospital

Overall rating: Requires improvement (Inadequate / Requires improvement / Good / Outstanding)

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement | Requires Improvement |
| Critical care | Good | Good | Good | Good | Requires Improvement | Good |
| End of life care | Good | Good | Good | Good | Good | Good |
| Outpatients | Good | Not rated | Good | Requires Improvement | Good | Good |
| Surgery | Inadequate | Requires Improvement | Good | Requires Improvement | Requires Improvement | Requires Improvement |

## Trust response to CQC actions

***March 2023 report incorporating Urgent and Emergency Services, Medical care and Surgery***

The 2023 report contained 51 'Must do' and 16 'should do' actions across both sites. The Trust structured these into a robust action plan incorporating a total of 194 actions.

These have been subject to Health Group and Executive oversight during the course of the year. In addition, the progress against plans has been reported to the monthly Quality Improvement Group which is chaired by NHS England (North East & Yorkshire) and NHS Humber and North Yorkshire ICB, with attendance by the CQC. This group receives progress against the actions but has a work plan to review outcome measures over the course of the year to ensure that actions are being sustained.

The Trust has already made significant progress with completing 78% of the action plans as at 31 March 2024. Progress on actions are as follows:

| Actions completed with evidence of completion provided | 153 |
|---|---|
| Actions implemented with ongoing monitoring | 38 |
| Actions not yet due but on track | 0 |
| Actions overdue | 3 |

There are two actions within our Surgery action plan still to implement. In addition, the Trust continues work to reconfigure the Ground floor model at the Hull Royal Infirmary.

Our action plans were subject to an independent review by the Trust's Internal Auditors in 2023/24 which provided reasonable assurance and for 35/35 actions reviewed were satisfied with the process and supporting evidence to sign these off as complete.

During the course of the year, the NHSE Quality Improvement Group has received progress updates against the action plan, in addition to detailed updates in respect of:

- **Staff training** – this was a consistent theme across services reviewed but the Trust is now ahead of its mandatory training targets, with the exception of resuscitation training which is on a trajectory to meet compliance in August 2024.
- **Nurse Staffing –** the status of nursing establishments, which during 2023/24 have been over established by c.120WTE Register Nurses across our theatres, wards and Emergency Department. This has been achieved by successful long term workforce planning including engagement with local colleges and universities.
- **Falls** – to monitor the reduction in both volume and harm of falls in the Trust. This included a reduction of greater than 50% of falls resulting in a FNOF since summer 2023.
- **Theatres Oversight group improvement –** the progress made against underpinning workstreams in respect of: NatSIPS2 (National Safety Standards for Invasive Procedures); Consent; Medicine management; IPC- Infection prevention control; and Never Events.
- **Nutrition and Hydration –** The work to provide better food provision to those patients waiting in the Emergency Department and steps to achieve compliance with NHSE National Standards for healthcare food and drink issued in November 2022.
- **Patient Safety Incident Response Framework –** The Trust was an early adopter and has concluded outstanding Serious Incident (SI) investigations and undertaken thematic reviews and after action reviews.
- **Emergency Department deep dive –** To monitor improvements in Emergency Department outcomes and receive updates on the ICB assurance visits. This includes the improved performance and reduction in patient harm during the winter 2023/24, including after the period that the Trust opened the Urgent Treatment Centre on the HRI site in February 2024.

***August 2023 Maternity Services report***

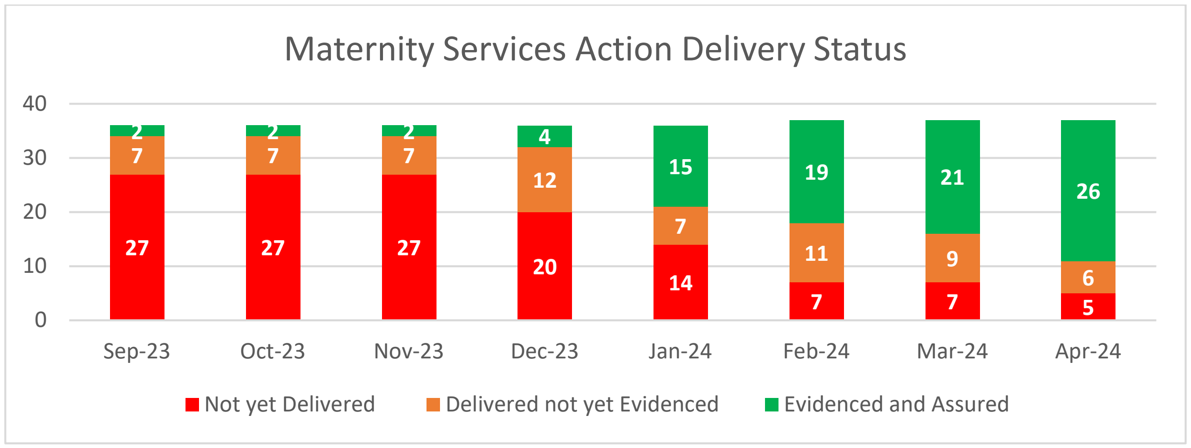
The CQC inspected the maternity service at Hull University Teaching Hospitals NHS Trust in March 2023 as part of its national maternity inspection programme. This was a focused inspection of the maternity service, looking only at the safe and well-led key questions.

Following the inspection the Trust was required to respond to urgent concerns, including action plans. In April 2023 a further visit was undertaken by the Care Quality Commission at which point the Section 31 notice was issued. The final report was published in August 2023 which provided a rating of 'Inadequate' in the Safe and Well-Led domains. There were 9 'Must Do' and 3 'Should' actions.

To address these stipulated actions, the service engaged external support and developed an action plan containing 37 actions, which an ambition to deliver these between October 2023 and April 2024.

The Trust utilised external support to map out the evidenced required to show that outcomes had been sustained at which point could be signed off as delivered and assured (green).

At the date of this report, the Trust has delivered 26/37 actions on the plan:




For the remaining actions in the plan, the Trust has made good progress which has been overseen by the Executive Led Maternity Transformation and Assurance Committee.

Against the conditions placed on the Trust's registration:

*Condition 1: ADU/ Maternity Triage Activity*

There has been continued improvement in ADU and Maternity triage. In response to the CQC visit, the service began electronic recording in March 2023 to measure comprehensively our waiting times.

Planned and unplanned activity was originally seen in the same area and was then separated in September 2023. The service's new Maternity Triage Unit opened in November 2023 and this has driven the significant improvement to ensure that women attending the hospital are triaged, assessed and streamlined in a timely manner by appropriately skilled and qualified staff.

At the point at which digital monitoring was commenced, **less than 60%** of patients were seen within the guidelines of 15 minutes. This was consistent with the challenges the CQC observed in March 2023. In the 2024 calendar year the Trust has embedded performance in **excess of 90%** of patients seen within 15 minutes and has since implemented BadgerNotes / BSOTS on 12 March 2024. We are firming up the sustainable staffing solutions to ensure our maternity triage provision remains robust overnight.

*Condition 2: Risk and governance systems*

A significant amount of work has been undertaken against this action and the overall governance arrangements within Maternity since the inspection in March 2023.

Progress on the action plans has been received by the Trust's Maternity Transformation and Assurance Committee (MTAC) which has met bi-weekly and is attended by the ICB Director of Midwifery, Maternity Improvement Advisor and Safety Champion. Progress is also provided to the ICB, NHSE and CQC on a monthly basis through a robust monitoring process at HUTH Quality Improvement Group which reviews outcomes.

As the Trust has now entered into a Group Collaboration with Northern Lincolnshire and Goole NHS Foundation Trust, the new Family Services Care Group is ratified revised governance arrangements which will also take into account the support from the National Maternity Improvement Advisor supporting the Trust.

**CQC National Maternity Survey 2023 (published 9 February 2024)**

The Maternity survey results were published on the 9th February 2024; the Trust had 214 responses (46%). There were 54 questions and of these, the CQC asked people to answer questions about different aspects of their care and treatment. Based on their responses, the CQC gave each NHS trust a score out of 10 for each question (the higher the score the better).

Each trust also received a rating of 'Much better', 'Better', 'Somewhat better', 'About the same', 'Somewhat worse', 'Worse' or 'Much worse' which compared to most other trusts in the country. 121 trusts took part in the survey.

At HUTH, for 49/54 questions the Trust's scores were considered 'About the same' which means that the trust is performing about the same for that particular question as most other trusts that took part in the survey. There was 1 question where the Trust scored 'somewhat worse' and 4 questions where the Trust scored 'worse'.

**Worse than expected**

- B3. Were you offered a choice about where to have your baby?
- B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?
- B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?
- C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

**Somewhat worse than expected**

- B14. Thinking about your antenatal care, were you involved in decisions about your care?

It is worth noting that the 2023 survey was undertaken at the same time of the March 2023 Maternity inspection, and the survey period for the 2024 survey has already passed.

As part of its response to the maternity inspection findings, the Trust revised its governance structures to have greater oversight of maternity services from Ward to Board. These have been further revised in early 2024/25 to reflect our Group Collaboration.

The Trust highly values the support of the local Healthwatch organisations who have participated in the Trust's monthly assurance visit programme. Healthwatch East Riding of Yorkshire and Healthwatch Kingston upon Hull have recently conducted a review of maternity services between October 2023 and January 2024 and concluded that '**there has been many improvements made by the staff of HRI to improve patient experience following the CQC report published in 2023**'.

Healthwatch raised 9 recommendations, which align with those actions we have not fully signed off as embedded as part of our CQC action plan. The report recognised the significant work undertaken to recovery staff training compliance but with a clear recommendation to devote protected time for staff to undertake their training. This has been incorporated in our establishments for 2024/25 with steps already taken to book next year's training.

The Trust is equally indebted to the enthusiast support from the Hull Maternity and Neonatal Voices Partnership (MNVP). The Trust continues to work through a comprehensive action plan from their 15 steps visits in March 2023 and follow up visit in September 2023 and looks forward to providing an update against this action plan, and the national CQC survey, at our next Maternity Transformation and Assurance Committee in June 2024.

# 2.3.6 Secondary Users Service

**What is Secondary Users Service?**

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

Hull University Teaching Hospitals NHS Trust submitted records during 2023/24 (as of March 2024) to the Secondary Users service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data:

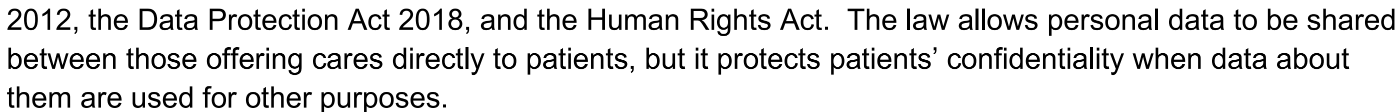
- That included the patient's valid NHS number:
    - **99.9%** for admitted patient care;
    - **99.9%** for outpatient care; and
    - **99.4%** for accident and emergency care.

- That included the patient's valid General Medical Practice Code:
    - **100%** for admitted patient care;
    - **100%** for outpatient care; and
    - **100%** for accident and emergency care.

# 2.3.7 Information Governance

**What is Information Governance?**

The legal framework governing the use of personal confidential data in a health care setting is complex and includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act 2018, and the Human Rights Act. The law allows personal data to be shared between those offering cares directly to patients, but it protects patients' confidentiality when data about them are used for other purposes.



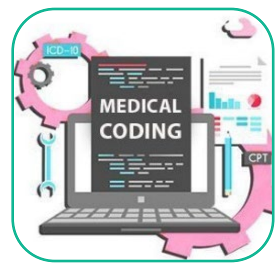
**Data Security & Protection Toolkit**

The Information Governance Data Security and Protection Toolkit (DSP Toolkit) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance.

It remains Department of Health policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is fundamental to the secure usage, sharing, transfer, storage and destruction of data both within the organisation and between external organisations. The Information Governance Assurance Statement is a required element of the DSP Toolkit and is re-affirmed by the annual submission to demonstrate that the organisation has robust and effective systems in place to meet statutory obligations on data protection and data security. The submission deadline for the 2023/24 DSP Toolkit Assessment is 30th June 2024 and updates can be accessed via the NHS Digital website: https://www.dsptoolkit.nhs.uk/OrganisationSearch/RWA.

The current status for Hull University Teaching Hospitals NHS Trust following submission of the 23/24 DSP toolkit is **Approaching Standards**. The Trust has developed an improvement plan which is monitored by NHS England.

# 2.3.8 Payment by results Clinical Coding Audit




**What is Clinical Coding**

Clinical coding is the process whereby information from medical records for each patient is expressed as a code. This may include the operation, treatment provided, a diagnosis, any complications and comorbidities. These codes are processed to result in one of a number of possible health resource group codes, each of which has a specific payment tariff that the hospital then receives.

**Clinical Coding Audit**

Hull University Teaching Hospitals was not subject to an external clinical coding audit during 2023/24.

A programme of internal speciality and individual coder audits has been completed by the Trusts NHS England Approved Auditors. A sample of audited FCEs (Finished Consultant Episodes) has been taken and summarised below:

| **Percentage Correct** | | | |
|---|---|---|---|
| Primary Diagnosis | Secondary Diagnosis | Primary Procedure | Secondary Procedure |
| 97.55% | 96.72% | 96.88% | 96.48% |

Department Priorities 23/24

| **Priority** | **Level** | **Progress Update** | **Status** |
|---|---|---|---|
| Achieve mandatory level in all internal spot checks and audits | High | Regular programme of internal coder and speciality audits | On-going rolling programme |
| Increase clinical engagement | High | Attended more Junior Doctor inductions than 2022. Coder/Clinical Engagement sessions established in areas identified at audit. Speciality guides produced in collaboration with clinicians. | On-going |
| Reduce reliance on paper casenotes | Medium | Additional wards and day case areas added to electronic coding source list. | Trial areas completed. On-going investigations to highlight other potential areas. |
| Maintain data quality, coding depth and accuracy | High | Internal and external validations. Investigating areas with, for example, low depth, high SHMI/HSMR | On-going |

# 2.3.9 Learning from deaths

This section provides an update against the NHS England prescribed information for learning from deaths, as well as an update on other key areas of work that have taken place to identify quality improvement both within the Trust and across the wider, more complex system of health care providers.

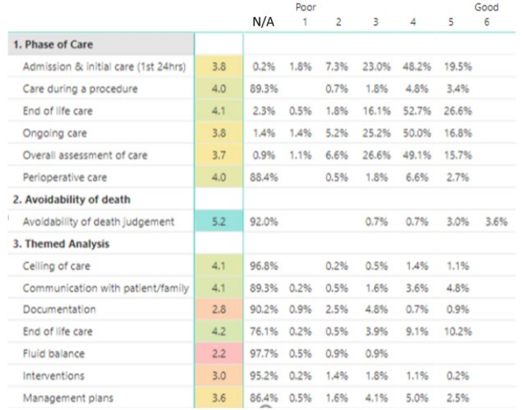
During 2023/24, **2,479** of Hull University Teaching Hospitals NHS Trust patients died within the hospital as an inpatient. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- **604** in the first quarter;
- **601** in the second quarter;
- **656** in the third quarter; and
- **618** in the fourth quarter.

During 2023/24 there were a total of **440** Structured Judgement Reviews completed (an increase from 268 in 2022/23).

Of these reviews undertaken, it was deemed that **6** deaths were more likely than not due to problems in care. The Trust has adopted the Patient Safety Incident Response Framework (PSIRF) and there were **4** cases where a SJR was undertaken as part of the PSIRF, however, none of these cases were identified to be more likely than not, avoidable deaths.

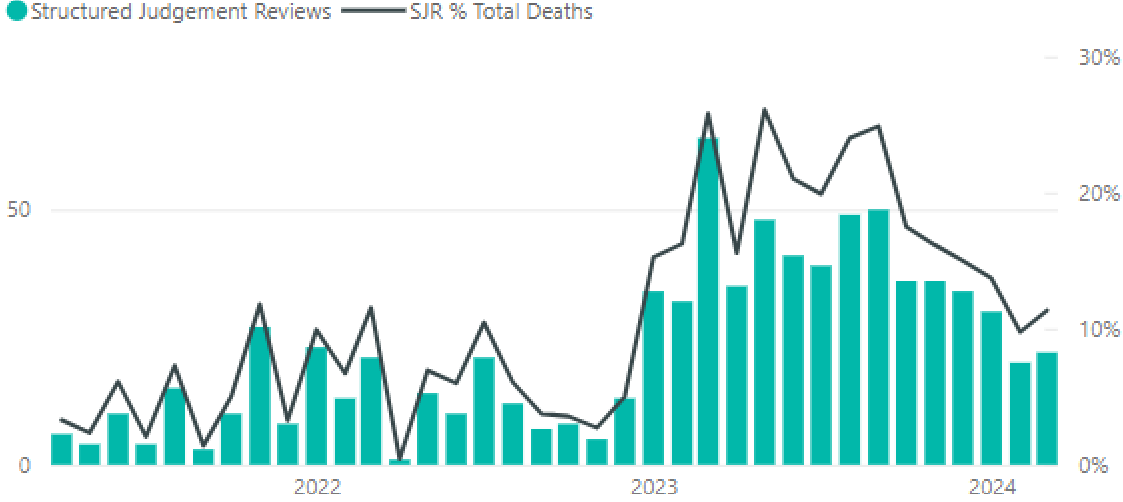
The Structured Judgement Methodology allows reviewers to subjectively judge the care delivered to patients during the various stages of care. A score out of 5 is given for each stage, ranging from 1 (Poor) to 5 (Excellent). The table below provides a breakdown of these scores that were given during the Structured Judgement Reviews during 2023/24



| | | N/A | Poor<br>1 | 2 | 3 | 4 | 5 | Good<br>6 |
|---|---|---|---|---|---|---|---|---|
| **1. Phase of Care** | | | | | | | | |
| Admission & initial care (1st 24hrs) | 3.8 | 0.2% | 1.8% | 7.3% | 23.0% | 48.2% | 19.5% | |
| Care during a procedure | 4.0 | 89.3% | | 0.7% | 1.8% | 4.8% | 3.4% | |
| End of life care | 4.1 | 2.3% | 0.5% | 1.8% | 16.1% | 52.7% | 26.6% | |
| Ongoing care | 3.8 | 1.4% | 1.4% | 5.2% | 25.2% | 50.0% | 16.8% | |
| Overall assessment of care | 3.7 | 0.9% | 1.1% | 6.6% | 26.6% | 49.1% | 15.7% | |
| Perioperative care | 4.0 | 88.4% | | 0.5% | 1.8% | 6.6% | 2.7% | |
| **2. Avoidability of death** | | | | | | | | |
| Avoidability of death judgement | 5.2 | 92.0% | | | 0.7% | 0.7% | 3.0% | 3.6% |
| **3. Themed Analysis** | | | | | | | | |
| Ceiling of care | 4.1 | 96.8% | | 0.2% | 0.5% | 1.4% | 1.1% | |
| Communication with patient/family | 4.1 | 89.3% | 0.2% | 0.5% | 1.6% | 3.6% | 4.8% | |
| Documentation | 2.8 | 90.2% | 0.9% | 2.5% | 4.8% | 0.7% | 0.9% | |
| End of life care | 4.2 | 76.1% | 0.2% | 0.5% | 3.9% | 9.1% | 10.2% | |
| Fluid balance | 2.2 | 97.7% | 0.5% | 0.9% | 0.9% | | | |
| Interventions | 3.0 | 95.2% | 0.2% | 1.4% | 1.8% | 1.1% | 0.2% | |
| Management plans | 3.6 | 86.4% | 0.5% | 1.6% | 4.1% | 5.0% | 2.5% | |

The overall care scores reflect good to excellent care delivered to patients. In some instances, there were potential issues relating to fluid balance. Upon review, it was noted that the level of documentation in relation to the recording of fluid balance needed to be improved. As a result of these issues around fluid balance, a task & finish group was formed which led to the creation of several quality improvement work-streams which targeted these issued and as a result, processes were put in place to further improve upon the recording and management of fluid balance.

**The Structured Judgement Methodology**
During 2023/24, one of the key focuses of the Trust was to ensure that the appropriate clinical staff received adequate training and support to enable them to undertake Structured Judgement Reviews. This resulted in a positive uptake of reviewers who are engaged with the process and has had a positive impact on the number of cases receiving review via the SJR methodology, as the following graph shows:




**Moving Towards Proactive**

In 2023/24 the Trust took positive steps to becoming more proactive in how it utilises its available resources, enabling to better learn from patient mortality, by identifying key areas in patient care that would benefit from proven quality improvement techniques. With the Trusts on-going commitment to quality improvement in the foreground of patient care, this has enabled the learning from deaths framework to expand upon the requirements set by the National Quality Board, enabling focus on deeper understanding of systemic factors that affect patient care, as well as providing bespoke quality improvement projects to areas that require improvements to be made.

**Key Learning from Mortality Review**

Some of the excellent practices highlighted from review include:

- A high level of ongoing communication with the patient and the next of kin; providing regular updates on patient care, including management plans.
- A high level of compassion and understanding, towards the patient as well as the patient's next of kin, including those who had a learning disability.
- Fast access to Specialist Palliative care review;
- Multidisciplinary approaches to care sought, with the aim of getting the best possible outcome for the patient;
- An excellent multidisciplinary approach to the mortality and morbidity discussion, drawing learning form a range of clinical areas with a strong commitment to quality improvement.

Some of the key ongoing improvements include:

- Further identification of areas of improvement for Sepsis care;
- Further identification of areas of improvement in caring for patients with fractured neck of femur;
- Development of a detailed mortality strategy to further improve outcomes of patients.

# 2.3.10 Reporting Against Core Indicators: NHS Digital

**What is NHS Digital?**

NHS digital support NHS staff at work through design, developing and operating the national Information Technology (IT) and data services that support clinicians and NHS staff at work, help patients get the best care, and use data to improve health and care.

**Reporting against core indicators**

Since 2012/13 Hull University Hospitals NHS Trust has been required to report on performance against a core set of indicators using data made available by NHS Digital. The core set of indicators are prescribed in the NHS Outcomes Framework (NHS OF) developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how NHS Trusts are performing and uses comparative data against the national average and other NHS organisations with the lowest and highest scores.

The Hull University Teaching Hospitals NHS Trust considers that this data is as described because performance information is consistently gathered and data quality assurance checks made as described in the next section.

**The table below details performance against the Summary Hospital-level Mortality Indicator (SHMI):**

| Prescribed Information | 2022/23 | 2023/24 | National Average | National Highest | National lowest |
|---|---|---|---|---|---|
| The value of the SHMI for the Trust for the reporting period* | 1.0965 | 1.1391 | 1.0 | 1.25 | 0.72 |
| The banding of the SHMI for the Trust for the reporting period* | 2 (as expected) | 1 (higher than expected) | 2 (as expected) | 1 (higher than expected) | 3 (lower than expected) |
| The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period* | 32% | 35% | 42% | 67% | 16% |

**Source:** NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of- interest/hospital-care/quality-accounts). *Reporting period January 2023 to December 2023

Hull University Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:

- The Trust continues with the processes to improve the quality and accuracy of the data that underpins statistical mortality calculations like the SHMI and improving the consistency of the learning from deaths programme of work.
- The improvement in the Hull Royal Infirmary metric is consistent with work to improve pneumonia outcomes which has reduced that SHMI condition to “as expected”.

Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve this score, and so the quality of its services:

- Development of a Mortality strategy;
- continually monitoring performance at the Trust Mortality and Morbidity Committee;
- designated work to improve the 3/10 diagnosis conditions that are ‘higher than expected’ which are Fracture Neck of Femur, Secondary malignancies, and Septicaemia.

**The table below details performance against the Patient Reported Outcome Measures (PROMs):**

The data detailed in the table below was made available to the Trust by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

a) Hip replacement surgery
b) Knee replacement surgery

| Type of surgery | Sample time frame | Trust adjusted average health gain | National average | National highest | National lowest |
|---|---|---|---|---|---|
| Hip replacement (Primary) | April 2020 – March 2021 | Not published in national data set | 0.472 | 0.574 | 0.393 |
| | April 2021 – March 2022 | 0.378 | 0.462 | 0.534 | 0.375 |
| Knee replacement (Primary) | April 2020 – March 2021 | Not published in national data set | 0.315 | 0.399 | 0.181 |
| | April 2021 – March 2022 | Not published in national data set | 0.324 | 0.417 | 0.245 |

**Source:** NHS Digital Quality Account Indicators Portal, Primary data used, EQ-5D Index used (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

The Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- continually monitoring performance – this has occurred during the 2023/24 year through the Trust Patient Experience and Engagement Committee.
- The Trust has taken steps to ensure all data submissions are made to ensure incorporation into national data sets.

**The table below details performance against the Readmission rate into hospital within 30 days of discharge**

| Prescribed Information | Trust (April 2021 to March 2022) | Trust (April 2022 to March 2023) | National average | National Highest | National Lowest |
|---|---|---|---|---|---|
| The percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period* | 11.6% | 11.4% | 12.8% | 302.9%* | 3.7% |
| The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the Trust during the reporting period* | 11.2% | 13.3% | 14.4% | 46.8% | 2.5% |

**Source:** NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of- interest/hospital-care/quality-accounts)

*Note* the score of 302.9% is considered an anomaly. The next highest data presented by NHS Digital is 37.9%.*

Hull University Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:

- The Trust is below national benchmarks.

Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve this score, and so the quality of its services:

- The Trust continues to monitor its readmission rates on a monthly basis (from locally available data) and compares these to the national rates in order to benchmark our performance.
- Patient flow and discharge workstreams continue in order to achieve national targets.

**The table below details performance against the Trust's responsiveness to the personal needs of our patients**

There has been no new data made available to the Trust by NHS Digital about the Trust's responsiveness to the personal needs of its patients since 2020. Therefore, the table below shows the data up to the most recent entry covering hospital stays between 01 July 2019 to 31 July 2019 (data collected between 01 August 2019 to 31 January 2020). Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100.

| Prescribed Information | Trust value 2019 - 2020 | National average | National highest | National lowest |
|---|---|---|---|---|
| The Trust's responsiveness to the personal needs of its patients during the reporting period* | 64.4 | 67.1 | 84.2 | 59.5 |

**Source:** NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of- interest/hospital-care/quality-accounts).

Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve this score, and so the quality of its services:

- Further build on the data collected from our patients, for example utilise the Friends and Family data from the 120,000 patients that responded during 2023/24 and identify improvement plans at care group (and ward) area.
- Respond robustly and timely to other stakeholder surveys (e.g. CQC surveys such as maternity) and other stakeholder input.
- Continued to undertake monthly assurance visits, incorporating Safety Champions and other stakeholders such as MNVP and healthwatch and apply 15 Steps process.

**The table below details performance against the Friends and Family Test for staff – would staff recommend the Trust as a provider of care to their family and friends**

| Prescribed Information | 2022 | 2023 | National Average | National highest | National lowest |
|---|---|---|---|---|---|
| The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends* | 51.7% | 55.21% | 63.32% | 88.82% | 44.31% |

*Most recent staff survey data – 2023 (Source: Bridget download slide 83)

Hull University Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:

- The data is collected from our staff as part of the latest National Staff Survey.

Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve this score, and so the quality of its services:

- Continue the work Proactive career planning within nursing, including expanding the apprenticeship framework to enrich nursing career opportunities and retain good staff.
- continually monitoring performance at the Trust Workforce and Transformation Committee.

**The table below details performance against the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE)**

| Prescribed Information | 2022/23 | 2023/24 | National Average | National Highest | National Lowest |
|---|---|---|---|---|---|
| The percentage of patients who were admitted to hospital and who were risk assessed for VTE during the reporting period* | Not published | Not published | Not published | Not published | Not published |

*Most recent data on NHS Digital for period - National data stopped March 2020

Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services:

- The Group Chief Medical Officer has commissioned a significant priority Quality Improvement project which commenced in Q4 of 2023/24.
- A training and awareness programme has been launched with Junior doctors.
- Additional system functionality to be developed and executed with a Nerve Centre Dashboard.
- Pilot underway on wards 500, 37 and 39 to be rolled out more widely in the Trust.

**The table below details performance against the C. Difficile infection rate, per 100,000 bed days**

| Prescribed Information | 2021/22 | 2022/23 | National Average (England) | National Highest | National Lowest |
|---|---|---|---|---|---|
| The rate per 100,000 bed days of cases of C Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period* | 10.83 | 7.05 | 18.48 | 73.34 | 0 |

* *(Most recent data published by NHS digital on 6 October 2023).*

Hull University Teaching Hospitals NHS Trust considers that this data is as described for the following reasons:

- The Trust has improved its performance in the most recent data available which is consistent with the targeted work. This ranges from better governance oversight, the implementation and utilisation of the IPC BAF and some estates changes, particularly within the Tower Block to reduce transmission.

Hull University Teaching Hospitals NHS Trust intends to take the following actions to improve this score, and so the quality of its services:

- continually monitoring performance at the Trust Infection, Prevention and Control Committee.
- the Trust has an evidence-based Clostridium difficile policy and patient treatment care pathway.
- multi-disciplinary team meetings are held for inpatient cases where required to identify any lessons to be learnt and post-infection review is conducted for hospital onset cases.

- As part of wider IPC improvements, launch a sustained bare below the elbow / back to basics campaign.

**The table below details performance against the number of patient safety incidents reported and the level of harm**

| Time period | Trust number of patient safety incidents reported | Trust rate of patient safety incidents reported per 1,000 bed days | Trust number of patient safety incidents reported involving severe harm or death | Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days | Percentage of safety incidents that resulted in severe harm or death |
|---|---|---|---|---|---|
| April 2021 – March 2022* | 17,760 | 55.0 | 43 | 0.30 | 0.24% |
| April 2022 – March 2023** | 18,467 | 45.6 | 102 | 0.25 | 0.55% |
| April 2023 – March 2024** | 20,722 | 47.6 | 113 | 0.27 | 0.55% |

**Source:** *NRLS Organisation data workbook for the reporting period April 2022 – March 2023. **From April 2022 there has been no data published nationally therefore this has been calculated internally by the Trust

The Hull University Teaching Hospitals NHS Trust intends to/has taken the following actions to improve this score, and so the quality of its services:

- The Trust continues to monitor incident rates locally and actively promotes and encourages staff to report all incidents including near misses as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicate a high level of safety awareness. This is particularly so when the high level of reporting is for no/low harm or near miss incidents.
- The Trust continues to monitor the data for understanding of key themes and sharing learning opportunities.
- In April 2023 the Trust commenced transition to the new Patient Safety Incident Response Framework (PSIRF) as part of the new national initiative. The Trust has completed a number of proportionate learning responses focusing on areas where improvement will have the greatest impact as outlined in the Trust's Patient Safety Investigation Response Plan. Findings from these reviews are used to identify themes and trends across the organisation for learning and improvement purposes.

# Part 3: Plans for the Future and Priorities for Improvement

This sections includes:


- 3.1 Plans for the future – consultation
- Priority One: End of Life
- Priority Two: Deteriorating Patient
- Priority Three: Sepsis
- Priority Four: Medication Safety
- Priority Five: Mental Capacity

# 3.1 2024/25 Quality Priorities

**Quality and Safety Improvement Priorities 2024/25**

For 2023/24 the Trust put together a list of potential quality improvement priorities by:

- Evaluating performance against the quality and safety priorities for 2023/24;
- Evaluating our performance against the quality improvement projects which are on the Trust's overall Quality Improvement Plan for 2023/24;
- Looking at national priorities and local priorities that have been agreed with our commissioners;
- Looking at what our regulators have identified as priorities, such as compliance with the CQC fundamental standards; and
- Areas we have identified as requiring improvement from incidents and patient feedback.

The Trust is now working closely with Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) as part of a Group. The Trust has agreed to combine the priorities as a Group and the approach was ratified by the Group's Quality and Safety Committee in Common. There was agreement that due to collective desire to fully embed new methodologies until significant improvement is achieved, and some constrains imposed by the ongoing PAS work at NLAG that no new topics should be considered and the existing 2023/24 quality priorities should be carried over to 2024/25. The below list demonstrates the priorities for both organisations for 2023/2024 which will be rolled forward into 2024/2025.

Our chosen priorities focus on patient safety, clinical effectiveness and patient experience as follows:

- **End of Life:** To improve personalised palliative and end of life care to ensure patients are supported to have a good death. *(Clinical effectiveness and patient experience).*
- **Deteriorating Patient:** Improved recognition and responding to the deteriorating patient. (Clinical effectiveness and patient safety).
- **Sepsis:** Improved recognition and responding to sepsis in patients. *(Clinical effectiveness and patient safety).*
- **Medication Safety:** To improve the safety of prescribing weight dependent medication to adults. (Clinical effectiveness and patient safety).
- **Mental Capacity:** Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording. *(Clinical effectiveness and patient experience).*

For HUTH, of the five priorities selected for 2024/25, *End of Life* and *Deteriorating Patient* reflect new additional priorities. The benefit of being part of the Group with NLAG means that we can apply significant learning from the work they have undertaken during 2023/24 to improve in these areas.

Our 2023/24 priorities in respect of *Learning from incidents* and *learning from deaths* will continue to be embedded as part of our routine governance processes which we have redesigned as part of our Group working.

# 2024/25 Priority One: End of Life

### Why is this important?

As stated by the National End of Life Care Strategy 2008, 'How we care for the dying is an indicator of how we care for all sick and vulnerable people'

Death and dying are inevitable therefore, palliative and end of life care must be a priority, as outlined in the ambitions for Palliative and End of Life Care.

| Aims | Objectives | Key Performance Indicators |
|---|---|---|
| • To improve personalised palliative and end of life care to ensure patients are supported to have a good death<br>• Improving the identification of patients at the End of Life at an earlier stage.<br>• Develop a mandated End of Life education programme and align to group structure. | • Asking what matters to patients<br>• Identify challenges staff face within end of life care<br>• Complete Trust Wide End of Life Survey Baseline.<br>• Follow-up Focus Groups with Staff, Bereaved Relatives<br>• Participation in the national audit of care at the end of life (NACEL)<br>• Triangulate data in regards to SJR's and PALS/Complaints and collaborate with of life providers regarding of End of Life Care to identify themes and learning.<br>• Increase community engagement promoting talking about death and dying and engaging with national initiatives.<br>• Establish regular End of Life Forum for staff support. | • Specialist Palliative Care Dashboard<br>• National Audit of Care at the End of Life (NACEL)<br>• Trust wide End of Life Survey Results<br>• Training data for the End of Life education programme. |

### Planned outcomes:

- **Patient Experience:** Patients and their friends and family will received personalised holistic palliative and end of life care.
- **Quality Experience:** Providing high quality patient centre end of life care.
- **Staff Benefits:** Improved support for staff through education and support forums.
- **Organisational Benefits:** Improved patient, carers and staff experience of Palliative and End of Life Care. Provide assurance and maintain a positive organisational reputation

### Monitoring arrangements:

- The project will be led by the End of Life /Specialist Palliative Care Team and supported by the Quality Improvement Team.
- Delivery of the project will be monitored by the:
  - End of Life Steering Group
  - Corporate Patient Experience Effectiveness and Safety Committee

# 2024/25 Priority Two: Deteriorating Patient

## Why is this important?

In order to improve the safe and effective care of patients in the communities and hospitals of Humber Health Partnership, it is of fundamental importance that we are able to recognise and act when our patients show signs of physical deterioration.

| Aims | Objectives | Key Performance Indicators |
|---|---|---|
| • Improve the identification and management of the deteriorating patient.<br>• Improve the outcome of patients with high NEWS2 score. | • Improve documentation for recording NEWS2 scores to support with appropriate escalation of the deteriorating patient.<br>• Improve patient outcomes from reduced readmission rates. | • Reduced number of incidents causing harm due to failure to recognise or respond to deterioration.<br>• Recording of and response to NEWS2 score for unplanned critical care admissions. New stretch target 80%.<br>• Percentage of adult observations recorded on time. New stretch target of 95% and reduction in grace period to within 15minutes.<br>• Evidence of Situation Background Assessment Recommendation (SBAR) escalation. Target 30%. |

## Planned outcomes:

- **Patient Experience:** Patients will receive the appropriate level of care in a timely manner to support optimised recovery.
- **Quality Experience:** Timely interventions and treatments provided.
- **Staff Benefits:** Staff will have improved knowledge and understanding of the deteriorating patient.
- **Organisational Benefits:** Improved care pathways for patients and reduction in mortality rates.

## Monitoring arrangements:

- The project will be led by the Associate CMO for Quality and Safety and supported by the Quality Improvement Team.
- Delivery of the project will be monitored by the Mortality and Morbidity Committee with reporting and escalation to the Group's Quality and Safety Committee in Common for assurance.

# 2024/25 Priority Three: Sepsis

### Why is this important?

Sepsis is defined as life-threatening organ failure in response to infection. Sepsis is one of the most common causes of patient deterioration and organ failure. It is vital to differentiate sepsis from other causes of patient deterioration. The Trust is committed to improving outcomes in relation to the early identification of sepsis and treatment.

| Aims | Objectives | Key Performance Indicators |
|---|---|---|
| • Improve the identification and management of patients with Sepsis<br>• Improve the outcome of patients with Sepsis. | • Improve compliance with administering antibiotics within appropriate timescales for patients with sepsis.<br>• Increase compliance rates for the 'Infection and Sepsis Screening and Management Pathway' | • Maintain/improve SHMI diagnosis groups outcome risk percentage (Note: to include diagnosis groups related to infections). Target is to be below England average.<br>• Adult primary sepsis screening completed within 15 minutes in response to elevated NEWS2 score. Target 90%.<br>• Paediatric Sepsis screening tool completed on presentation to ED/Paediatric Assessment Unit. Target 90%. |

### Planned outcomes:

- **Patient Experience:** Patients will receive the appropriate level of care in a timely manner to support optimised recovery.
- **Quality Experience:** Timely interventions and treatments provided.
- **Staff Benefits:** Staff will have improved knowledge and understanding of Sepsis and the required treatment and timescales.
- **Organisational Benefits:** Reputational benefits, improved care pathways for patients, reduction in mortality outlier status.

### Monitoring arrangements:

- The project will be led by the Associate CMO for Quality and Safety and supported by the Quality Improvement Team.
- Delivery of the project will be monitored by the Sepsis Steering Group and Mortality and Morbidity Committee with reporting and escalation to the Group's Quality and Safety Committee in Common for assurance.

# 2024/25 Priority Four: Medication Safety

### Why is this important?

Medicines optimisation is a patient-focused approach that aims to maximise the benefits of medication through enhanced patient care and collaboration between healthcare professionals, patients, and caregivers. It involves ensuring that the right patient receives the appropriate medication at the correct time.

In line with the NHS Patient Safety Strategy, healthcare providers must be committed to minimising risk and harm to patients, ensure quality, effective care alongside good patient experience. Medication safety contributes to optimising medications, saving lives, promoting a transparent reporting culture to learn from mistakes, decrease errors and harm, and reduce over-prescribing.

The following table outlines the key aims and objectives alongside some key performance indicators for the quality priority:

| Aims | Objectives | Key Performance Indicators |
|---|---|---|
| • Collaborative approaches with the group and system wide partners to improve medicines optimisation.<br>• Improving medication safety through learning from incidents to promote a just reporting culture and reduce harm.<br>• Explore digital solutions to improve medicines optimisation.<br>• Support anti-microbial stewardship initiatives across the group. | • Harmonisation of policies and procedures across the group to support staff to keep patients safe.<br>• Joint area prescribing committee to support formulary of medicines.<br>• System wide approach to managing medicines and medication safety.<br>• Development, alignment and collaborative working for medicines governance meetings e.g. safer medicines prescribing committee prescriber, medicines and therapeutics committee, medical gas committee and non-medical prescribing group.<br>• Review digital systems to improve patient safety from medicine related incidents including ePMA, electronic medicines storage and identifying suitable solutions. | • Reduction in harm impact for weight related medication-prescribing incidents.<br>• Weight recorded in ePMA within 24 hours of admission. Target 80%.<br>• Weight recorded in ePMA within 48 hours of admission. Target 95%<br>• Improve medicine reconciliation within 24 hours of admission<br>• Increase in the number of near miss or no harm medication related incidents |

### Planned outcomes:

- **Patient Experience:** Patients and carers will be involved in decisions made about their medication. Patients will be supported to take their medicines as intended. Improved patient experience will support enhanced clinical outcomes.
- **Quality Experience:** Enhanced patient safety and experience relating to medication.
- **Staff Benefits:** Workforce planning, development, education, and training to support and deliver optimal use of medicines. Services will be delivered by competent and well-trained staff.
- **Organisational Benefits:** Supporting services to the best value out of medicines and Pharmacy.

### Monitoring arrangements:

- The project will be led by the Chief Pharmacists and supported by the Quality Improvement Team.
- Delivery of the project will be monitored by the Medicines oversight group with reporting and escalation to the Group's Quality and Safety Committee in Common for assurance.

# 2024/25 Priority Five: Mental Capacity

### Why is this important?

All patient should be involved in decision making in their health care. This upholds our statutory duty to the Mental Capacity Act (2005).

Where patients are assessed as having an impairment of the mind or brain that may impact on their decision making all reasonable adjustments must be made and demonstrated to allow the patient to make their own decision.

When a patient is assessed as lacking capacity, the law requires health professionals to provide clear documentary evidence of this assessment and adherence to the best interest process. By adhering to the law this balances the wishes of the patient and the proposed actions of the health professional.

| Aims | Objectives | Key Performance Indicators |
|---|---|---|
| • Where health professionals identify that a patient may have an impairment of the mind or brain, the mental capacity assessment and best interest process, is correctly followed | • Review current paper/digital pathways on how health professionals determine if the patient is able to make their own decisions<br>• Complete review of available MCA training and implement changes in collaboration across NHS Humber Health Partnership<br>• Baseline data of surgical consent training<br>• Review AMAT database relating to consent audits and adherence to MCA process – e.g. surgical consent 4 process<br>• Digitalise Deprivation of Liberty Safeguards (DoLS) application process<br>• Embed MCA process within Diamond Standards pathways | • Clear MCA process guidance across all operational care groups<br>• All relevant patients identified on the Enhanced Care Assessment tool<br>• Identified staff groups attend MCA training (compliance at 85%)<br>• Identified staff groups attend surgical consent training (compliance at 85%)<br>• 95% of DoLS applications are successful on first submission<br>• 95% of surgical consent form 4's have associated MCA documentation |

### Planned outcomes:

- **Patient Experience:** Patients are involved making decisions about their health care/support needs. This may include providing reasonable adjustments and independent mental capacity advocates (IMCA)
- **Quality Experience:** Provide patient-centred care and treatment
- **Staff Benefits:** Safe practice within professional registration
- **Organisational Benefits:** Adherence to legislation, provide inspection assurance and maintain a positive organisational reputation

**Monitoring arrangements:**

- The project will be led by the Safeguarding Team and supported by the Quality Improvement Team.
- Delivery of the project will be monitored by;
  - Cross sectional case note review based on the Diamond Standards pathway
  - Quarterly DoLS audit
  - Surgical consent audit via AMAT
  - Linking with Consent Task and Finish Group
  - PSII investigations
  - Data received from IMCA Advocacy Agency
  - Data received from Patient Experience – PALS/Complaints
  - Training records
- Escalation to the Group's Quality and Safety Committee in Common for assurance.

# ANNEXES

This section includes:


- Annex 1:
    - Statements from Key Stakeholders
    - Trust response to Stakeholder Statements
- Annex 2:
    - Statement of Directors' Responsibilities in respect of the Quality Account
- Annex 3
    - Abbreviations and definitions
    - How to provide feedback
    - Other formats

# Annex 1: Stakeholder feedback

This section includes:


- Statement from NHS Humber and North Yorkshire Integrated Care Board (ICB)
- Joint Statement from Healthwatch Kingston upon Hull and Healthwatch East Riding of Yorkshire
- Hull Overview and Scrutiny Committee
- East Riding Overview and Scrutiny Committee.
- Trust response to Stakeholder Statement

# Statements from Key Stakeholders

***Statement from NHS Humber and North Yorkshire Integrated Care Board (ICB)***

***Joint Statement from Healthwatch Kingston upon Hull and Healthwatch East Riding of Yorkshire***

***Hull Overview and Scrutiny Committee***

***East Riding Overview and Scrutiny Committee***

***Trust response to Stakeholder Statement***

# Annex 2: Statement of Directors' Responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS trust boards on the form and content of annual quality accounts (which incorporate the above legal requirements) and on the arrangements that NHS Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The content of the Quality Account meets the requirements set out in the supporting guidance published by NHS England for 2023/24
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2023 to March 2024
    - Papers relating to quality reported to the board over the period April 2023 to March 2024
    - Feedback from commissioners
    - Feedback from Local Healthwatch organisations
    - Feedback from Overview and Scrutiny Committees
    - Latest national inpatient survey 2022
    - Latest national staff survey 2024
    - CQC inspection report published March 2023 and August 2023
- The Quality Account presents a balanced picture of the NHS Trust's performance over the period covered;
- The performance information reported in the quality account is routinely quality checked to ensure it is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality account is routinely quality checked to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with NHS England's supporting guidance and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

.

**Chair:** **Date:**

**Group Chief Executive:** **Date:**

# Annex 3

This section includes:

- Abbreviations and Definitions
- How to provide feedback
- Other formats

# Abbreviations and Definitions

The below table is a list of abbreviations and definitions used throughout the Quality Accounts:

| Abbreviation | Definition |
|---|---|
| Audit | An audit is a way to find out if healthcare is being provided in line with standards and let's care providers and patients know where their service is doing well, and where there could be improvements. |
| Barrett Values survey | The Barrett Values Survey is used to identify the values of individuals and groups through a series of assessments. |
| CQC | Care Quality Commission (CQC) regulates and monitors the Trust's standards of quality and Safety. |
| CAS | The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. |
| CEPPD | Clinical, Effectiveness, Policies and Practice Development Committee |
| CHCP | City Healthcare Partnership CIC |
| CHH | Castle Hill Hospital |
| Clinical Audit | This is a quality improvement process that looks at improving patient care and outcomes through a review of care against a set of criteria. This helps to ensure that what should be done in a Trust is being done. |
| Clinical Commissioning Group (CCG) | Clinical Commissioning Groups (CCGs) commission a majority of the hospital and community NHS services in the local areas for which they are responsible. Commissioning involves deciding what services are needed for diverse local populations and ensuring that they are provided. |
| Clinical Outcomes | A clinical outcome is the "change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions. |
| Clinical Research | Clinical research is a branch of medical science that determines the safety and effectiveness of medication, diagnostic products, devices and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease. |
| Commissioning for Quality & Innovation (CQUIN) | A payment framework which enables commissioners to reward excellence, by linking a proportion of payments to the achievement of targets |
| COVID-19 | A highly contagious respiratory disease caused by the SARS-CoV-2 virus. |
| Data Quality | Ensuring that the data used by the organisation is accurate, timely and informative. |
| DATIX | DATIX is the Trust wide incident reporting system |
| Duty Of Candour | Involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. |
| ED | The Emergency Department (ED) assesses and treats people with serious injuries and those in need of emergency treatment. Its open 24 hours a day, 365 days of the year. |
| 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 |

| Abbreviation | Definition |
|---|---|
| | morale. It also means involving all key stakeholders in every step of the process to help us provide high quality care. |
| ePMA | Electronic Prescribing and Medicines Administration |
| 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. |
| Fundamental Standard Inspections | A formal review process, which reviews objectively the quality of care delivered by our clinical teams, is set around nine fundamental standards, with the emphasis on delivering high quality, safe effective care. Each fundamental standard is measured against a set of key questions that relate to that specific standard of care. |
| Health and Wellbeing Boards | Health and wellbeing boards are statutory bodies whose role is to promote integrated working among local providers of healthcare and social care. |
| 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 | Healthwatch is an independent national champion for people who use health and social care services. |
| HUTH | Hull University Teaching Hospitals NHS Trust |
| HRI | Hull Royal Infirmary Hospital |
| 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. |
| Lorenzo | The Trust's electronic patient record system |
| National Patient Safety Agency Alerts | Through analysis of reports of patient safety incidents, and safety information from other sources, the National Reporting and Learning Service (NRLS) develops advice for the NHS that can help to ensure the safety of patients. Advice is issued to the NHS as and when issues arise, via the Central Alerting System in England and directly to NHS organisations in Wales. Alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices. |
| Near Miss | A Near Miss is an incident that had the potential to cause harm, loss or injury but was prevented. These include cyber, clinical and non-clinical incidents that did not lead to harm, loss or injury, disclosure or misuse of confidential data but had the potential to do so. |
| NerveCentre | An electronic patient record system which provides the electronic capture of patient information, via hand held devices, at the bedside, enabling timely and accurate data collection. |
| Never Event | A Never Event is a type of serious incident (SI). These are defined as 'serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. |
| NEWS2 | National Early Warning Score (NEWS) is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate |

| Abbreviation | Definition |
|---|---|
| | and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness. |
| **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. |
| **NHSI** | NHS Improvement (NHSI) is a non-departmental body in England, responsible for overseeing the National Health Service's foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. |
| **NICE** | The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to health and social care organisations to ensure the service provided is safe, effective and efficient. |
| **NIHR** | The National Institute for Health Research commissions and funds research in the NHS and in social care. |
| **NLAG** | Northern Lincolnshire and Goole NHS Foundation Trust is a Group member alongside Hull University Teaching Hospitals NHS Trust in the new NHS Humber Health Partnership. |
| **NMC** | The Nursing and Midwifery Council (NMC) are the professional regulator for nurses and midwives in the UK, and nursing associates in England. |
| **NRLS** | National Reporting and Learning Service is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. |
| **PPE** | Personal Protective Equipment is equipment that will protect the user against health or safety risks at work. It can include items such as safety helmets, gloves, eye protection, high-visibility clothing, safety footwear and safety harnesses. It also includes respiratory protective equipment. |
| **QIP** | Quality Improvement Plan (QIP) - The purpose of this plan is to define, at a high level; the overall continuing quality improvement journey the Trust is making and the improvement goals that the trust will work towards over the next 12 months. The plan includes all of the MUST DO and SHOULD DO recommendations in the CQC Quality Reports and detailed plans are being developed for each project/work area. However, the plan is broader than those actions and includes longer-term pieces of work that the trust is pursuing to improve overall quality and responsiveness across the organisation, for example in relation to Quality Accounts. |
| **RCEM** | The Royal College of Emergency Medicine (RCEM) is an independent professional association of emergency physicians in the United Kingdom which sets standards of training and administers examinations for emergency medicine in the United Kingdom and Ireland. |
| **RECOVERY** | Randomised Evaluation of COVID-19 Therapy is an international clinical trial aiming to identify beneficial treatments for people hospitalised with suspected or confirmed COVID-19 |
| **ReSPECT** | A Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) provides a summary for a person’s clinical care and treatment in a future emergency in which they do not have capacity to make or express choices |

| Abbreviation | Definition |
|---|---|
| **Root Cause Analysis (RCA)** | RCA is a method of problem solving that tries to identify the root causes of faults or problems. |
| **Sepsis** | Sepsis is a medical condition that is characterised by a whole body inflammatory state and the presence of a known infection. |
| **Serious Incident (SI)** | An SI is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern. |
| **SHMI** | Standardised Hospital Mortality Indictor - is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations. |
| **SIREN** | SARS-CoV-2 Immunity and Reinfection EvaluatioN – national study to better understand whether individuals who have recovered from COVID-19 are protected from future SARS-CoV-2 infection |
| **Stakeholders** | A group of people who have a vested interest in the way Hull University Teaching Hospitals NHS Trust operates in all aspects. For example, the deliverance of safe and effective patient care. |
| **SystmOne** | An electronic patient record system |
| **Task and Finish Group** | A Task and Finish group is a group set up as a sub group as part of larger project group and looks at specific items that needs to be delivered. |
| **Tissue viability** | Tissue viability is a speciality that primarily considers all aspects of skin and soft tissue wounds including acute 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. |
| **Virginia Mason Institute** | Virginia Mason Institute works with organisations worldwide to continuously innovate and solve healthcare's largest challenges. |
| **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, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE). |

# How to provide feedback

**We would like to hear your views on our Quality Account**

The Quality Account gives the Trust the opportunity to tell you about the quality of services we deliver to our patients. We would like your views to help shape our report so that it contains information which is meaningful to you and reflects, in part, the aspects of quality that matters most to you.

If you have any feedback regarding the Quality Account please e-mail your comments to:
hyp-tr.quality.accounts@nhs.net

However, if you prefer pen and paper, your comments are welcome at the following address:

**The Compliance Team**
**Quality Governance and Assurance Department**
Medical Education Centre
Hull Royal Infirmary
Anlaby Road
Hull
HU3 2JZ

# Other formats

This document can also be made available in various languages and different formats including Braille, audio tape and large print.

For more information, you can contact Rebecca Thompson:

**Call:** (01482) 674828

**Email:** Rebecca.thompson71@nhs.net

**Write to:** Rebecca Thompson
Corporate Affairs
Alderson House
Hull Royal Infirmary
Hull
HU3 2JZ

# Northern Lincolnshire & Goole NHS Foundation Trust

# Annual Quality Account

# 2023/2024

Compassion - Honesty - Respect - Teamwork

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# PART 1: Statement on quality from the Chief Executive of the Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)

I would like to start this statement by thanking all our staff. I joined the Trust as Group Chief Executive, in a joint role with Hull University Teaching Hospitals (HUTH), in August 2023. Since my first week I have spent much time visiting services across NLaG's three hospitals and community services and speaking with staff. I am privileged to have met so many committed, hard-working staff who want to make a real difference to patients.

As with every part of our NHS, our services are under pressure. The Covid-19 pandemic had an impact on already long waiting lists and I am sorry for the extended waiting times that a number of our patients have had. I am pleased that our Trust was able to continue treating some of its elective patients during the pandemic, working in partnership with neighboring organisations. Our staff worked hard to treat patients who had waited the longest in this reporting year of 2023-24 and I thank all the teams involved in doing that.

We have seen increased pressure on our two Emergency Departments (EDs). Greater numbers of patients have presented to our Departments as well as an increase in ambulance conveyances, similar to other parts of the country. The target to see and admit or discharge patients in Emergency Departments was 76% for March 2024, and was a target we were not able to meet. Whilst we did manage to see and treat most patients in four hours 60% of the time during the year, this is not good enough and I am sorry that this has been our patients' experience.

Our patient wards have had consistently high levels of occupancy. As such, many patients who needed to be admitted had to wait a long time. Far too many waited longer than 12 hours and I sincerely apologise to these patients for this poor experience.

The patients and staff working in the EDs are starting to see the benefits of our investment in the new departments at both Grimsby and Scunthorpe. Building work continued in areas close to both new EDs to create Integrated Acute Assessment Units (IAAUs) and Same Day Emergency Care (SDEC) facilities at both hospitals. The Grimsby unit opened in winter 2023 and the Scunthorpe units opened in April 2024.

However, many staff face the challenge of providing patient care in wards and areas that are of quite poor quality and in need of investment or refurbishment. The Trust Board is acutely aware of this issue, and we are exploring ways to bring in much needed capital to improve these areas as well as those buildings where our support staff face similar working conditions.

Our staff remained focused on patient care during periods of industrial action taken by medical staff around their national terms and conditions. Thank you to everyone who worked over these periods as well as staff who have worked closely with patients whose appointments had to be cancelled and rescheduled. We did, by the end of the year, more or less catch up on our backlogs with a reduction in 65 week waits, which is a fantastic achievement in the circumstances.

Since joining the Trust in August 2023, I have been working with senior staff to put in

place a single shared Executive team as well as a new clinical service structure for the NHS Humber Health Partnership, the new branding name for the Group organisation. With new leadership teams in place in our 14 clinical service care groups as well as a new Group Executive Team too. The next financial year will be one where we can really start to realise the benefits of Group working.

As reported in the 2022/23 Quality Account the Care Quality Commission inspected NLaG's hospitals and community services in early 2022 and published their report in December 2022. The progress the Trust had made was recognised in May 2023 when NHS England, the Trust's regulator, took the decision to allow NLaG to exit the Recovery Support Programme. This was important step and recognised the Trust's progress improving both its clinical services and its financial position. The CQC also identified areas that required further improvements and teams across the Trust have put together a comprehensive action plan to respond to the improvement requirements of the CQC's published report. This will remain a key area of focus in 2024/25.

End of Life (EOL) care was the single area where the CQC rating was 'Inadequate', their lowest available rating. This is why EOL was chosen as one of our five quality priorities for 2023/24, specifically to improve personalised palliative and end of life care to ensure patients are supported to have a good death. There has been the successful recruitment of three additional specialist palliative care clinical nurse specialists and an EOL practice educator. Implementation of seven-day Specialist Palliative Care started at Scunthorpe hospital in August 2023 utilising single point for WebV (electronic) referral. Collaborative working with the Care Plus Group has enabled electronic referrals to the EOL team to be rolled out at Grimsby Hospital in October 2023. A training video for doctors to help recognition of EOL pathway at an earlier stage has been developed. The percentage of in hospital deaths with anticipatory medications prescribed has significantly increased to 93% in February 2024 from 27.7% in 2023.

We have also seen significant progress in other areas of our quality priorities, in particular the Deteriorating Patient workstream, with sustained improvement in the percentage of adult observations recorded on time exceeding the 90% target. The Trust has also sustained achievement of the Commissioning for Quality and Innovation (CQUIN) recording and response to the National Early Warning Score (NEWS2) for unplanned critical care admissions, exceeding the maximum national target 30% in all three quarters to date with the latest quarter 3 compliance of 76.92%.

Our commitment to delivering safe maternity care has been recognised by CQC with their latest inspection of our Midwifery led unit at Goole being rated as Good overall. The Trust also achieved all 10 safety actions in the NHS Resolution Maternity Incentive Scheme. Actions included making sure we have an effective workforce in place, ensuring we co-produce maternity services with the Maternity and Neonatal Voices Partnership, showing we have a process in place for getting feedback from people using our services and making sure processes are in place to keeps mums and babies together where possible. This is great news for anyone using our maternity services, as it gives us confidence that the care is of the highest standard.

As has been reported in previous Quality Accounts our challenge for 2024/25 will be to make sure our staff are able to offer the best possible patient care, by looking after our staff and supporting them whilst, at the same time, we do everything we can to reduce

our waiting times and managing the increased demand we are experiencing for urgent and emergency care. I know our staff will continue to rise to the challenge ahead and would like to close this statement by thanking them once again.

I can confirm that the Board of Directors has reviewed this report and can confirm that, to the best of my knowledge, the information contained within it is an accurate and fair account of our performance.

Signature:

**Group Chief Executive and Accountable Officer:** Jonathan Lofthouse
Northern Lincolnshire and Goole NHS Foundation Trust
**Date:**

## About Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust (referred to as 'the Trust' throughout this report) consists of three hospitals and community services in North Lincolnshire. The Trust provides acute hospital services and community services to a population of more than 450,000 people across North and North East Lincolnshire and East Riding of Yorkshire and has approximately 750 beds across three hospitals. The site locations are:

- Diana, Princess of Wales Hospital in Grimsby (also referred to as DPoW),
- Scunthorpe General Hospital located in Scunthorpe (also referred to as SGH),
- Goole & District Hospital (also referred to as GDH), and
- Community services in North Lincolnshire.

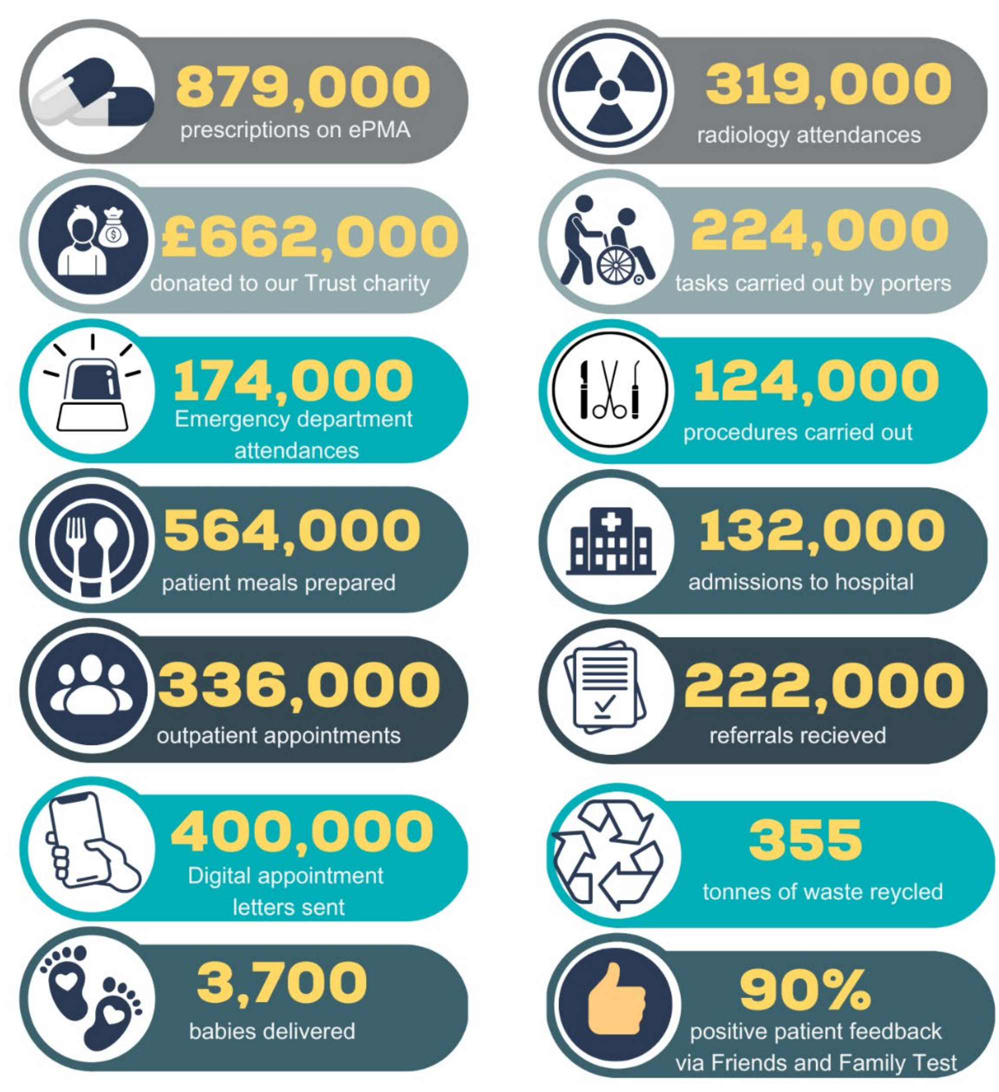
The Trust was originally established as a combined hospital Trust on April 1 2001, and achieved Foundation Status on May 1 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the Trust became a combined hospital and community services Trust (for North Lincolnshire). As a result of this the name of the Trust, while illustrating the geographical spread of the organisation, was changed during 2013 to Northern Lincolnshire and Goole NHS Foundation Trust to reflect that the Trust did not just operate hospitals in the region. The Trust is now part of a Group – NHS Humber Health Partnership – as we work more closely with our colleagues at Hull University Teaching Hospitals NHS Trust.

The Group manages five main hospitals sites: Hull Royal Infirmary, Grimsby Diana Princess of Wales Hospital, Scunthorpe General Hospital, Castle Hill Hospital and Goole Hospital. It provides a wide range of community services across North and North East Lincolnshire, including district nursing, physiotherapy, psychology, podiatry and specialist dental services.

NHS Humber Health Partnership employs over 17,000 staff, sees more than 1,000,000 patients each year and has a budget of £1.4bn.

# 2023/2024

# A YEAR IN NUMBERS

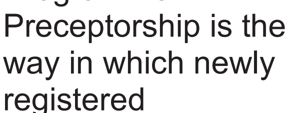


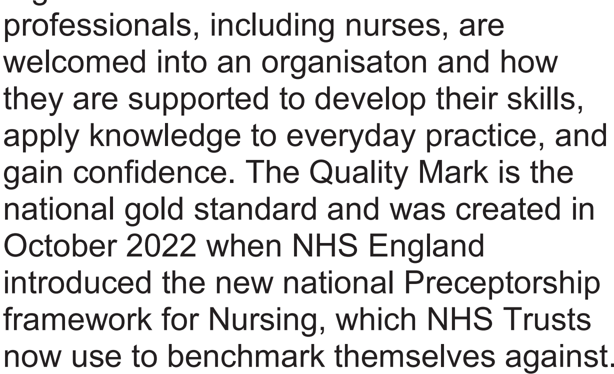

Figures from 1 April 2023 to 31 March 2024. Rounded figures used

**Figure 1: 2023/24 - A year in numbers**

## Proud Moments of 2023/24

The Trust have received the National Preceptorship for Nursing Quality Mark from the NHS England National Preceptorship Programme. Preceptorship is the way in which newly registered professionals, including nurses, are welcomed into an organisaton and how they are supported to develop their skills, apply knowledge to everyday practice, and gain confidence. The Quality Mark is the national gold standard and was created in October 2022 when NHS England introduced the new national Preceptorship framework for Nursing, which NHS Trusts now use to benchmark themselves against.






Our Macmillan Information Centre at Scunthorpe has been awarded an accreditation in recognition of the high-quality service it provides. The centre has not only achieved the Macmillan Quality Environment Mark (MQEM) award, but received the highest possible overall score, exceeding the level required to maintain the standard. The MQEM award recognises environments that meet the standards required by people living with cancer and celebrates those that go above and beyond to create welcoming and friendly spaces.

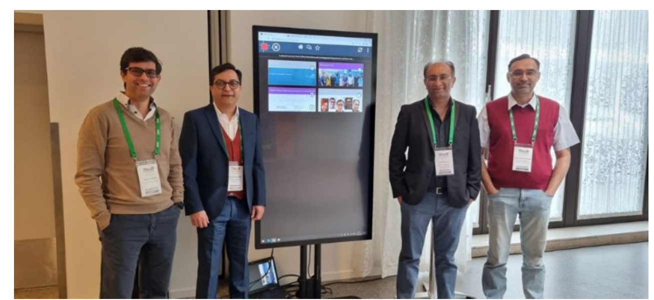
The Hospital at Home team at Grimsby hospital was selected from more than 900 entries as finalists in the Community and General Practice Nursing category of the Royal College of Nursing (RCN) Nursing Awards for supporting children to remain at home with their families. Families overwhelmingly rate the service as excellent.

The Safeguarding team and WebV team were shortlisted as finalists at the Health Service Journal (HSJ) Partnership Awards in the Safety Improvement Through Technology category. They have been recognised for transforming their referral system from an outdated, complex system using paper forms, telephone and webpage referrals, to a new streamline electronic system on WebV, our electronic patient record system.

Our new Same Day Emergency Care (SDEC) and Integrated Acute Assessment (IAA) units at the Diana, Princess of Wales Hospital and Scunthorpe General Hospital opened providing us with modern, well-equipped facilities that are purpose-built to meet the needs of our communities for years to come.

## Proud Moments of 2023/24

Medicine Division colleagues were honored



to present at the Society for Acute Medicine's Spring 2023 conference in Copenhagen. They highlighted the quality improvement approach they had taken in redesigning the Trust's emergency care pathways moving from Clinical Decisions Units to the Integrated Assessment Units and Same Day Emergency Care model.

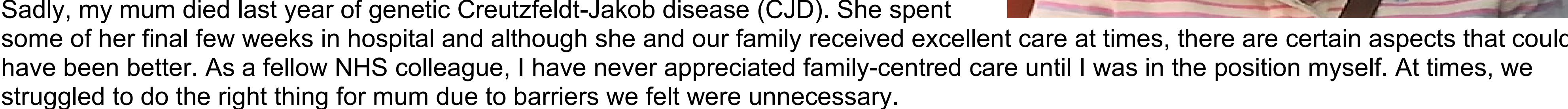
The Care Quality Commission (CQC) has rated the Trust's midwifery led unit within Goole District Hospital as good, following an inspection in November 2023.Our commitment to delivering safe maternity care has also been recognised by a national scheme as the Trust achieved all 10 safety actions in the NHS Resolution maternity incentive scheme.

The Trust's international recruitment efforts and commitment to colleague wellbeing has been recognised by a national NHS award. The NHS Pastoral Care Quality Award is a benchmark for recruitment of international nurses and midwives across England. By achieving the award, the Trust has demonstrated a commitment to supporting internationally educated nurses and midwives at every stage of our recruitment and beyond.

All three hospital sites were recognised for successfully achieving high quality data provision recognition with the National Joint Registry (NJR). The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes primarily for the benefit of patients, but also to support orthopaedic clinicians and industry manufacturers.

More than 250 staff attended the Trust's Quality Improvement (QI) conference to celebrate the great improvement work that is happening at the Trust.

# Carol’s Story – As Told By Her Daughter Sarah



I'm Sarah, my mum was a patient last year which has led me to work with the Trust on a new campaign to improve patient care and experience.

My mum, Carol, was a hairdresser by background but worked as a Phlebotomist at Scunthorpe hospital for 18 years. She was well known and popular with staff and patients because of her kind and empathetic nature. You could always hear her before you saw her, especially her distinctive laugh. She was a shopaholic, obsessed with Alan Titchmarsh and loved going for walks with my dad. She lived for her family.

Sadly, my mum died last year of genetic Creutzfeldt-Jakob disease (CJD). She spent some of her final few weeks in hospital and although she and our family received excellent care at times, there are certain aspects that could have been better. As a fellow NHS colleague, I have never appreciated family-centred care until I was in the position myself. At times, we struggled to do the right thing for mum due to barriers we felt were unnecessary.

For us, it was the little things that made a big impact. For example, due to the disease, mum's cognitive functions were declining rapidly. She experienced a long wait in the Emergency Department (ED) overnight with no access to food or drink. When we were able to feed her, we were spoken to by a staff member for sitting on the bed while trying to do so. She was moved wards during the night which was distressing for her and the presence of security in her room frightened her. As a family, we'd have liked to have spent more time with her on the ward to alleviate some of her confusion. We also felt it would be beneficial to assist with her feeding, but this didn't feel easy outside of visiting hours.

Sarah has worked in partnership with the Trust to improve some of the factors that negatively impacted on her mum’s care and experience and wanted a common sense, person centred approach. We agreed to focus on 4 aspects:

- Time lost with her family when ultimately all the life Carol had left was 5 weeks.
- Visiting – Sarah questioned if our visiting arrangements were really meeting the needs of hospital or patients and families.
- The best utilization of our Security staff when they are called for older confused people – Sarah asked what do staff want security to do & what are security able to do.
- Could the care for older people in emergency areas be improved and is there enough being done to ensure nutrition, hydration and comfort are being addressed for older people in ED’s.

Carol's Campaign was born out of a commitment to work in partnership with Sarah to make changes and influence culture. We agreed we were, without doubt, in this together.

We launched Carol's Campaign in March 2023 after it is presented to Trust Board by Sarah herself.

The key elements to the campaign were:

- Refining the level of security for frail/vulnerable patients.
- Reviewing the accessibility of visiting arrangements across the Trust.
- Positively influencing the culture through compassionate leadership.
- Enhancing the care of older people in the Emergency Department.

What we have done:

- We commenced a quality and compassionate improvement journey with Sarah endorsing all the aspects associated with this campaign as we wanted Carol's name to be synonymous with these partnership developments and for the positive changes to be a legacy to the positive life Carol led.
- We have reviewed thoroughly the training for our security leads to ensure they receive appropriate compassion training.
- We have commenced extended visiting from January 2024 and introduced Care Partners and we will review the visiting.
- We have shared Sarah's story and Carol's campaign widely throughout the Trust so all staff have access to this.
- We have worked closely with the Associate Chief Nurses to review our ED to assess the area and make any improvement needed.

What the changes aim to ensure is that we are providing compassionate and patient-centred care for people when they most need it. We know that having access to the person you need most when you are ill or in hospital can be massive and it can have a huge impact on a person's mental and physical wellbeing.

# PART 2: Priorities for improvement, statements of assurance from the Board and reporting against core indicators

## 2.1 Quality priority planning for 2024/25

In February 2024 the Trust migrated the Patient Administration System (PAS). In preparation for this significant undertaking, an information services development freeze was put in place in 2023/24 to divert resource to ensure the PAS transition was successful. The work involved to ensure a smooth transition has reduced resource available to support the electronic reporting on the full suite of process and balancing measures associated with the 2023/24 quality priorities which has in turn impacted on the pace of progress.

Drawing on triangulated information from a wide range of quantitative and qualitative data sources including complaints, incidents, inquests, litigations, Structured Judgment Reviews (SJRs), clinical audit, risk registers, staff, and patient surveys and linkages to the Trust's Quality Strategy a long list of potential 2024/25 quality priority topics was developed and shared with staff, the Trust Governors, stakeholders, the Quality Governance Group and the Trust's Quality and Safety Committees in Common. There was agreement that due to the constraints imposed by the ongoing PAS work and the collective desire to fully embed new methodologies until significant improvement is achieved no new topics should be considered and the existing 2023/24 quality priorities should be carried over to 2024/25. Therefore, the 5 quality priority topics for 2024/25 covering patient safety, clinical effectiveness, and patient experience will remain with stretch targets and a refocus on underlying workstreams:

(1) **End of Life:** To improve personalised palliative and end of life care to ensure patients are supported to have a good death. *(Clinical effectiveness and patient experience).*

(2) **Deteriorating Patient:** Improved recognition and responding to the deteriorating patient. *(Clinical effectiveness and patient safety*).

(3) **Sepsis:** Improved recognition and responding to sepsis in patients. *(Clinical effectiveness and patient safety).*

(4) **Medication safety:** To improve the safety of prescribing weight dependent medication to adults. *(Clinical effectiveness and patient safety).*

(5) **Mental capacity:** Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording. *(Clinical effectiveness and patient experience).*

Recognising that communication is a key element linked to our workstreams, it will be included within the quality priorities as an associated qualitative KPI where appropriate. Communication is known to be a broadly applicable element of many aspects of how care is provided, so focusing on patient communication for critical phases of care, such as End of Life and managing patients' mental capacity to make decisions are areas where undertaking patient and their carers views through surveys to gain insight into their

experiences brings value. We also see that elements of communication between staff can contribute to safe and effective care, so the Trust will explore this through the Deteriorating patient workstream as well.

Progress against the 2024/25 quality priorities will be monitored monthly through a defined approach of data analysis and review in the Quality and Safety section of the Integrated Performance Report (IPR), with overall outcome measures included in the Trust Board IPR. Success will be measured through tracking progress and trends against baseline and targets for each of the quality priorities associated Key Performance indicators (KPIs).

Assurance and performance against the quality priorities will also be monitored via the Trust's Quality & Safety Committee in Common, Quality Governance Group and Care Group's monthly performance meetings.

## 2.2 Looking back on our priorities for improvement in 2022/23

As part of the Trust's annual setting of priorities in 2023/24, the Trust had set 5 quality priorities:

(1) **End of Life:** To improve personalised palliative and end of life care to ensure patients are supported to have a good death.

(2) **Deteriorating Patient:** Improved recognition and responding to the deteriorating patient in patients age 16+.

(3) **Sepsis:** Improved recognition and responding to sepsis in patients.

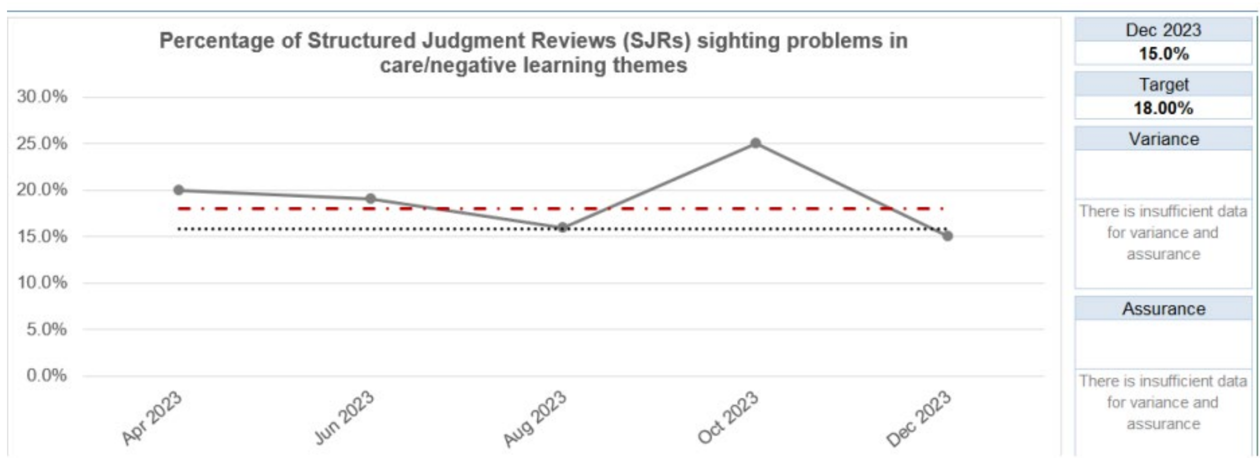
(4) **Medication safety:** To improve the safety of prescribing weight dependent medication to adults.

(5) **Mental capacity:** Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording.

The Trust has not fully achieved all its priority ambitions however there is evidential progress in several areas with sustained improvements. The graphs and narrative below show a summary of achievement against the key measures of success for each of the quality priorities.

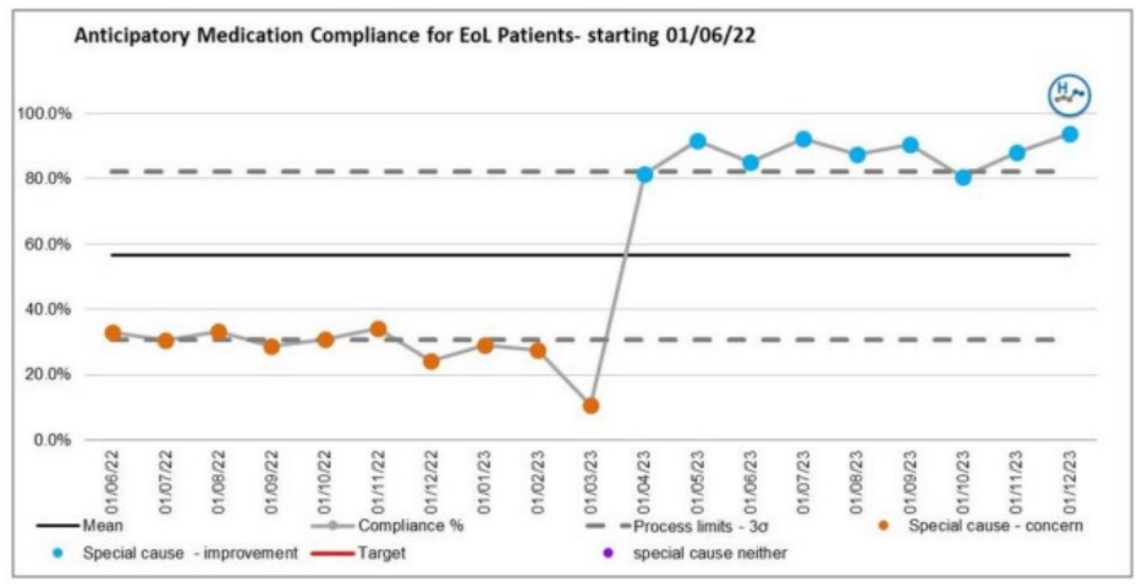
## End of Life - Summary of milestones achieved, challenges and next steps

**Outcome measure:** Reduction in the percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes associated with recognition of end of life pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation.




Progress has been made towards reducing the percentage of SJRs sighting problems in care/negative learning themes associated with recognition of end of life pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation with the latest data available in December 2023 achieving 15% which is below the 18% target (lower value is positive).

**Process measure:** Percentage of in hospital deaths with anticipatory medication prescribed.

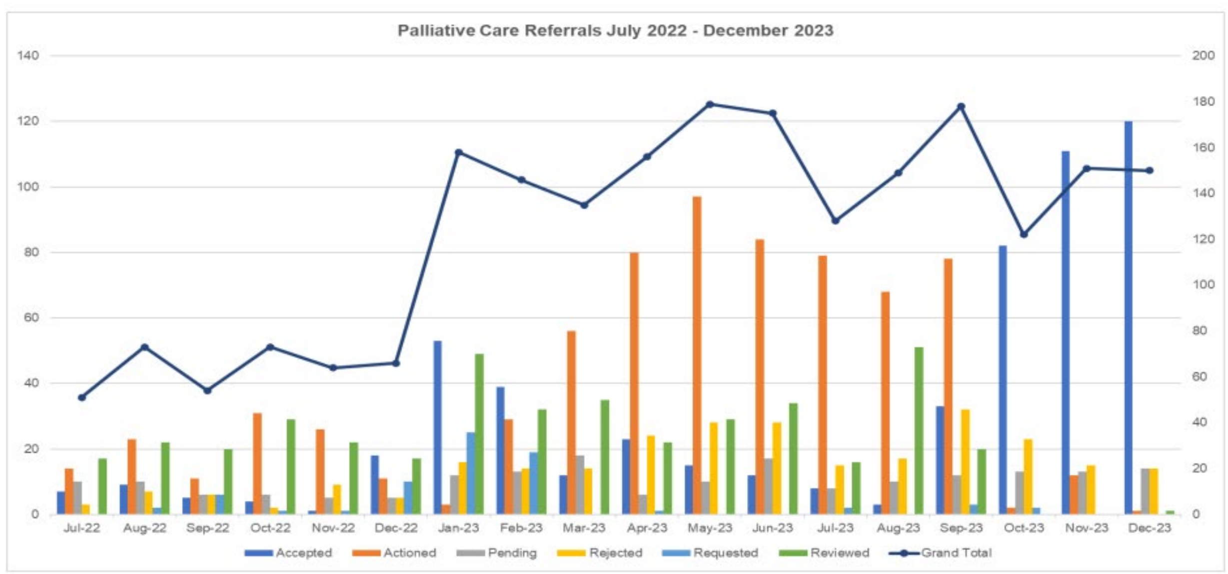



*Note: Data from 01/06/22 to 01/03/23 pulled from previous power BI data. From 01/04/23 data pulled direct from WebV.*

The deceased patient audit tool that captured data relating to anticipatory medication and linked to the End of Life PowerBI dashboard was moved from Sharepoint to WebV

in March 2023 as part of the End of Life QI project to improve completion compliance. Unfortunately, due to the PAS development freeze the information services team were not able to re-establish automated reporting of this metric. An interim report from WebV was produced which allowed manual identification of this data by the QI team. 94% of anticipatory medication was prescribed in December 2023 and the SPC chart shows special cause improvement since April 2023 coinciding with moving the tool from Sharepoint to WebV.

**Process measure:** Establish baseline of number of referrals to the End of Life team.




Due to the PAS development freeze automated reporting on the number of referrals to the End of Life and the time from referral to assessment was not possible. An interim report from WebV was produced which allowed manual identification of the number of referrals by the QI team to provide a baseline. It is hoped that reporting on the time from referral to treatment will be developed in 2024/25.

Implementation of 7-day Specialist Palliative Care commenced at SGH on 5 August 2023 utilising single point for WebV referral. Collaborative working with Care Plus Group enabled electronic referrals to the End of Life team to be rolled out at DPoW in October 2023.

There has been successful recruitment of three additional specialist Palliative care clinical nurse specialists and an End of Life practice educator. A gap in access to a Palliative Care Consultant at DPoW remains despite recruitment drives. Planned increase in Consultant capacity is on hold in both North Lincolnshire and North East Lincolnshire currently due to changes in allocated funds. Next steps regarding medical staffing are being considered through the Northern Lincolnshire Strategy Group as a new business case will be required.

An End of Life staff survey was launched to help understand the challenges and areas of focus. There were 109 responses and wards 22 and 17 at SGH and wards IAAU and C3 at DPoW became pilot wards to allow targeted support. Following success in the pilot wards, the care in the last days of life document was electronically rolled out Trust wide significantly increasing completion compliance.

The use of ReSPECT forms is now fully rolled out in all areas. Work has been completed to help improve the level of communication in our discharge summaries around DNACPR decisions and ceiling of care recorded on ReSPECT forms.

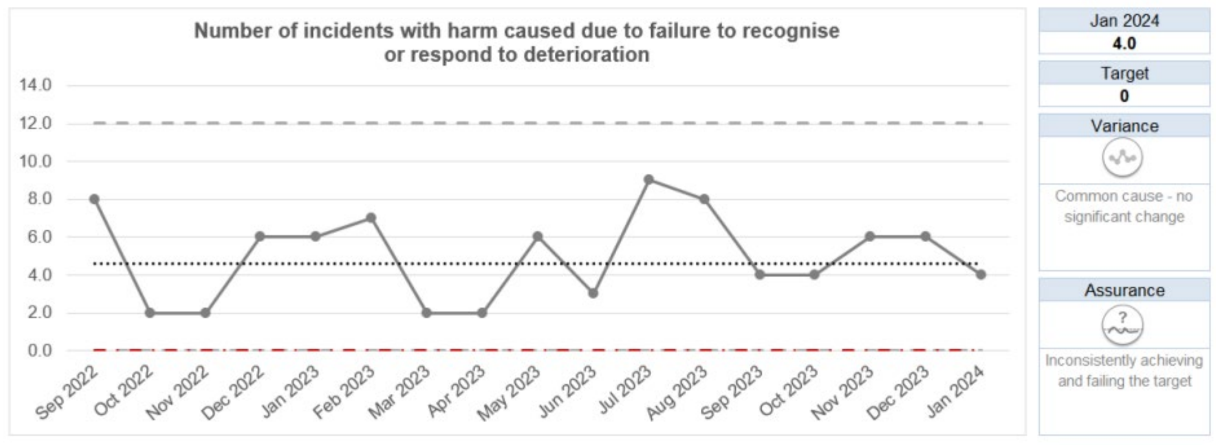
The divisional Doctors Induction has been updated to include an early introduction to ReSPECT and End of Life. Recognition and care planning are included in training delivered by the specialist End of Life team with different options of training delivery offered to improve compliance, including face to face, virtual training and targeted sessions. A training video for doctors to help recognition of End of Life pathway at an earlier stage has been recorded and a tiered approach to training is in development. A questionnaire for Medical staff has been launched to further understand the barriers to early recognition of End of Life and decision making to stop active treatment.

A patient and carer survey has been developed with support from Healthwatch to further understand patient and family experience related to end of life/palliative care communication.

A conference to understand the barriers to early End of Life recognition is planned for June 2024. The focus of the 2024/25 End of Life quality priority will be on improving recognition of End of Life pathway at an earlier stage.

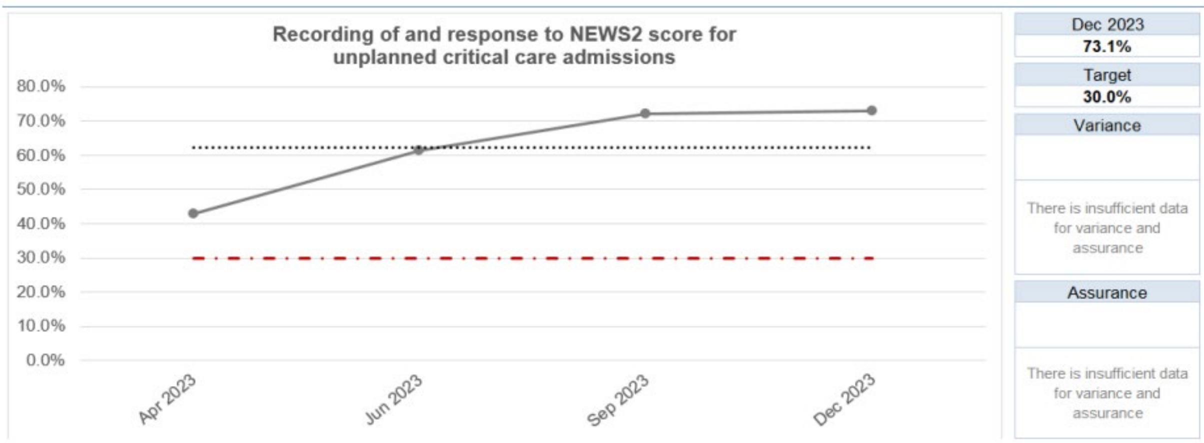
## Deteriorating Patient - Summary of milestones achieved, challenges and next steps

**Outcome measure:** Reduction in the number of incidents with harm caused due to failure to recognise or respond to deterioration.



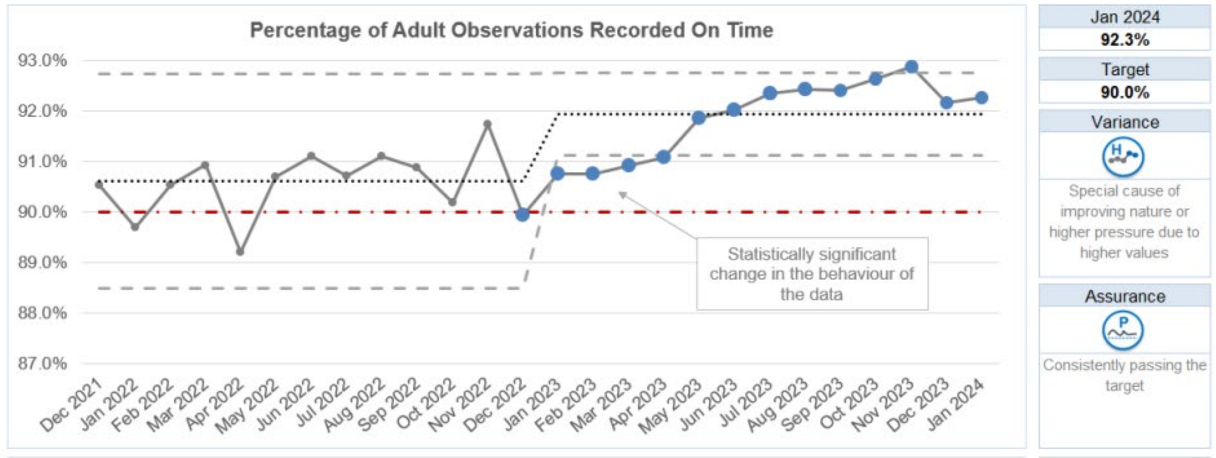

The SPC chart shows normal variation with no significant change in the number of harm incidents reports with a mean of 5.2. All incidents reported between 1 April 2023 to 31 January 2024 were either, near miss, no harm or low/minor harm. It was identified that there were inconsistencies in the category coding used by staff reporting incidents as not all the incidents reported under the deteriorating patient categories were explicitly related to a deteriorating patient. New incident category options have been added to Ulysses to improve accuracy of deteriorating patient incident coding which include failure to follow up on observations/recognise deteriorating patient, failure to escalate deteriorating patient, failure to treat deteriorating patient. Deteriorating patient incidents continue to be monitored through the Deteriorating patient/sepsis group to identify themes and learning.

**Process measure:** Recording of and response to NEWS2 score for unplanned critical care admissions (Aligned to CQUIN07 2023/24)




Sustained achievement of the CQUIN recording of and response to NEWS2 score for unplanned critical care admissions, exceeding the maximum National target 30% in all quarters to date with the latest quarter 3 compliance of 73.1%. Agreed allocation of time for Clinical Sisters to focus on NEWS2 QI work with nursing teams.

**Outcome measure:** Percentage of adult observations recorded on time (within 30minute grace period)




There has been a successive improvement in the percentage of adult observations recorded on time exceeding the 90% target. All divisions are expected to present a highlight report to the Deteriorating patient/sepsis group. This has helped to improve engagement and encourage clinical ownership of the improvement work. All clinical sisters and ward managers are continuing to undertake applying QI training to focus on deteriorating patient and escalation. Stop and check continues to be embedded across all areas, encouraging use through night shifts. In the Medicine Division, the escalation pathway has been distributed to all ward nurse base areas and staff rooms to raise awareness.

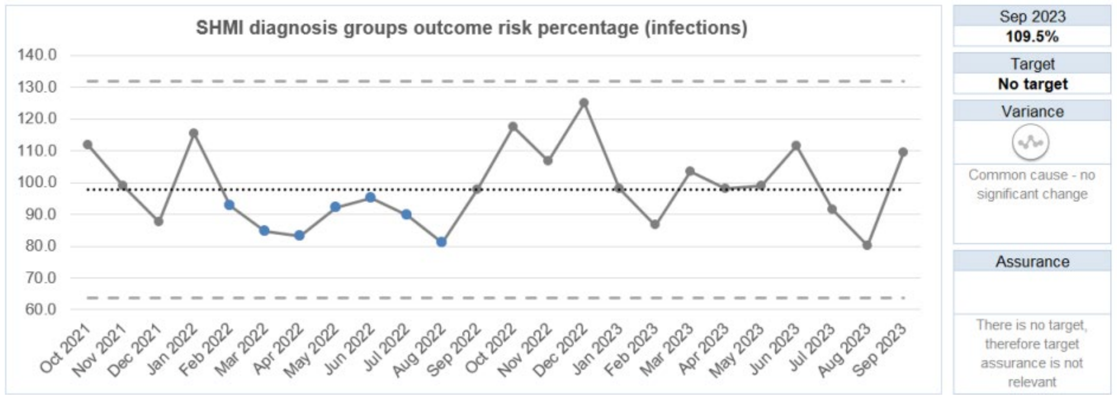
Clinical sisters and key members of staff within the Surgery and Critical Care division are continuing to undertake QI work on escalation of patients. This should support the recognition of deterioration and the appropriate escalation in line with the policy. Monitoring of referrals to Critical Care continues with oversight by the Deteriorating Patient/Sepsis group. Critical Care Outreach at DPoW are planning an electronic escalation pilot on wards

C2 and B3.

Building on the success of the 2023/24 deteriorating patient quality priority, stretch targets will be introduced for 2024/25 to strive towards 95% of adult observations recorded on time with a reduction in the grace period from 30 minutes to 15 minutes. The CQUIN target for recording of and response to NEWS2 score for unplanned critical care admissions will be increased from 30% to 80%. A new process measure of evidence of Situation Background Assessment Recommendation (SBAR) escalation will be introduced with a target of 30%.

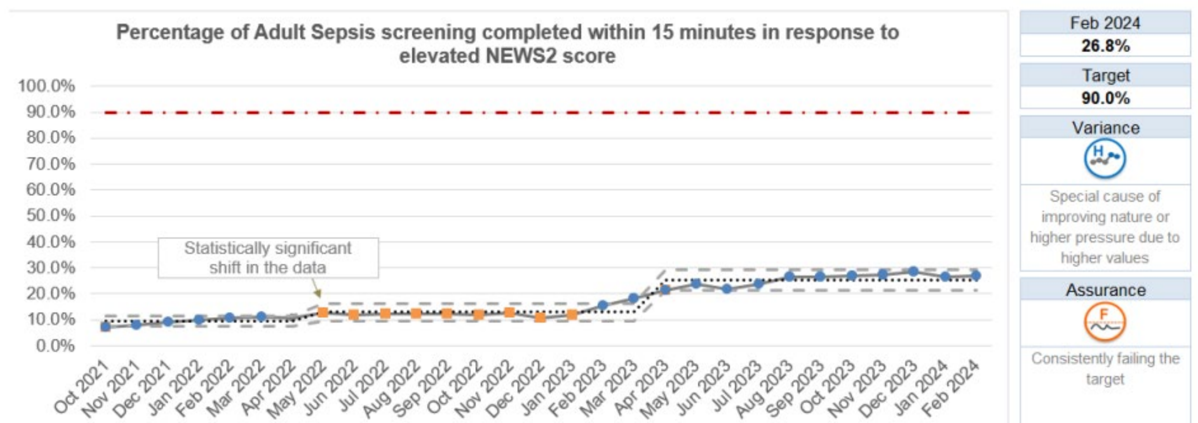
## Sepsis - Summary of milestones achieved, challenges and next steps

**Outcome measure:** Maintain/improve SHMI diagnosis groups outcome risk percentage *(Note: to include diagnosis groups related to infections).*




The SPC chart shows normal variation. The average rate (observed deaths/expected deaths) x 100) of patients that died with an infection related cause, for the period 1 April 2023 to 30 September 2023, was 98.6 which is below the England average 100.

**Process measure**: Adult primary sepsis screening completed on WebV within 15minutes in response to elevated NEWS2 score.



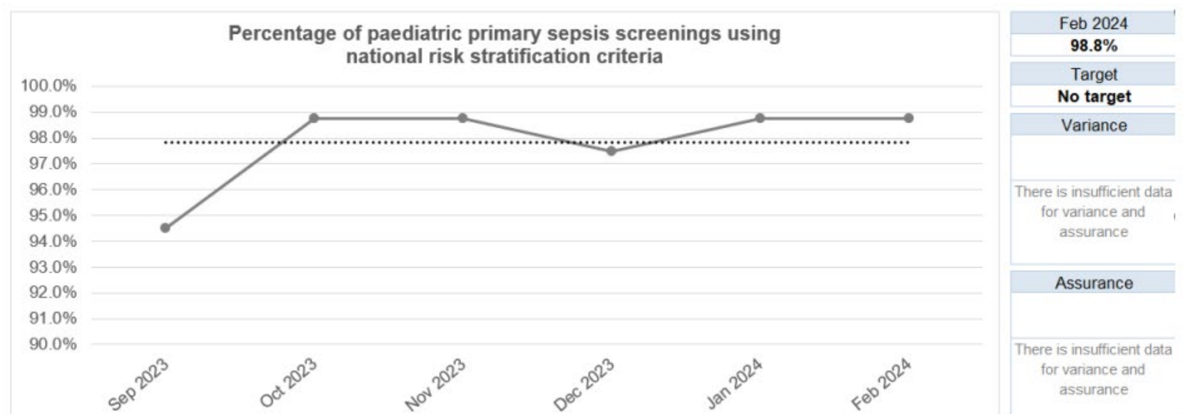

The SPC chart for the percentage of adult sepsis screening completed within 15 minutes in response to elevated NEWS2 score shows sustained special cause of improving nature rising to 26.8% in February 2024 compared to 10.81% in February 2022.

Electronic sepsis screening has been introduced in both Emergency Departments (ED) but challenges exist around IT systems as there is no automatic link to WebV to record sepsis screening from the ED Symphony system resulting in duplication and delays as 2 systems

are in use. A solution is being sought but will require financial investment. Despite these challenges, improvement was seen overall with sepsis screening but further work and system changes are required to improve recording within 15 minutes. With the time constraint removed, compliance of sepsis screening is better and has improved from 32.4% in February 2022 to 50% recorded in February 2024.

A snapshot audit has shown that the time delay of greater than 15 minutes to complete the sepsis screening tool is potentially due to the Health Care Assistant completing observations and escalating to a registered nurse who is then actively caring for the patient but is not completing the sepsis screen on WebV. DP/Sepsis nursing lead and QI lead continue to engage with frontline teams to progress QI work streams. Spot checks continue on the wards to ensure correct pathways and treatments have been followed.

**Process measure:** Paediatric primary sepsis screening completed in response to triggers to undertake screening using National risk stratification tools for “high risk” and “moderate to high risk” criteria.



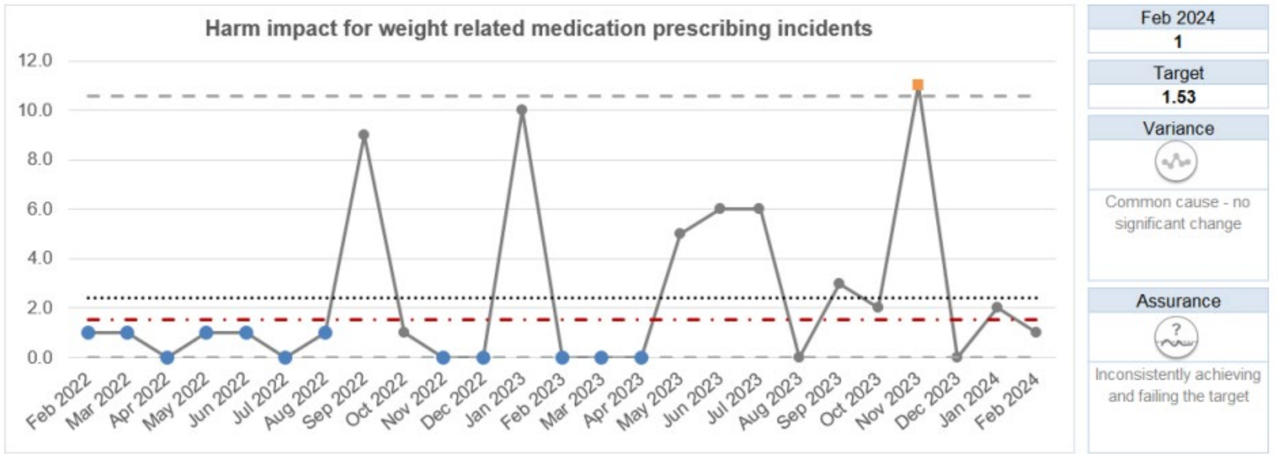

Paediatric sepsis screening audit data was collected from four areas (SGH Disney Ward, SGH Paediatric Assessment Unit, DPoW Rainforest Ward and DPoW Paediatric Assessment Unit). The mean percentage of Paediatric primary Sepsis screening completed in response to triggers to undertake screening using national risk stratification tools for “High Risk” and “Moderate to high risk” criteria was 97.8% although it should be noted that poor documentation and timeliness of treatment has been identified as an issue and will be the focus of improvement work in 2024/25. The audit results are shared with staff at team meetings and ward displays with a focus on a standard of the month.

The Symphony system in ED has been updated to include new prompts to complete a paper screening tool; Has a sepsis screen been considered? and What is the sepsis screen outcome? An audit is underway to quality check compliance with the new prompts.

To improve documentation of assessment, a new process measure of 90% of Paediatric Sepsis screening tools to be completed on presentation to ED/Paediatric Assessment Unit will be introduced as part of the 2024/25 sepsis quality priority.

## Medication Safety - Summary of milestones achieved, challenges and next steps

**Outcome measure:** Reduction in harm impact for weight related medication prescribing incidents.




A low number of incidents and infrequent incidents with harm have been identified, so applying a weighted scoring for harm being the 5-point scale of no harm to death caused by the incident has been used. The harm value from 1-5 has been squared to illustrate the significant impact of incidents that cause more harm than others, while monitoring the no harm/near-miss incidents cumulatively. This means that a patient's death would score 25; severe harm 16; moderate harm 9; low harm 4; no harm 1. Whilst not reflected in the chart above, the SPC chart limits have been set in line with historical data points following the SI case in March 2018 with a score of 25. All weight related medication incidents reported between 1 April 2023 and 17 March 2024 were all near miss, no harm, low/minor harm incidents. All incidents are discussed at the Safer Medication Group to raise awareness and share learning.

The National Reporting and Learning System (NRLS) ceased to exist and was superseded with the Learning From Patient Safety Events (LFPSE). The National benchmark reports on under-reporting of patient safety incidents are no longer available. Therefore, the Trust was unable to monitor and report on the previously agreed balancing measure:

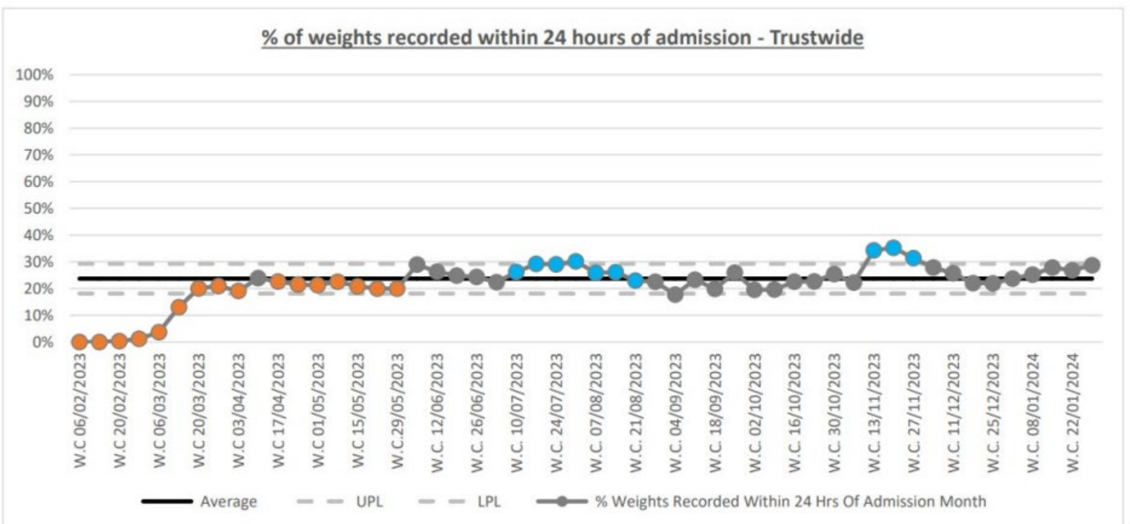
- **Balancing measure:** Potential under-reporting of patient safety incidents.

Weight entry on ePMA and WebV is challenged by dual systems as the two systems don't currently enable data to be shared between the systems meaning it must be entered into both systems manually. Weight data values also cannot be reported by ePMA which combined with the PAS development freeze has meant the Trust was unable to monitor or report on the previously agreed process and balancing measures:

- **Process measure:** Actual weight recorded on WebV within 24 hours.
- **Process measure:** Weight recorded on EPMA matches actual weight recorded in WebV.
- **Balancing measure:** MUST screening within 24 hours of admission.

The Trust is exploring investing in a bot to electronically transfer weight data between systems. In mitigation a self-serve excel dashboard showing data per site, division and ward has been created to allow wards to monitor their own compliance levels with weight

recorded on ePMA within 24 hours and 48 hours. A monthly summary report is taken to the Safer Medication Group and is shared with the Divisions to be discussed at Divisional Governance meetings. A monthly summary report was also provided to ward leaders highlighting the top 3 and lowest 3 wards per division per site to encourage improvement.




The SPC chart shows that the percentage of weights recorded on ePMA within 24 hours of admission has remained static with only slight improvement from 21.42% in April 2023 to 26.69% in January 2024. Due to the PAS migration in February 2024 there has been a pause in available data. In the interim data is being collected manually on pilot wards.

Presentations to raise awareness of the importance of weight recording on ePMA have been delivered to all levels of medical staff as well as sharing at Divisional Governance meetings.

A working group has been formed and a QI project has commenced. Surveys on all inpatient wards were completed to identify problems with recording weights on ePMA. Pilot wards A1, IAAU, B7 and Short Stay at DPoW and wards 5, 24, 28 and Stroke Unit at SGH were identified to trial Plan Do Study Act (PDSA) cycles before rolling out change ideas Trust wide.

The two new EDs have weighing bridges to allow patients arriving to be weighed by Ambulance crews. An observational audit of Ambulance staff weighing patients on arrival at both EDs has been completed which highlighted a site difference in practice with 100% of patients being weighed by the ambulance staff on arrival at DPoW but only 33% of patients were weighed by the ambulance staff on arrival at SGH. Ambulance staff at both sites are weighing patients with additional personal belongings on the trolley. Trust wide 49% were weighed with additional items. SGH had poorer compliance with 77% of patients being weighed with additional items on the trolley compared to 36% of patients at DPoW. An action plan has been developed and a re-audit is planned.

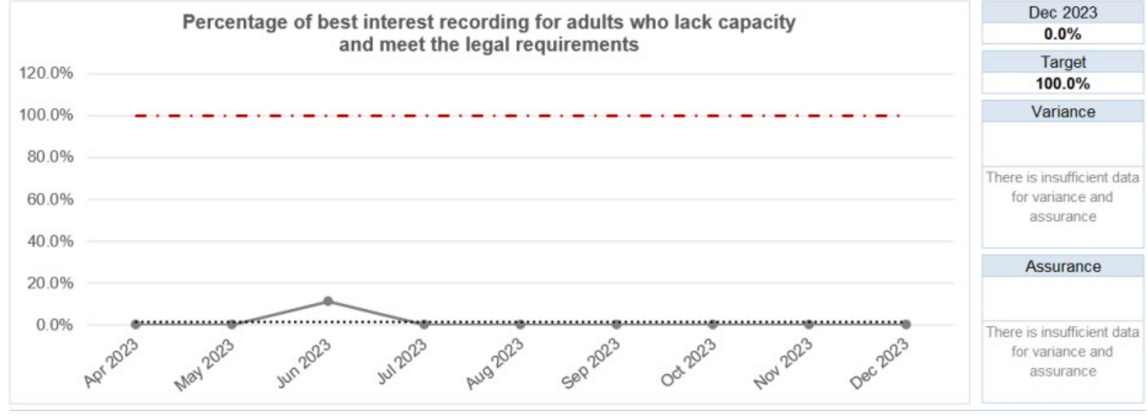
The 2024/25 Medication Safety quality priority will build on the 2023/24 QI work to further improve compliance with weight recorded in EPMA within 24 hours of admission.

## Mental Capacity - Summary of milestones achieved, challenges and next steps

**Outcome measure**: Percentage of MCA assessments that meet the legal requirements.

The percentage of MCA assessments that meet the legal requirements remains below target but has significantly improved from 6% in November 2023 to 35% in December 2023. We are starting to see improvements in the completion of some elements of the assessments. For example, 66% of assessments completed on Ward B6 in December 2023 had evidence that the patients had been supported to make a decision compared to 0% in May 2023.

**Outcome measure:** Percentage of best interest recording for adults who lack capacity and meet the legal requirements.




Compliance with best interest recording remains challenged. Progress has been limited due to single resource in the MCA/DoLS team and limited support from the QI team to support the Mental Capacity Quality Priority. Recruitment of a Specialist Nurse MCA/DoLS commenced their substantive post on 17 November 2023.

The **Process measure:** Attendance at bespoke training sessions on MCA assessments and best interest decision recording, was not formally monitored. Instead, bitesize training sessions have been delivered to Ward B6 and bespoke feedback forms for staff who have completed MCA assessment and best interest forms have been introduced and are shared for learning. MCA resource folders have been created and shared with all wards. A staff

survey to measure confidence and understanding of the MCA 2005 was undertaken. The MCA working group continue to meet to share learning and change ideas. The MCA/DoLS lead and Specialist Nurse MCA/DoLS continue to provide targeted support to wards.

The Community & Therapy Services Division have undertaken an audit in MCA assessments in community nursing to determine how many patients admitted to adult nursing caseload have had an MCA assessment undertaken when risk identified. The initial assessment template on SystmOne has been amended. A pathway to support the MCA assessment process has been developed. Best practice examples of MCA assessments tailored to community settings have been shared for learning.

The MCA assessment documentation audit has been transferred over to the Trust's new electronic Audit Management and Tracking System (AMaT). This will enable ward managers access to real time data giving greater oversight. A new process measure monitoring compliance with documenting key elements of the MCA/best interest record audit will be introduced to enable recognition where improvements are made as well as identifying areas for targeted improvement work.

## 2.3 Statements of assurance from the Board

### 2.3a Information on the review of services

During 2023/24 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health services. The 7 services are taken from the Trust's standard contract with the ICB as the "categories of service which the Provider is commissioned to provide under this contract". These are:

- A&E Services
- Acute Services
- Cancer Services
- Community Services
- Diagnostic, Screening and/or Pathology Services
- End of Life Care Services
- Urgent Treatment Centre Services

The Trust has reviewed all the data available to them on the quality of care in 7 of these relevant health and care services.

The income generated by the relevant health services reviewed in 2023/24 represents 100% of the total income generated from the provision of relevant health and care services for 2023/24.

### 2.3b Information on participation in clinical audits and national confidential enquires

During 2023/24, 72 national clinical audits and 7 National Confidential Enquiries into Patient Outcomes and Deaths (NCEPODs) were listed in the Quality Accounts for completion. During 2023/24, 51 national clinical audits and 7 NCEPODs covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

During that period the Trust participated in 50 (98%) of the national clinical audits and 7

(100%) of the NCEPODs. Whilst 2 projects were listed for completion at the beginning of the year, these were delayed by the national audit supplier and will commence in 2024/25. Both audits have been excluded from the Trust's overall participation rate.

Participation did not occur for 1 (2%) national clinical audit; the National Ophthalmology Database Audit as the audit data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.

The tables below list all National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes which NHS England advise Trusts to Participate in. It also provides a breakdown of those applicable to the Trust and participation details during 2023/24.

**Table 1: National Clinical Audits**

| Count | Programme / Workstream | Eligible for NLAG | NLAG Participated | No. of Cases Submitted | Rate of Participation | Outcome |
|---|---|---|---|---|---|---|
| **1.** | Adult Respiratory Support Audit (BTS) | ✓ | ✓ | 29 | 100% | Awaiting National Report |
| **2.** | BAUS Nephrostomy Audit | ✓ | ✓ | 4 | 100% | Awaiting National Report |
| **3.** | Breast and Cosmetic Implant Registry | ✓ | ✓ | 34 | 97% | Awaiting National Report |
| **4.** | British Hernia Society Registry | N/A | N/A | N/A | N/A | Not yet commenced |
| **5.** | Case Mix Programme (CMP) | ✓ | ✓ | 1338 | On-going | Project still underway |
| **6.** | Child Health Clinical Outcome Review Programme (NCEPOD) | ✓ | ✓ | Please refer to Table 2 | Please refer to Table 2 | Please refer to Table 2 |
| **7.** | Cleft Registry and Audit NEtwork (CRANE) Database | X | X | N/A | N/A | N/A |
| **8.** | Elective Surgery (National PROMs Programme) | ✓ | ✓ | 514 | 78% | Awaiting National Report |
| **9.** | **Emergency Medicine QIPs:** | | | | | |
| | Care of Older People | ✓ | ✓ | 231 | 115% | Awaiting National Report |
| | Mental Health (Self-Harm) | ✓ | ✓ | 388 | 100% | Awaiting National Report |

| Count | Programme / Workstream | Eligible for NLAG | NLAG Participated | No. of Cases Submitted | Rate of Participation | Outcome |
|---|---|---|---|---|---|---|
| **10.** | Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People | ✓ | ✓ | 186 (Cohort 5) | 100% | Awaiting National Report |
| **11.** | **Falls and Fragility Fracture Audit Programme (FFFAP):** | | | | | |
| | Fracture Liaison Service Database (FLS-DB) | ✓ | ✓ | 291 | On-going | Project still underway |
| | National Audit of Inpatient Falls (NAIF) | ✓ | ✓ | 5 | On-going | Project still underway |
| | National Hip Fracture Database (NHFD) | ✓ | ✓ | 533 | 100% | Awaiting National Report |
| **12.** | Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit] | ✓ | ✓ | 468 (Cumulative) | 100% | Action Planning |
| **13.** | Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) | ✓ | ✓ | 24 | 100% | Action Planning |
| **14.** | Maternal, Newborn and Infant Clinical Outcome Review Programme | ✓ | ✓ | 25 | On-going | Project still underway |
| **15.** | Medical and Surgical Clinical Outcome Review Programme | ✓ | ✓ | Please refer to Table 2 | Please refer to Table 2 | Please refer to Table 2 |
| **16.** | Mental Health Clinical Outcome Review Programme | X | X | N/A | N/A | N/A |
| **17.** | **National Adult Diabetes Audit (NDA)** | | | | | |
| | National Diabetes Footcare Audit (NDFA) | ✓ | ✓ | 89*** | On-going | Project still underway |
| | National Diabetes Inpatient Safety Audit (NDISA) | ✓ | ✓ | 8 | On-going | Project still underway |
| | National Pregnancy in Diabetes Audit (NPID) | ✓ | ✓ | 38 | 100% | Awaiting National Report |
| | National Diabetes Core Audit | ✓ | ✓ | 1138 | 100% | Action Planning |
| **18.** | **National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:** | | | | | |
| | a) COPD Secondary Care | ✓ | ✓ | 535 | On-going | Project still underway |
| | b) Pulmonary Rehabilitation | X | X | N/A | N/A | N/A |
| | c) Adult Asthma Secondary Care | ✓ | ✓ | 174 | On-going | Project still underway |

| Count | Programme / Workstream | Eligible for NLAG | NLAG Participated | No. of Cases Submitted | Rate of Participation | Outcome |
|---|---|---|---|---|---|---|
| | d) Children and Young People's Asthma Secondary Care | ✓ | ✓ | 80 | On-going | Project still underway |
| **19.** | National Audit of Cardiac Rehabilitation | ✓ | ✓ | 1093 | On-going | Project still underway |
| **20.** | National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent) | X | X | N/A | N/A | N/A |
| **21.** | National Audit of Care at the End of Life (NACEL) | ✓ | ✓ | 40 | On-going | Project still underway |
| **22.** | National Audit of Dementia (NAD) | ✓ | ✓ | 243 | 100% | Awaiting National Report |
| **23.** | National Audit of Pulmonary Hypertension | X | X | N/A | N/A | N/A |
| **24.** | National Bariatric Surgery Registry | X | X | N/A | N/A | N/A |
| **25.** | National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer | ✓ | ✓ | 278 NABCOP | 100% | Awaiting National Report |
| **26.** | National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer | ✓ | ✓ | As Above | 100% | Awaiting National Report |
| **27.** | National Cardiac Arrest Audit (NCAA) | ✓ | ✓ | 74 | On-going | Project still underway |
| **28.** | **National Cardiac Audit Programme (NCAP)** | | | | | |
| | National Adult Cardiac Surgery Audit (NACSA) | X | X | N/A | N/A | N/A |
| | National Congenital Heart Disease Audit (NCHDA) | X | X | N/A | N/A | N/A |
| | National Heart Failure Audit (NHFA) | ✓ | ✓ | 397 | On-going | Project still underway |
| | National Audit of Cardiac Rhythm Management (CRM) | ✓ | ✓ | 312 | On-going | Project still underway |
| | Myocardial Ischaemia National Audit Project (MINAP) | ✓ | ✓ | 408 | On-going | Project still underway |
| | National Audit of Percutaneous Coronary Intervention (NAPCI) | ✓ | ✓ | 334 | On-going | Project still underway |
| | National Audit of Mitral Valve Leaflet Repairs (MVLR) [estimated start date April '23] | X | X | N/A | N/A | N/A |

| Count | Programme / Workstream | Eligible for NLAG | NLAG Participated | No. of Cases Submitted | Rate of Participation | Outcome |
|---|---|---|---|---|---|---|
| | The UK Transcatheter Aortic Valve Implantation (TAVI) Registry | X | X | N/A | N/A | N/A |
| **29.** | National Child Mortality Database (NCMD) | X | X | N/A | N/A | N/A |
| **30.** | National Clinical Audit of Psychosis (NCAP) | X | X | N/A | N/A | N/A |
| **31.** | **National Comparative Audit of Blood Transfusion** | | | | | |
| | 2023 Audit of Blood Transfusion against NICE Quality Standard 138 | ✓ | ✓ | 67 | 84% | Awaiting National Report |
| | 2023 Bedside Transfusion Audit | N/A | N/A | N/A | N/A | Postponed until March 2024 |
| **32.** | National Early Inflammatory Arthritis Audit (NEIAA) | ✓ | ✓ | 59 | On-going | Project still underway |
| **33.** | National Emergency Laparotomy Audit (NELA) | ✓ | ✓ | 221 | On-going | Project still underway |
| **34.** | **National Gastrointestinal Cancer Audit Programme (GICAP)** | | | | | |
| | a) National Bowel Cancer Audit (NBOCA) | ✓ | ✓ | 333 | 100% | Awaiting Publication of Results |
| | b) National Oesophago-Gastric Cancer Audit (NOGCA) | ✓ | ✓ | 103 | 100% | Awaiting Publication of Results |
| **35.** | National Joint Registry | ✓ | ✓ | 845 | 99% | Awaiting National report |
| **36.** | National Lung Cancer Audit (NLCA) | ✓ | ✓ | 382 | 100% | Project still underway |
| **37.** | National Maternity and Perinatal Audit (NMPA) | ✓ | ✓ | 3939 | On-going | Project still underway |
| **38.** | National Neonatal Audit Programme (NNAP) | ✓ | ✓ | 454 | 100% | Awaiting National report |
| **39.** | National Obesity Audit (NOA) | X | X | N/A | N/A | N/A |
| **40.** | National Ophthalmology Database (NOD) Audit* | ✓ | X | N/A | N/A | N/A |
| **41.** | National Paediatric Diabetes Audit (NPDA) | ✓ | ✓ | 269 | Ongoing | Project still underway |

| Count | Programme / Workstream | Eligible for NLAG | NLAG Participated | No. of Cases Submitted | Rate of Participation | Outcome |
|---|---|---|---|---|---|---|
| **42.** | National Prostate Cancer Audit (NPCA) | ✓ | ✓ | 346 | 100% | Awaiting Publication of Results |
| **43.** | National Vascular Registry (NVR) | X | X | N/A | N/A | N/A |
| **44.** | Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) | X | X | N/A | N/A | N/A |
| **45.** | Paediatric Intensive Care Audit Network (PICANet) | X | X | N/A | N/A | N/A |
| **46.** | Perinatal Mortality Review Tool (PMRT) | ✓ | ✓ | 24 | On-going | Project still underway |
| **47.** | Perioperative Quality Improvement Programme | ✓ | ✓ | 67 | 100% | Ongoing |
| **48.** | **Prescribing Observatory for Mental Health (POMH)** | | | | | |
| | Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services | X | X | N/A | N/A | N/A |
| | Monitoring of patients prescribed lithium | X | X | N/A | N/A | N/A |
| **49.** | Sentinel Stroke National Audit Programme (SSNAP) | ✓ | ✓ | 884 | On-going | Project still underway |
| **50.** | Serious Hazards of Transfusion UK National Haemovigilance Scheme | ✓ | ✓ | 17 | 100% | Awaiting National report |
| **51.** | Society for Acute Medicine Benchmarking Audit | ✓ | ✓ | 70 | On-going | Project still underway |
| **52.** | The Trauma Audit & Research Network (TARN) | ✓ | ✓ | 478** | 100% | See below** |
| **53.** | UK Cystic Fibrosis Registry | X | X | N/A | N/A | N/A |
| **54.** | UK Renal Registry Chronic Kidney Disease Audit | X | X | N/A | N/A | N/A |
| **55.** | UK Renal Registry National Acute Kidney Injury Audit | X | X | N/A | N/A | N/A |

**Note: The Trust did not participate in the National Ophthalmology Database Audit as this is not a mandated audit under NCAPOP and data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data*

*required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.*

***The University of Manchester (UoM) switched off the TARN platform and allied resources, such as the TARN website, in June 2023 because of the cyber breach. The Trust continued to collect data locally using the nationally established dataset.*

****Scunthorpe General Hospital were unable to submit to the National Diabetes Footcare audit (NDFA) for 11 months of the 2023-2024 period due to accessibility issues. Scunthorpe General Hospital regained access to submit to the NDFA audit as of March 2024.*

**Table 2: National Confidential Enquires**

| Count | Programme / Workstream | Eligible for NLAG | NLAG participated | No. of cases submitted | Participation Rate | Outcome |
|---|---|---|---|---|---|---|
| **6.** | Testicular torsion | ✓ | ✓ | 7 | 100% | Action Planning |
| | Juvenile Idiopathic Arthritis | ✓ | ✓ | 2 | 100% | Awaiting national report |
| **15.** | Community Acquired Pneumonia | ✓ | ✓ | 3 | 43% | Action Planning |
| | Chron's Disease | ✓ | ✓ | 6 | 75% | Action Planning |
| | Epilepsy: Hospital Attendance | ✓ | ✓ | 7 | 100% | Action Planning |
| | End of Life Care | ✓ | ✓ | 9 | On going | N/A |
| | Endometriosis | ✓ | ✓ | 16 | 100% | Awaiting national report |

The reports of 20 National clinical audits were reviewed by the provider in 2023/24 and the Trust intends to take the following actions to improve the quality of healthcare provided:

| National Audit Programme | Summary of some actions taken |
|---|---|
| National Maternity & Perinatal Audit | - Current leaflets relating to instrumental intervention & caesarean births reviewed to ensure information is in a language and format which is accessible and tailored to each birthing person's circumstances. |

| National Audit Programme | Summary of some actions taken |
|---|---|
| National Paediatric Diabetes Audit | - Dietician in post to ensure children receive a dietician review to educate children and young people with Type 1 diabetes from diagnosis around carbohydrate counting.<br>- Increase clinic slots to ensure children & young people have at least 4 HbA1c measurements in a year, by managing cancelations and DNA rates. |
| Epilepsy 12 | - Local epilepsy pathway to be implemented based on NICE guidelines to ensure eligible patients have an MRI performed within 6 weeks.<br>- A QIP has been undertaken by the Medical Physics service to improve EEG referral requests to be carried out within 4 weeks of request.<br>- Nurse in post to support mental health issues. |
| MBRRACE-UK Perinatal Mortality Surveillance | - All stillbirths are reviewed and a PMRT carried out for all deaths to assess care, identify and implement service improvements to prevent future similar deaths. |
| National Audit of Breast Cancer in Older People | - To introduce the Fitness assessment form for older patients. |
| National Audit of Care at the End-of-Life (NACEL) | - Relaunch the End of Life document and have an electronic version on WebV<br>- Palliative Care Nursing service to provide a seven day service (8hours during the day)<br>- QI project in progress and new bespoke training package launched. |
| National Joint Registry (NJR 2022) | - To improve compliance rate for consent taken by alerting trauma coordinators and pre assessment nurses of the possibility of gaining consent retrospectively.<br>- Escalate to the S&CC business manager the number of cases at Goole where consent will be submitted as 'not recorded' and the potential result in the 2023 report if the patients aren't contacted retrospectively. |
| National Hip Fracture Database (NHFD 2022) | - Discussions with the trauma coordinators and the administrator (DPOW) about the collection and submission of data relating to several lower scoring standards.<br>- The project lead at Scunthorpe to escalate to senior management the importance of having a designated ward for T&O patients as he believes that this is key to improving some of the results.<br>- A business case to be written regarding the development of a dedicated geriatric team for the S&CC Division, either within the division or working with the Medicine Division. |
| BAUS Management of the Lower End in Nephroureterectomy Audit 21-22 | - Review the 2 open cases to establish the reason for the longer length of stay and also the higher than average blood loss and present back to the group for learning. |
| Sentinel Stroke National Audit programme (SSNAP) | - Stroke Assessment Area to move from ED to within Stroke Unit to improve performance for patients being admitted to Stroke Unit within 4 hours of arrival to hospital.<br>- Recruitment of 0.6 WTE SALT therapist to improve access to SALT therapies |
| Cardiac Rhythm Management (CRM) Audit | - All Pacing in AV blocks were reviewed by lead clinician to ensure accuracy / learn lessons where applicable. Findings discussed at a regional meeting to prove each case was acting in the patients best interests. |
| National Oesophageal Cancer Audit (NOGCA 2023) | - Set up a process whereby the UGI CNS staff create a spreadsheet / complete forms on all of the Oesophago-gastric cancer cases they encounter via an emergency admission to try and establish why the patient has presented as an emergency.<br>- To review the patients records of those who were diagnosed following an emergency admission and present findings back to the group. |

| National Audit Programme | Summary of some actions taken |
| --- | --- |
| National Bowel Cancer Audit (NBCA 2022) | - A request should be made to NBOCA to identify the cases that have an unreversed stoma after 18 months so that these specific cases can be reviewed. |
| National Prostate Cancer Audit (NPCA 2022) | - Ask the cancer tracker to input performance status into Somerset from 2WW referral.<br>- Recruit additional hours to the cancer tracking team to assist with submitting quality data. |
| ICNARC Case Mix Programme (2021-2022) | - To review the mortality cases for DPOW ITU and present results back to group for learning.<br>- To undertake a review of late discharges from DPOW HDU and present results back to group for learning.<br>- ICNARC Clinical Audit Officer to provide the doctors with a minimum set of criteria as per ICNARC standards that need to be documented in the notes.<br>- DPOW ITU Manager to send the admission forms to SGH ITU Managers so they can order and roll the forms out on their units and both sites can start trialing. |
| National Emergency Laparotomy Audit (NELA) 2022 | - Invite Sepsis CNS to attend an audit meeting to discuss on-going work in the trust around sepsis and prescribing antibiotics within an hour |
| COPD Audit | - Piloted daily in-reach to AAU & Respiratory wards to identify patients with COPD for review within 24hrs of admission |
| Fracture Liaison Service Database | - Fracture Liaison Nurse working directly with acute care, setting up a process where radiology also informs FL Nurse when Spinal fractures are identified. |
| Early Inflammatory Arthritis | - Implemented a small reduction on new and follow up clinic lists to facilitate improved performance for EIA patients against National Key Performance indicators |
| National Audit of Dementia | - Acute and Emergency Clerking forms amended to incorporate Delirium screen using 4AT. Agreement to mandate 4AT within the Emergency Department electronic system for patients over 75 with a NEWs score of 4 or below. |

The reports of 18 local clinical audits were reviewed by the provider in 2023/24 and the Trust intends to take the following actions to improve the quality of healthcare provided:

| Local Audit Topic | Summary of some actions taken |
| --- | --- |
| Medical Documentation | - Attendance of Medical Defence Union at Medicine Quality and Safety/Audit Committee to discuss clinical documentation with examples if issues identified Nationally |
| Frailty in the ED Audit (CQUIN Pilot) | - Introduction of mandated Frailty Scoring within ED Electronic Systems for patients over 65yrs and implementation of Improved Frailty Pathway documentation to capture comprehensive geriatric assessment. |
| Local Version of National Ophthalmology Database Audit (NOD 2022-2023) | - Individual reports to be sent to the clinicians, reporting on VA Loss and PCR rate based on the operating surgeon. |

| Local Audit Topic | Summary of some actions taken |
|---|---|
| Paediatric SEPSIS Audit | - Monthly data displayed on the ward to raise awareness.<br>- SEPSIS E learning for all staff<br>- SEPSIS discussed in the Nursing huddle and Dr's safety huddle daily to ensure patients on the ward have been screened.<br>- SEPSIS communication tool to be introduced to aid SBAR. Credit card style awaiting to be approved and printed. |
| Paediatric Early Warning Scoring | - The Monthly Dashboard is used to monitor the use of the PEWS Tool and presented at the Clinical Audit Meeting.<br>- Areas of low compliance are displayed as standard of the month in the wards. |
| Paediatric Documentation | - Implementation of electronic documentation at DPOW, awaiting role out at SGH. |
| S&CC Documentation Audit 2021/2022 | - To add where applicable to the "DNACPR status should be documented on admission" question to avoid cases being marked as non compliant when they weren't applicable.<br>- Project lead to ask junior doctors to update the Web-V clinical handover every day with patient details to improve documentation for General Surgery. |
| Seven Day Hospital Services S&CC 2021/2022 | - The group to discuss at the General Surgery Business Meeting the practicalities of trying to ensure that patients who have been admitted longest without a review are seen first on the ward round. |
| Intentional Rounding | - New weekly pressure ulcer review group commenced. To review documentation and embed changes for the pressure ulcer management pathways part of the audit.<br>- Daily Stop & Check introduced to review documents and care by nurse in charge |
| Adult Nursing Documentation | - Electronic Nursing admission document currently being trialled at Goole and rolled out across the Trust once WebV3 introduced |
| MUST – Nutrition Risk Assessment | - Nutritional CNS to instigate weekly ward round.<br>- Training package reviewed and delivered to all new staff both RN, NQN and HCA on induction. |
| Audit on efficacy of MatNeo tool in the prevention of reducing major PPH >1500ml | - Medical staff huddle to include the PPH protocol to ensure the Mat Neo is used for every patient and updated. |
| Seven day services (Gynae) | - Consultants to document post-take ward round to ensure patients are reviewed with 14 hours of admission. |
| Safe and Secure: Controlled Drug Monitoring and Storage | - Each area of non-compliance is incident reported and investigated, reviewed and actions taken by the ward/area manager.<br>- Any trends are discussed at the Safer Medication group, and Pharmacy governance group and any lessons learnt will be shared via the safer medicines newsletter. |
| Safe and Secure: Controlled Stationary Monitoring and Storage | - Each area of non-compliance is incident reported and investigated, reviewed and actions taken by the ward/area manager.<br>- Any trends are discussed at the Safer Medication group, and Pharmacy governance group and any lessons learnt will be shared via the safer medicines newsletter. |
| JAG Colonoscopy Audit | - Implement a trial of different bowel preparation, which will be reviewed on a monthly basis. |

| Local Audit Topic | Summary of some actions taken |
|---|---|
| JAG Endoscopy Service 30-Day Mortality and 8-Day Readmission 2022 | - Information services to adjust the coded section that the SQL Server collects data for the report from. This will provide some assurance that all of the patients who have an endoscopic procedure will be identified in the report. |
| JAG Trust wide flexible Sigmoidoscopy Audit | - After the EndoVault update in November all audit templates to be reviewed to ensure all data required is captured. |
| Chest X-ray Quality Audit | - In order to improve chest radiograph positioning and centering feedback to radiographers regarding issues with chest positioning. Include image examples from the audit demonstrating incorrect technique.<br>- Increase the radiographer comments for sub-optimal examinations by feeding back to radiographers the results of the audit and why examinations are needed. |

The Trust takes part in the annual Learning Disability improvement standards audit that measures performance against the NHS improvement standards (2018). The aim of the standards is to ensure the provision of high quality, personalised and safe care for adults and children with learning disabilities and/or autism across England. The standards against which trust performance is measured are respecting and protecting rights, inclusion and engagement, workforce and specialist learning disability services, the first three are universal standards that apply to all NHS trusts, and the fourth is a specialist standard that applies specifically to trusts that provide services commissioned exclusively for people with a learning disability or autism. The audit consists of data collection around factors such as the percentage of patients admitted to the Trust with a learning disability in a 12 month period, reasonable adjustments that are provided to patients and audits carried out specifically into patient with a learning disability, In addition 50 staff and 100 patient surveys are sent out that were directly returned to NHSBN that look at factors such as waiting times in A+E, patient choice and carer engagement. Compliance with these standards demonstrates that a trust has the right pathways and resources in place to deliver high quality patient outcomes that people with a learning disability or autism, their families and carers deserve and expect. The timing of the audit changed in 2023 and therefore we are currently awaiting the results from 2022/23. For those areas where there is an identified gap the Trust has an improvement plan to address these, this will be updated following receipt of the report.

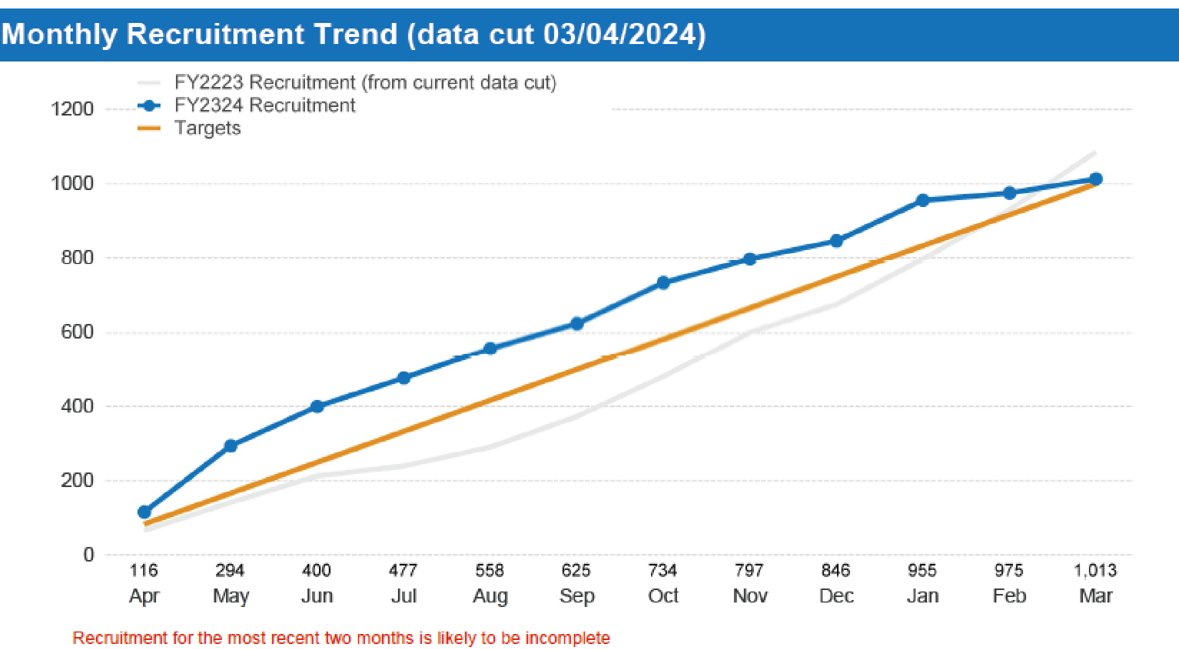
## 2.3c Information on participation in clinical research

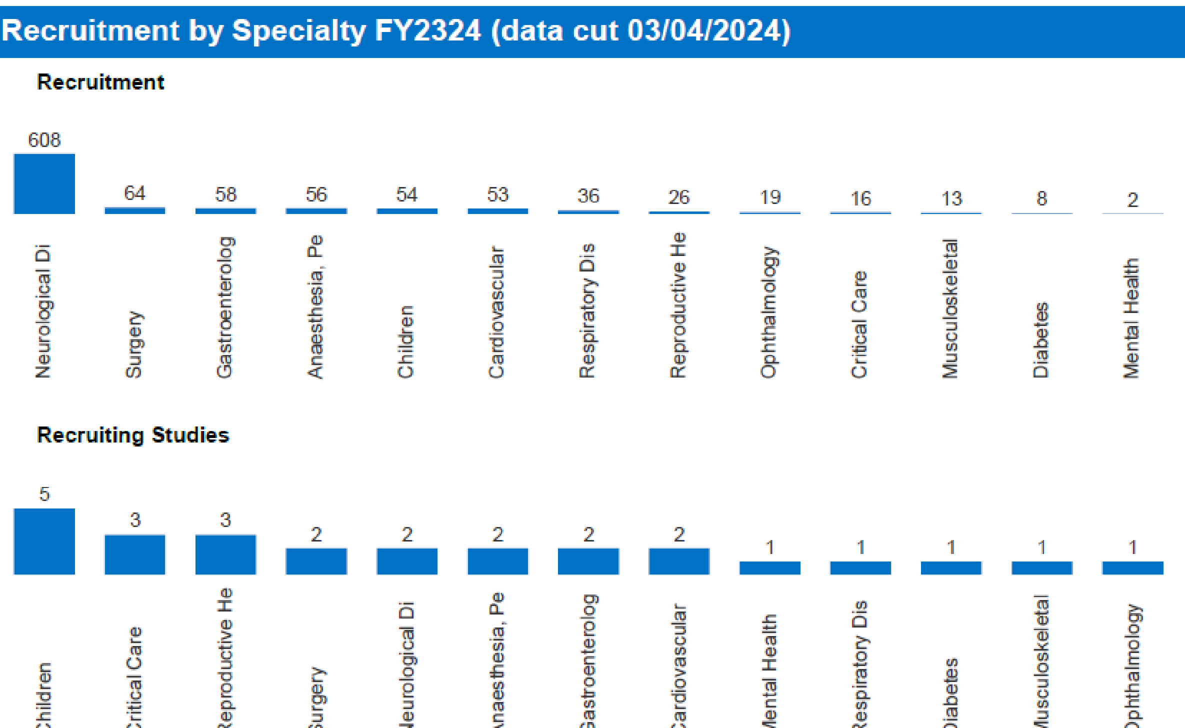
**What is Clinical Research?**
Clinical Research is an arm of medical science that establishes the safety and effectiveness of Medication, Diagnostics products, Medical devices, and Treatment regimens which may be used for the prevention, treatment, diagnosis of relieving symptoms of a disease.

*'Todays Research is Tomorrows Treatment'*

**Participation in Clinical Trials**

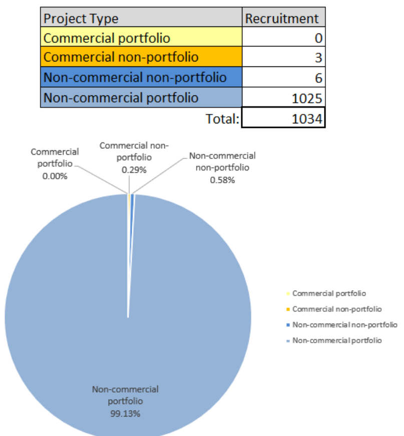
The number of patients receiving NHS services provided or sub – contracted by Northern Lincolnshire & Goole NHS Foundation Trust in 2023/2024 that were recruited during that period to participate in research approved by a research ethics committee or Health authority was 1034 and the target for the Trust was set at 1000.






## Commercial Trials

Over the last year we have had an imbalance of commercial trials that we had hoped for within the Trust. We have recruited very well into non-commercial trials and the National Institute for Health and Care Research (NIHR) Portfolio trials.



| Project Type | Recruitment |
|---|---|
| Commercial portfolio | 0 |
| Commercial non-portfolio | 3 |
| Non-commercial non-portfolio | 6 |
| Non-commercial portfolio | 1025 |
| Total: | 1034 |



We would like to concentrate as a Trust into building up our commercial portfolio, this will be noted in the next financial report.

## Participation in Research Patient Survey

| PRES Target | PRES Total | PRES % Tar... | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|
| 43 | 54 | 125.58% | 7 | 16 | 19 | 12 |

The NIHR Clinical Research Network asks thousands of patients that take part in research to share their experiences of taking part in a clinical trial. The Participant in Research Experience Survey (PRES) aims are to place participation and experience in research at the heart of research delivery. Responses from our research patients have highlighted through the years we have taken part that we have improved year on year. This year’s responses to date are no exception we have 97% of our patients feel they are fully prepared for their research experience with NLAG research staff and feel valued when taking part in NLAG research. The patients gave 100% as they felt they were treated with courtesy and respect by the NLAG research staff. The patients that took part in research have said that they would consider taking part in research again 97%.

**Celebrating Research Success**
Paediatric Research Nurse has managed to achieve great success with her trials and has managed to recruit her first patient into a commercial trial called M21-572. We now have a Research Midwife who is proceeding to make good progress within the Obstetrics and Gynaecology team. We are as a Trust currently supporting the set-up of the Born and Bred in (BABi) this study originated from the Bradford Teaching Hospitals Trust. This study is a data linkage birth cohort study supporting the review of to the health and well being of families across our region. The study offers fantastic potential to assess the contributing factors of childhood disease, assess the impact of migration, explore the influences of pregnancy and childbirth on subsequent health and generate future research work that has potential to improve the health for some of our most disadvantaged within our region and society. The Trust are looking to work with maternity services and external partners in North Lincolnshire, North East Lincolnshire and East Yorkshire. This will enable us to maximise the benefits of cohort work.

**Research and communications and engagement strategy**
The Research Department are now collaborating with HUTH and providing information with regards to a Newsletter. We do promote research through social media page within the Trust and this is accessible to the patients who live in the community. We promote research within the Trust on the internal and external internet.

**Black Asian and Minority Ethnic (BAME) and Research Trials**
The Trust are looking at how best we can provide opportunities to engage BAME and socially deprived communities in research participation.

**Partnerships: Hull University Teaching Hospitals NHS Trust**
The Research departments of both Northern Lincolnshire & Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust at both Hospitals have commenced dialogue as to how we can pool resources, expand research programmes across sites and streamline the governance processes

## 2.3d Information on the Trust's use of the CQUIN framework

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience, and improvements against outcomes.

**Use of the CQUIN payment framework**
A proportion of the Trust's income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement, or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

For 2023/24 the requirement for national ICB CQUINs was to report on all applicable CQUINs but also choose 5 schemes, for each contract, that would have a financial value attached.

The breakdown of the National CQUIN indicators is based on 1.25% of contract value. Funding was given to the Trust based on the assumption that the Provider would achieve full compliance with the applicable CQUIN Indicators and would therefore earn the full 1.25% value.

National CQUIN schemes 2023/24 for ICBs include:

- Flu vaccinations for frontline healthcare workers (Non-financial)
- Supporting patients to drink, eat and mobilise (DrEaMing) after surgery (Financial)
- Compliance with timed diagnostic pathways for cancer services (Non-financial)
- Prompt switching of intravenous to oral antibiotic (Non-financial)
- Identification and response to frailty in emergency departments (Financial)
- Timely communication of changes to medicines to community pharmacists (Financial)
- Recording of NEWS2 score, escalation time and response time for unplanned critical care services (Financial)
- Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway (Non-financial)
- Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery (Financial)
- Assessment and documentation of pressure ulcer risk (Financial)
- Assessment, diagnosis and treatment of lower leg wounds (Financial)

**NHS England Specialised Services (NHSE):**
The Trust receives a CQUIN value of 1.25%. The CQUIN payment was based on the block contract value: however, CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Payment System and all other expenditure contracted on "pass through" basis.

The NHSE specialised schemes of 2022/23 include:

- Shared Decision Making (SDM) conversations (Financial)

The Trust has achieved the highest performance to date with the full CQUIN programme. Of the 6 financially incentivised CQUINs, 5 have exceeded the maximum targets. The assessment and documentation pressure ulcer risk assessment CQUIN did not achieve the full target but did exceed the minimum target and was within the payment range. Operational pressures impacting on completing the risk assessments within 6 hours of admission remains a challenge and will be taken forward in 2024/25 with the introduction of electronic risk assessments.

For the non-financial CQUINs, the Trust exceeded the maximum target for 3, showed improvement over each quarter for 1 and has not achieved the target for 1. There has been a national apathy towards vaccinations which has contributed to the under performance. The biggest improvement was seen in the non-financial CQUIN13 (Assessment, diagnosis and treatment of lower leg wounds) which achieved 39.43% in Q4 compared to 18.33% in Q1.

| Key | |
|---|---|
| Green | Maximum target achieved or exceeded |
| Amber | Minimum target achieved |
| Red | Target not achieved |

| Indicator | Financial / Non financial | Min | Max | Q1 | Q2 | Q3 | Q4 | Full year performance |
|---|---|---|---|---|---|---|---|---|
| **CQUIN01** Flu vaccinations for frontline healthcare workers | Non-financial | **75%** | **80%** | **N/A** | **N/A** | **27.27%** | **26.55%** | Red |
| **CQUIN02** Supporting patients to drink, eat and mobilise (DrEaMing) after surgery | Financial | **70%** | **80%** | **83%** | **93%** | **98%** | **92.5%** | Green |
| **CQUIN03** Compliance with timed diagnostic pathways for cancer services | Non-financial | **35%** | **55%** | **76.3%** | **74.2%** | **68.3%** | **64.1%** | Green |
| **CQUIN04** Prompt switching of intravenous to oral antibiotic (Target: Lower is better) | Non-financial | **60%** | **40%** | **32%** | **37%** | **38%** | **33%** | Green |

| Indicator | Financial / Non financial | Min | Max | Q1 | Q2 | Q3 | Q4 | Full year performance |
|---|---|---|---|---|---|---|---|---|
| **CQUIN05** Identification and response to frailty in emergency departments | Financial | **10%** | **30%** | **67.51%** | **68.51%** | **69.10%** | **70.44%** | |
| **CQUIN06** Timely communication of changes to medicines to community pharmacists | Financial | **0.5%** | **1.5%** | **1.07%** | **1.53%** | **1.46%** | **1.57%** | |
| **CQUIN07** Recording of and response to NEWS2 score for unplanned critical care admissions | Financial | **10%** | **30%** | **61.53%** | **72.41%** | **76.92%** | **73.27%** | |
| **CQUIN10** Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway | Non-financial | **80%** | **85%** | **92.30%** | **90%** | **92.85%** | **83.33%** | |
| **CQUIN11** Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery | Financial | **65%** | **75%** | **N/A** | **83%** | **N/A** | **83%** | |
| **CQUIN12** Assessment and documentation of pressure ulcer risk | Financial | **70%** | **85%** | **80%** | **81.37%** | **71.05%** | **72.54%** | |
| **CQUIN13** Assessment, diagnosis and treatment of lower leg wounds | Non-financial | **25%** | **50%** | **18.33%** | **26.43%** | **38.98%** | **39.43%** | |

## 2.3e Information relating to the Trust's registration with the Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust is registered with the Care Quality Commission for the provision of a number of regulated activities at three locations managed by the Trust. The Trust had a Trust wide inspection in 2019 and 2022 and a service level inspection in 2023 for Maternity at the Goole Midwifery Led Unit.

The Care Quality Commission has not taken enforcement action against the Trust during 2023/24. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reported period.

**Care Quality Commission (CQC) ratings grid for the Trust:**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Trustwide | **Requires Improvement** ↑ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Good** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 |
| Diana Princess of Wales Hospital | **Requires Improvement** ↑ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Good** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 |
| Goole District Hospital | **Good** ↑ Feb 2024 | **Good** ↔ Nov 2022 | **Good** ↔ Nov 2022 | **Good** ↑ Nov 2022 | **Requires Improvement** ↔ Feb 2024 | **Good** ↑ Nov 2022 |
| Scunthorpe General Hospital | **Requires Improvement** ↑ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Good** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 |
| Overall Trust | **Requires Improvement** ↑ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Good** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 | **Requires Improvement** ↔ Nov 2022 |

The Trust underwent a Care Quality Commission inspection in June and July 2022, with the visit report published in December 2022. Arising from that inspection the Trust retained its overall rating of ‘Requires Improvement’ although significant improvements were noted. The Trust received a rating of ‘Good’ for the ‘caring’ domain and for Goole District Hospital overall. A ‘Requires Improvement’ rating was given for the: ‘safe’, ‘effective’, ‘responsive’, ‘use of resources’ and ‘well-led’ domains. The Trust underwent a focused maternity inspection for the Goole Midwifery Led Unit in November 2023, the findings of which helped to retain the overall ‘Good’ rating for Goole Hospital.

Following the last Trust wide inspection report in 2022, the Trust amended the action plan rating system to an assurance based system, meaning that actions would no longer be rated blue/green/amber/red to language in line with Recovery Support Programme and uses these ratings for all CQC action plans:

| | |
|---|---|
| **Full assurance** | Evidence of embedded and sustained improvement |
| **Significant assurance** | Evidence of improvement and the improvements becoming embedded, but yet to be sustained |
| **Moderate assurance** | Some evidence of improvement but this has yet to be embedded and sustained |
| **Limited assurance** | Limited evidence of improvement and limited evidence of the improvements being embedded or sustained |
| **No assurance** | No evidence of improvement |

A monthly report provides detail and assurance on progress for the Trust’s action plan and is presented at the following Committees-in-Common with Hull University Hospitals NHS Trust: Quality and Safety, Workforce, Education & Culture and Performance, Estates and Finance.

At the time of writing in March 2024, the Trust had 122 CQC actions on the combined plan.

- 30 rated **full assurance**
- 32 rated **significant assurance**
- 45 rated **moderate assurance**
- 15 rated **limited assurance**
- Zero rated **no assurance**

Of these actions rated full assurance, 23 have been submitted to the CQC with details of how assurance has been attained and the action has been met.
In April 2024, following the move to a group structure with Hull University Teaching Hospitals NHS Trust, a full review of the action plan commenced to align actions with new care groups. The action plan was refreshed and some actions that had been closed have been removed. Four additional actions were included that had arisen form the latest Goole Midwifery Led Unit inspection. This has resulted in a much more focused action plan with fewer number of actions for monitoring.

The the Trust has in place a quarterly review of all closed CQC actions. If assurance is obtained that the actions remains embedded the action remains closed, if sufficient evidence isn't available or the action lead has identified a deterioration in performance then the action will be re-opened. This process provides assurance that actions previously considered to be completed are still embedded.

The Trust continues to have engagement meetings with the CQC and provides them with regular updates on progress with the plan along with supporting evidence.

## 2.3f Information on Quality of Data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2023/24 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data (as of April 2024) which included the patient's valid NHS Number was:

- 99.76 % for admitted patient care
- 99.97 % for outpatient care
- 99.39 % for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- 100 % for admitted patient care
- 100 % for outpatient care
- 100 % for accident and emergency care.

## 2.3g Information governance assessment report

The Information Governance Data Security and Protection Toolkit (DSPT) is part of the Department of Health's commitment to ensuring the highest standards of information governance.  It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance.

It remains Department of Health and Social Care policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is

fundamental to the secure usage, sharing, transfer, storage, and destruction of data both within the organisation and between external organisations. The Trust are currently working on the current version of the DSPT which was launched July 2023. The submission deadline for the 2023/2024 DSPT Assessment is the 30th June 2024.

The 2022/23 Version of the DSPT was released in July 2022, with an initial baseline assessment date of the 28 February 2023 followed by the final submission of the 30 June 2023. The current status for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust following submission of the 22/23 DSPT was Approaching Standards.

As of March 2023, there was 1 action remaining on the improvement plan. Responses to this action will be captured in the 2023/24 return. The remaining action is detailed below, at the time of submission the Trust reported 90% of staff had completed their mandatory Data Security Training with the Toolkit year.

| 22/23 DSP ref | 2020/21 DSPT Evidence Item Text |
|---|---|
| 3.2.1 | Have at least 95% of all staff, completed their annual Data Security Awareness Training? |

## 2.3h Information on payment by results clinical coding audit

Northern Lincolnshire & Goole NHS Foundation Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission as these no longer take place.

To provide coding quality assurance Northern Lincolnshire & Goole NHS Foundation Trust audited a sample of just over 200 Finished Consultant Episodes (FCEs - the time a patient spends under the continuous care of one care professional) for the period April 2023 – March 2024. A regular programme of individual coder audits conducted by NHS England approved Clinical Coding Auditors is in place. Established coders are audited every 12 months, novice and trainees coders are audited every 3 to 6 months.

Using the Data Security and Protection Toolkit Attainment Levels for Clinical Coding in an Acute Trust (table below) the Trust's coding sample achieved the level of Standards Exceeded. The Trust will continue a rolling programme of yearly audits for all Clinical Coding staff throughout 2024/25.

Data Security and Protection Toolkit Attainment Levels for Clinical Coding in an Acute Trust

| | Level of Attainment | |
|---|---|---|
| | Standards Met | Standards Exceeded |
| Primary Diagnosis | >=90% | >=95% |

| Secondary Diagnosis | >=80% | >=90% |
|---|---|---|
| Primary Procedures | >=90% | >=95% |
| Secondary Procedures | >=80% | >=90% |

Trust coding sample results

| Date | Primary diagnosis % | Secondary diagnosis % | Primary procedure % | Secondary procedure % | FCEs | Number of case notes examined |
|---|---|---|---|---|---|---|
| April 2023-March 2024 | 96.06% | 98.32% | 97.35% | 94.54% | 203 | 164 |

## 2.3i Learning from Deaths

During 2023/2024, 1,796 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died in hospital as an inpatient. In addition to this, 256 deaths occurred in ED or were dead on arrival and there were 16 still births. The inpatient deaths comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 471 in the first quarter
- 365 in the second quarter
- 450 in the third quarter
- 510 in the fourth quarter

As at the 1st April 2024, 1,793 have been reviewed by the Medical Examiners, 141 have had a Structured Judgement Review (SJR) and 3 have been subject to a serious incident investigation. There were no cases which were subjected to both a SJR and a serious incident investigation. The number of deaths in each quarter for which an SJR or a serious incident investigation was carried out (as of 1st April 2024) was:

- 48 in the first quarter
- 26 in the second quarter
- 29 in the third quarter
- 38 in the fourth quarter

6 representing 0.3% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. [Definition: using Royal College of Physicians (RCP) question: "Avoidability of Death Judgement Score" for patients with a score of 3 or less – see narrative below for more information].

In relation to each quarter, this consisted of:

- 2 representing 0.20% for the first quarter.
- 1 representing 0.06% for the second quarter.
- representing 0.15% for the third quarter.
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the SJR which includes a 6 factor Likert scale ranging from Score 6: "Definitely Not Avoidable" to Score 1: "Definitely Avoidable". The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6-factor scale. This assessment is the initial reviewer's evaluation from the retrospective analysis of the medical record.

Any SJR completed that identifies that further understanding is needed is subject to a second independent review. This process links into the Trust's Serious Incident process. This data is not a measure of deaths that were avoidable, but as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care.

**Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2023/24**

**And,**

**Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2023/24**

**And,**

**An assessment of the impact of the actions taken by the Trust during 2023/24:**

Following on from the success of the introduction of the Medical Examiner Service at the Diana Princess of Wales Hospital site in April 2021 the Trust expanded the service in July 2022 to include Scunthorpe General Hospital and all Emergency Department non-coronal deaths. The service now has full establishment with 1.2 whole time equivalent Medical Examiners comprising of 9 Medical Examiners and 4 full time equivalent Medical Examiner Officers. This is an invaluable service that oversees and scrutinises the quality of care for patients who die during admission. The benefits of the service for the families or carers are likely to be the most impactful as the service provides clarity, dissipates doubts, and helps to alleviate negative thoughts and experiences the families or carers may be experiencing. Providing a voice to the bereaved at this most difficult of times is critically important and rewarding. It allows them to make significant improvements in what happens after death, including identifying areas for improvement as well as highlighting good practice. The service ensures a correct and accurate cause of death is registered and appropriate deaths are referred to the coroner.

Representatives from the Medical Examiners attend the Trust's Mortality Improvement Group and share a case review for learning bi-monthly. The Trust has invested in a bespoke module for SystmOne to allow primary care to refer deaths to the Medical Examiner Service for review. This will facilitate more robust scrutiny of community deaths.

In November 2023, the Trust transitioned onto a new electronic Audit Management and Tracking (AMaT) system which has a Mortality and Morbidity Review (MaMR) module for completing SJRs. This system was to replace the previous, SJR Plus System, provided by NHS England that had proved problematic resulting in a backlog of SJRs. The new system has gained positive feedback from users and engagement with timely completion of SJRs, clearing the backlog of SJRs.

The Trust is committed to continuously learning from deaths to improve the quality of care provided to patients, their families, and carers. The following learning themes have been identified in 2023/24:

- Incomplete or poor-quality documentation in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents.
- Missed opportunity for recognition of End of Life (EOL) pathway at earlier stage.
- Lack of anticipatory care planning.
- Quality of inpatient Medical/Nursing Documentation.

Actions implemented to address areas for improvement include:

- The divisional Doctors Induction has been updated to include an early introduction to ReSPECT and End of Life.
- Recognition and care planning are included in training delivered by the specialist End of Life team with different options of training delivery offered to improve compliance, including face to face, virtual training and targeted sessions.
- A training video for doctors to help recognition of End of Life pathway at an earlier stage has been recorded and a tiered approach to training is in development.
- A questionnaire for Medical staff has been launched to further understand the barriers to early recognition of End of Life and decision making to stop active treatment.
- The palliative care consultant at SGH has been attending the Medicine Quality and Safety/Audit Committee to provide ReSPECT training.
- The General Medicine Council (GMC) attended the medicine Division’s Quality Safety meeting and provided a very detailed presentation in relation to Clinical Documentation.
- The implementation of the 7-day Specialist Palliative Care Clinical Nurse Specialists commenced on 1 August 2023.
- The Bluebell model fully rolled out across the trust in all 3 acute sites with good evidence of how individual elements impact on patient care being documented in the Care in the Last Days of Life document.
- Introduction of electronic referrals to the End of Life team via WebV introduced.
- Collaboration with chaplaincy and voluntary services continues.
- Re-design of the Family Voices Diary to improve compliance.
- The care in the last days of life document was electronically rolled out Trust wide significantly increasing completion compliance.
- End of Life champions are in place within ward areas.
- The Mental Capacity Act/Deprivation of Liberty Safeguards team have been providing additional training and support to staff to improve compliance and quality of mental capacity assessments and best interest forms.
- An End of Life staff survey was launched to help understand the challenges and areas of focus.
- There has been successful recruitment of three additional specialist Palliative care clinical nurse specialists and an End of Life practice educator.

- Work has been completed to help improve the level of communication in our discharge summaries around DNACPR decisions and ceiling of care recorded on ReSPECT forms.
- A patient and carer survey has been developed with support from Healthwatch to further understand patient and family experience related to end of life/palliative care communication.

## 2.3j Details of ways in which staff can speak up

All NHS staff should be able to speak up regarding any concerns they may have in full confidence of not suffering any form of detriment as a result. The Trust is committed to ensuring that employees working for the Trust are not only encouraged to do this but are actively supported and guided as to how they can do this, should they feel the need to, whether they are concerned about quality of care, patient safety or bullying and harassment within their workplace.

The Trust has encouraged and supported staff to speak up by instituting several mechanisms for staff to raise concerns, these include:

- Raise concerns with their line manager. If this is not possible for any number of reasons, staff have further established routes in place and available to them to speak up, including:
  - Through the Trust's nominated Freedom to Speak Up Guardian (FTSU).
  - Via the Human Resources Department, a part of the Trust's People Directorate.
  - Logging an incident on the Trust's incident reporting tool hosted on Ulysses.

The Trust's Freedom to Speak Up Guardian, their role, contact details and the principles of Freedom to Speak Up process is communicated to all new starters within the Trust as part of the corporate induction programme. The Trust's appointment of a substantive guardian in 2020 has led to a significant increase in the number of concerns raised and the role of the Guardian is widely publicised to all. Feedback shows staff would feel safe to speak up again.

The Guardian role and the Speaking Up process is further promoted through printed and digital materials.

In the Trust and in the past 12 months there have been several promotional events (including a highly publicised campaign for the NGO Speak Up month in October), and additional magazine features. The Guardian is active on social media and regularly uses it as a way of communicating to staff. The Freedom to Speak Up Guardian is accessed via a generic email address and a dedicated mobile telephone number. Staff can also raise concerns using the Staff App, which gives another portal to access Guardian support.

In October 2023, the Guardian began a recruitment campaign for colleagues to volunteer to become 'Speak Up Champions', this role will support the work of the Guardian as they will be available for colleagues to speak to, raise awareness of the Guardian and will be able to signpost to appropriate support services. Champions had to complete an application and have line manager support, so that they will be given the time to be actively involved in making speaking up, business as usual. Champions will not take on any cases. The development of Champions is something that the National Guardian's Office recommend to support the work of the FTSU Guardian. All Champions must complete recognised NGO/HEE Speak Up, Listen Up and Follow Up modules to increase their awareness and also undertake National Guardian Office Champions Training. To date (March 2024), there are 15 Champions trained. The Guardian will continue to advertise the role as part of their Communications strategy.

In February 2023, the Trust formally adopted the Freedom to Speak Up Policy and Process for the NHS, which was developed by the NGO and NHSE with a recommendation that all Trusts adopt it. The Policy has been amended to include relevant Trust contacts. The Freedom to Speak Up Guardian responds to all concerns raised under this process and follows through each case according to the individual requirements providing regular communications and feedback until the case is concluded. Evaluation feedback from staff raising concerns has shown confidence in the Guardian and the overall process.

The Trust's Freedom to Speak Up Guardian meets monthly with the Chief Executive and the Director of People (who is the Executive Sponsor) and bi-monthly with the Trust Chair and Non- Executive Director with specific responsibility for Freedom to Speak Up who provides support to this function. The Freedom to Speak Up Guardian also meets monthly with the Trust Patient Safety Specialist to discuss any concerns raised in relation to Patient Safety. A quarterly Freedom to Speak Up Guardian report is reviewed by the Trust Management Board and the Workforce Sub-committee prior to being presented to the Trust Board by the Freedom to Speak Up Guardian. This ensures the Trust, and its board are kept up to date on concerns including sufficient details as per the National Guardian's recommendations. An overview of the report is shared with all staff by quarterly infographics. The Guardian is also sharing information to all Divisions about the number and nature of the concerns raised via the HR business partners. This information now forms part of the Divisions performance review meetings and information and can be used in conjunction with other HR intelligence data to highlight potential areas for further analysis.

During 2022/23 there was a significant increase in concerns raised with 220 cases brought to the Guardian. This figure has already been exceeded for 2023/24 and is expected to be over 300. The latest staff survey results indicate an increased confidence in staff being able to raise concerns either clinical or about anything else to the organization and an

increase in confidence that the organization will address issues.

The FTSU Guardian has produced an annual progress report against the Trust's Freedom To Speak Up Strategy 2020-2024 which looked at the objectives set out in the strategy, progress made against them, and if additional actions are required to fulfil them. It is hoped that most objectives set out in the strategy will be met by 2024 and no additional actions were identified at this stage.

Future workstreams for the FTSU Guardian in 2024/25 include working with HUTH FTSU Guardian to produce a Group 'Freedom To Speak Up' strategy, and alignment of reporting themes for consistency of reporting. As we are two sovereign organisations, submission of data to the National Guardians Office will be separate and the Guardians will support employees of their respective organisations, this is in line with National Guardian Office requirements.

## 2.3k Information about the Guardian of Safe Working Hours

The 2016 national contract for junior doctors encouraged stronger safeguards to prevent doctors from working excessive hours. With this came the introduction of a 'Guardian of Safe Working Hours' in organisations that employ, or host, NHS doctors and dentists in training to oversee the process of ensuring they do not work excessive hours with inadequate breaks. The contract has stipulations on the length and frequency of shifts as well as rest breaks.

Exception reporting is a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

The Guardian of Safe Working will support safe care for patients through protection and prevention measures to stop doctors working excessive hours. The Guardian of Safe Working oversees the exception reporting process and has the power to levy financial penalties where safe working hours are breached. The role sits independently from the management structure, and the Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and / or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The safety of patients is a paramount concern for the NHS and for us as a Trust. Staff fatigue is a hazard to both patients and staff. The safeguards for working hours of doctors in training are outlined in the TCS and are designed to ensure that this risk is mitigated, and that this mitigation is assured.

There are no trainees within the Dentistry service at the Trust and so the Annual Report applies only to doctors in training. Fill rates for doctors in training at the Trust continue to be high, over 80%, which has helped with rotas, working hours, and ensuring access to

educational opportunities.

Rota design and co-ordination currently sits within the Workforce Resource Centre. This provides oversight of rota design and ensures that the terms and conditions of service as per the Junior Doctors Contract are met within that design.

**Data Analysis**
Number of training posts (total): 317.98
Number of doctors in training posts: 315.44 (includes 243.24 doctors in training programmes and 72.2 doctors in trust grade positions)
Number of training post vacancies: 2.54
Number of LTFT trainees: 52

The table below, provides a breakdown by specialty of the total number of exception reports received during the period April 2023 to March 2024.

| Directorate | Total number of exceptions submitted | Number of trainees Per Area | Reports per trainee (2023/24) | Reports per trainee (2022/23) |
|---|---|---|---|---|
| Surgery and Critical Care | 27 | 65 | 0.42 | 0.7 |
| Family Services | 40 | 59 | 0.68 | 0.3 |
| Medicine | 158 | 128 | 1.2 | 1.7 |
| **Grand Total** | **225** | **252** | **-** | **-** |

The number of immediate safety concerns received this year had decreased - 9 of the 225 reports received highlighted an immediate safety concern this year, in comparison with 25 of 252 reports the previous year. This ratio of immediate safety concerns to overall reports highlights that the system is being used appropriately and isn't just being used as a last resort when things are unsafe. This is a reassuring finding which we hope to see continue.

The majority of the reports received concern excess hours worked. The reason for this is likely to be that it is an easily recognisable incident which can be quantified, and thus is more likely to be reported. There appears to be an increase in the number of reports submitted in July and August, which is to be anticipated owing to the Junior Doctors rotating jobs. This usually settles down as the doctors, in particular the foundation year one doctors, become more familiar with their roles and therefore more efficient and less likely to need to stay after hours. There has been a high rate of reporting for excess hours during January and February, this is in keeping with what has been experienced in previous years and is likely to be due to a combination of winter pressures and staff sickness. It is reassuring to see that the impact of the consultant strikes seems to have been fairly minimal, with lower levels of reporting for lack of support during service commitments in the strike months of September and October.

The Trust was granted £60,000 of national money in 2021 to improve facilities for doctors in training and working in partnership with the doctors this has now been used to upgrade the doctors rest facilities and enhance the doctor's mess. This work has now been completed, and upgraded rest areas are available on both sites.

Fill rates remain high but this does not always translate in the reduction in need for locums and further work at Directorate level is required to understand the demands for locums, with the aim to reduce the reliance on locum doctors.

There have been no fines imposed for breaches of the Doctors in Training Contract. These fines were imposed for doctors missing breaks, and for excessive working hours. All money previously generated through fines has been spent on wellbeing resources to benefit the Doctors in Training.

This past year continued to see an improvement in engagement with our doctors in training. We will continue to build on this during the next academic year.

The Guardian of Safe Working holds monthly Junior Doctor Forums (JDF). Issues addressed at the JDF over the past year have included:

- Rota concerns
- Working conditions
- Locum pay
- Mandatory training requirements

There is a defined slot at the JDF to discuss quality improvement and there is a dedicated point of contact within the quality improvement office to support the Junior doctors.

The Guardian of Safe Working circulated a survey in the last quarter of the year. This showed that the role is well embedded in the trust, and the Junior Doctors felt able to approach the Guardian for help when needed. The role is held in positive regard, which we hope will continue in the coming years.

## 2.4 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. However, due to the impact of COVID-19 some national data collection was paused leading to delays in publication. Consequently, to retain consistency and to comply with the national guidance the tables within the report have been populated with the latest published data that is available from NHS Digital. Where appropriate the narrative provides a local update.

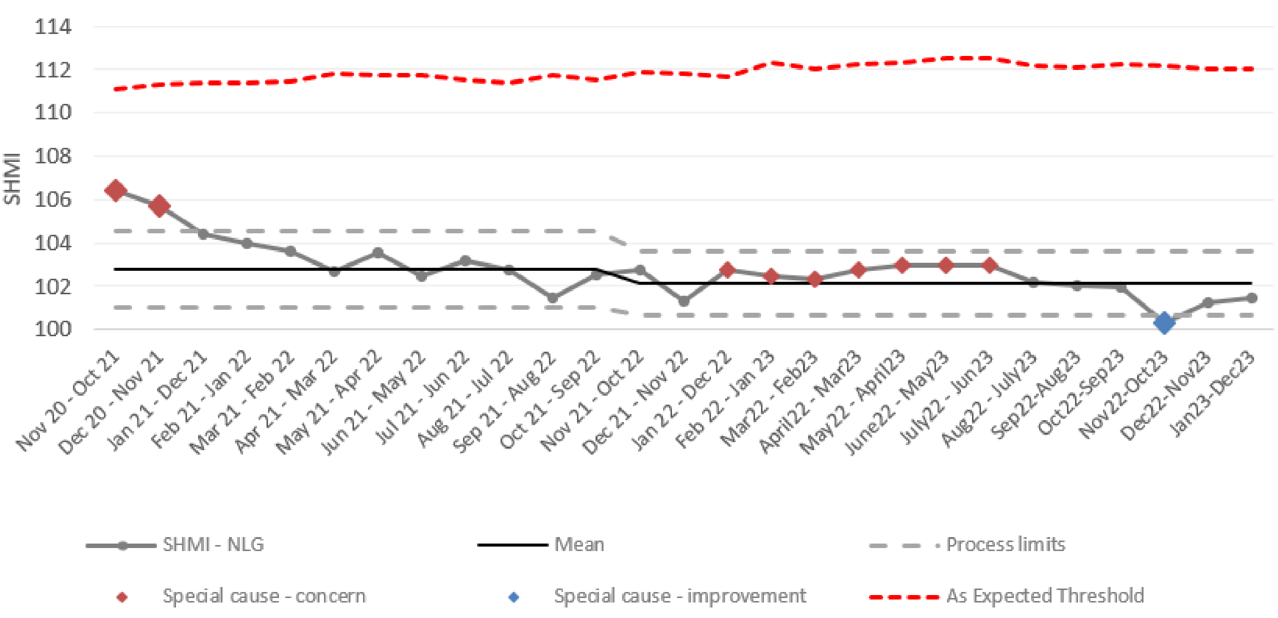
For each indicator, the number, percentage value, score, or rate (as applicable) for the last two reporting periods as well as the lowest and highest values and national average for each indicator for the latest reporting period will be represented in table format below. Some of the mandatory indicators are not relevant to Northern Lincolnshire and Goole NHS Foundation Trust; therefore, the following indicators reported on are only those relevant to

the Trust.

## 2.4a Domain 1 – Preventing people from dying prematurely

| Indicator | Trust value Jan 2022 Dec 2022 | Trust value Jan 2023 Dec 2023 | NHS (England) Jan 2023 Dec 2023 | National highest Jan 2023 Dec 2023 | National lowest Jan 2023 Dec 2023 |
|---|---|---|---|---|---|
| The value of the SHMI for the Trust for the reporting period* | 1.03 | 1.01 | 1.00 | 1.25 | 0.72 |
| The banding of the SHMI for the Trust for the reporting period* | 2 (as expected) | 2 (as expected) | 2 (as expected) | 1 (higher than expected) | 3 (lower than expected) |
| The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period* | 23% | 23% | 42% | 67% | 16% |

**Source:** NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of- interest/hospital-care/quality-accounts). *Reporting period January 2021 to December 2022



- The above chart illustrates the Trust's performance against the Summary Hospital Mortality Indicator (SHMI). The SHMI is a Standardised Mortality Ratio (SMR). SHMI is the only SMR to include deaths out-of-hospital (within 30 days of hospital discharge). The SHMI is a measure of observed deaths compared with 'expected deaths', derived statistically from the recording and coding of patient risk factors.

- NHS Digital guidance on SHMI interpretation states that the difference between the number of observed deaths and the number of expected deaths cannot be interpreted as 'avoidable deaths'. The 'expected' number of deaths is not an actual count but is a statistical construct which estimates the number of deaths that may be expected based on the average England figures and the risk characteristics of the Trust's patients. The SHMI is therefore not a direct measure of quality of care.

- The Trust, as demonstrated in the chart above, has demonstrated statistically significant improvement in the SHMI resulting in the Trust being categorised as having mortality that is 'as expected'. The rolling 12-month SHMI value for the Trust for the period January 2023 – December 2023 was 101.14.

- Palliative care coding is a group of codes used by hospital coding teams to reflect palliative care treatment of a patient during their hospital stay. There are strict rules that govern the use of such codes to only those patients seen and managed by a specialist palliative care team.

- The SHMI does not exclude or make any adjustments for palliative care. Other Standardised Mortality Ratios (SMRs) like the Hospital Standardised Mortality Ratio (HSMR) adjust for palliative care.

**Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:**

- The Trust continues with the processes to improve the quality and accuracy of the data that underpins statistical mortality calculations like the SHMI and improving the consistency of the learning from deaths programme of work.

- Data continues to highlight a difference between hospital sites with SGH having higher levels of palliative care coding than DPoW. This reflects the disparity of consultant-led Palliative care provision between both hospitals. Planned increase in consultant capacity is on hold in both North Lincolnshire and North East Lincolnshire currently due to changes in allocated funds. Next steps regarding medical staffing are being considered through the Northern Lincolnshire Strategy Group.

The Trust has taken the following actions to improve the indicator and percentage in indicators a and b, and so the quality of its services by:

- Clinician led coding validation sessions and mortality screening reviews have continued throughout 2023/24.
- Education around requirements to complete Co-morbidities sheet to be completed.

- Education to clinicians regarding coding rules supported by appropriate phrasing guide.
- Fracture of neck of femur, reintroduced dedicated ward at SGH.
- Teaching sessions and case study presentations have been shared at Divisions Quality & Safety meetings to share learning and reduce coding errors.
- The Trust is taking a pro-active approach to monitoring outcome risk of death for each SHMI diagnosis group and undertakes deep dive work with case reviews to learn from any early warning indicators to prevent future outlier alerts.
- Quality Summit packs created triangulating information from NICE, GIRFT, National Audits and Model Hospital identifying areas of good practice and areas for improvement.
- Referral for Gastrointestinal Bleed under review.
- Education for Junior Doctors on the appropriateness of referring patients with suspected Gastrointestinal Bleed.
- The Clinical Coding team receive monthly palliative care contacts extract from North Lincolnshire Community and Therapy Services and North East Lincolnshire Care Plus Group. This is cross referenced against the patient coded data and any omissions are added for data quality purposes.
- Implementation of 7-day Specialist Palliative Care commenced at SGH on 5 August 2023 utilising single point for WebV referral. Collaborative working with Care Plus Group enabled electronic referrals to the End of Life team to be rolled out at DPoW in October 2023.
- Successful recruitment of three additional specialist Palliative care clinical nurse specialists and an End of Life practice educator.

## 2.4b Domain 3 – Helping people to recover from episodes of ill health or following injury

### Patient Reported Outcome Measures (PROMS)

The data detailed in the table below was made available to the Trust by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

a) Hip replacement surgery
b) Knee replacement surgery
c) Varicose vein surgery *(Not applicable as no longer performed by the Trust)*

The PROMs is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The table shows the adjusted health gain reported by the patient reported using the EQ-5D index, following their surgery. EQ-5D index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value. The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health). As participation is voluntary, patients can choose not to participate in PROMs.

| Type of surgery | Sample time frame | Trust adjusted average health gain | National average | National highest | National lowest |
|---|---|---|---|---|---|
| **Hip replacement (Primary)** | April 2020 – March 2021 | 0.410 | 0.472 | 0.574 | 0.393 |
| | April 2021 – March 2022 | 0.465 | 0.462 | 0.534 | 0.375 |
| **Knee replacement (Primary)** | April 2020 – March 2021 | 0.334 | 0.315 | 0.399 | 0.181 |
| | April 2021 – March 2022 | 0.288 | 0.324 | 0.417 | 0.245 |

**Source:** NHS Digital Quality Account Indicators Portal, Primary data used, EQ-5D Index used (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

**Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:**

The data period of April 2020 – March 2021 was during the peak of the COVID-19 pandemic and this resulted in some activity being cancelled altogether and limited restoration for the remainder of the period, the number of modelled records more than halved from the previous year. Also, some lower risk patients were transferred to the independent sector which would likely influence the Trust's average patient reported outcomes scores.

Patient-reported outcomes following primary knee and hip replacement surgery are within the statistically calculated confidence intervals for EQ-5D measures.

**The Trust has taken the following actions to improve these outcome scores, and so the quality of its services by:**

- Data made available from the PROMs dataset is presented within the division of surgery to support reflective practice and agreement of actions required for improvement. A summary report is presented at the Quality Governance Group and also the Quality and Safety Committee.
- Some lower risk patients were transferred to the independent sector to help reduce waiting lists.
- To improve participation rates, the process for handing out the questionnaires should be the same across the Trust so patients who are pre-assessed at one site and then have surgery at another won't be missed. A trial is taking place at DPOW for the ward clerk to hand out the pre-operative questionnaires on the day of the patient's surgery which will mirror the current process at GDH.

## Patients readmitted to a hospital within 30 days of being discharged

The data made available to the Trust by NHS Digital with regard to the percentage of patients aged:

a) 0 to 15; and
b) 16 or over,

readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital during the reporting period.

| Indicator | Trust value April 2021 March 2022 | Trust value April 2022 March 2023 | National average | National highest | National lowest |
|---|---|---|---|---|---|
| Percentage of patients aged between 0 to 15 readmitted to a hospital within 30 days of being discharged. | 12.4 | 14.9 | 12.8 | 302.9* | 3.7 |
| Percentage of patients aged 16 or over readmitted to a hospital within 30 days of being discharged. | 12.1 | 12.6 | 14.4 | 46.8 | 2.5 |

**The score of 302% is considered an anomaly. The next highest data presented by NHS Digital is 37.9%.*

**Source:** NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of- interest/hospital-care/quality-accounts)

**Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:**

The Trust is below the England average for readmissions in patients aged over 16 years. This is borne out by local performance reporting against peer benchmarked data.

The Trust is above the England average for readmissions in patients aged between 0 to 15. This is thought to be a data quality issue relating to ward attenders following treatment from the Hospital at Home team being coded incorrectly as readmissions.

**The Trust intends to take the following actions to improve these percentages, and so the quality of its services by:**

- The Trust continues to monitor its readmission rates on a monthly basis (from locally available data) and compares these to the national rates in order to benchmark our performance.
- Patient flow and discharge workstreams continue in order to achieve national targets.
- Discharge lounge consultation to standardise and extend opening to 10pm completed.
- Weekly expert panel in place to review adult patients with multiple admissions, supported by Northern Lincolnshire system partners.
- A deep dive into the coding of Hospital at Home and ward attender patients is underway to improve coding accuracy.

## 2.4c Domain 4 – Ensuring people have a positive experience of care

### Responsiveness to the Personal needs of patients

The Trust reviews its responsiveness to the needs of patients through monitoring responses to five specific questions:

1. Were you involved as much as you wanted to be in decisions about your care and treatment?
2. Did you find someone on the hospital staff to talk to about your worries and fears?
3. Were you given enough privacy when discussing your condition or treatment?
4. Did a member of staff tell you about medication side effects to watch for when you went home?
5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

There has been no new data made available to the Trust by NHS Digital about the Trust's responsiveness to the personal needs of its patients since 2020. Therefore, the table below shows the data up to the most recent entry covering hospital stays between 01 July 2019 to 31 July 2019 (data collected between 01 August 2019 to 31 January 2020). Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100.

| Indicator | Trust value 2019 2020 | National average | National lowest | National highest |
|---|---|---|---|---|
| Responsiveness to inpatients personal needs | 62.5 | 67.1 | 59.5 | 84.2 |

**Source:** NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of- interest/hospital-care/quality-accounts).

**Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:**

The data is provided by the national survey contractor.

**The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:**

The Trust continues to gather patient feedback about patient involvement in care and decisions through its monthly INSIGHT survey programme, which supports the national inpatient survey questions, and the 15 Step assurance programme. This feedback provides opportunity for divisions to work closely with areas where feedback indicates further improvement is required.

The recent National Maternity Survey shows a consistent position, in comparison to the 2022 survey with a positive or maintained improvements to our internal and external benchmark scores.

The Trust recommenced Friends and Family Test (FFT) feedback which had been paused during the pandemic, this is collected via text message, paper cards and QR codes. There has seen an increase in staff engagement and positive responses. The introduction of the new FFT provider service has also seen a recent improvement in Emergency Department responses. From mid-November 2023 monthly reports were available for all wards and services. FFT will be utilised as a thematic tool for all areas to allow for triangulation of themes and feedback, to improve quality of service.

The Trust Patient Advice and Liaison Service (PALS) team always provide a supportive signposting service for patients and families. Dedicated work within the PALS team has seen a significant increase in reducing the timeliness of responses to patients and relatives. A change to the complaints process has seen the time to resolve complaints reduce which ensures patients or their relatives receive a response in a timely manner.

Following a complaint from a family member Carols campaign was launched which resulted in a review of hospital visiting times. The Trust recognizes the positive benefits that visiting offers so the times were changed to 11-8 to offer visitors increased flexibility to visit. What the changes aim to ensure is that we are providing compassionate and patient-centered care for people when they most need it.

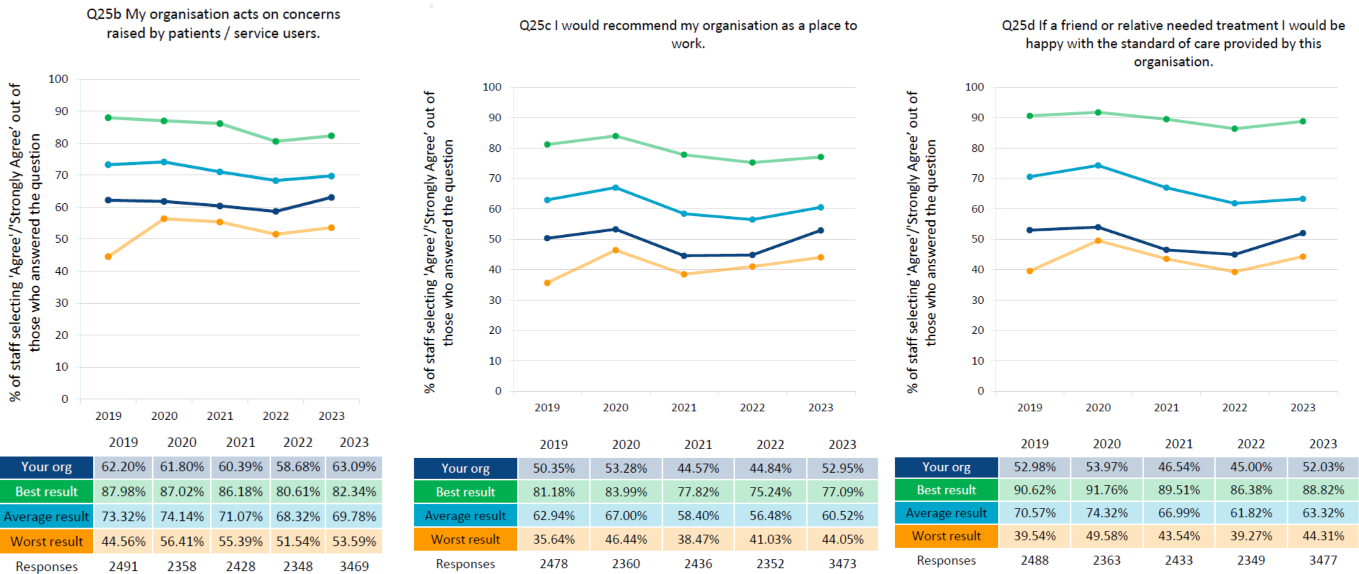
This change included the launch of the care partner scheme. Care Partners are people who support or care, unpaid, for a friend or family member. It is usually the person who the patient wants to support them in times of need or distress. They will have open access to visit when required by the patient.

We know that having access to the person you need most when you are ill or in hospital can be massive and it can have a huge impact on a person's mental and physical wellbeing.

## Staff recommending Trust as a provider to friends and family

The data made available by NHS Digital with regards to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends is taken from the Trust's NHS Staff Survey Benchmark report 2023 published on 07 March 2024.

| Indicator | Trust value 2022 | Trust value 2023 | National average | National lowest | National highest |
|---|---|---|---|---|---|
| The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. | 45% | 52.03% | 63.32% | 44.31% | 88.82% |




Q25b

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 62.20% | 61.80% | 60.39% | 58.68% | 63.09% |
| Best result | 87.98% | 87.02% | 86.18% | 80.61% | 82.34% |
| Average result | 73.32% | 74.14% | 71.07% | 68.32% | 69.78% |
| Worst result | 44.56% | 56.41% | 55.39% | 51.54% | 53.59% |
| Responses | 2491 | 2358 | 2428 | 2348 | 3469 |

Q25c

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 50.35% | 53.28% | 44.57% | 44.84% | 52.95% |
| Best result | 81.18% | 83.99% | 77.82% | 75.24% | 77.09% |
| Average result | 62.94% | 67.00% | 58.40% | 56.48% | 60.52% |
| Worst result | 35.64% | 46.44% | 38.47% | 41.03% | 44.05% |
| Responses | 2478 | 2360 | 2436 | 2352 | 3473 |

Q25d

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 52.98% | 53.97% | 46.54% | 45.00% | 52.03% |
| Best result | 90.62% | 91.76% | 89.51% | 86.38% | 88.82% |
| Average result | 70.57% | 74.32% | 66.99% | 61.82% | 63.32% |
| Worst result | 39.54% | 49.58% | 43.54% | 39.27% | 44.31% |
| Responses | 2488 | 2363 | 2433 | 2349 | 3477 |

**Source:** Northern Lincolnshire and Goole NHS Foundation Trust Staff Survey Benchmark Report 2023.

**Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:**

The above table illustrates the percentage of staff answering that they “Agreed” or “strongly agreed” with the question: “If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust” as published on the Staff Survey Coordination Centre website.

52.03% of staff surveyed would recommend the Trust (+7% since 2022); the increase in the Trust’s score is higher compared with other organisations nationally and in the integrated Care System (ICS) and is likely to be a response to the positive changes that the Trust has made in the last year. It should be noted that the England average increased from 61.9% in 2022 to 63.32% (+1.4% since 2022).

Whilst 2022 scores demonstrated that pressures and backlog of responses to health concerns and treatment the COVID-19 pandemic impacted on overall staff wellbeing and levels of engagement, resulting in a reduction in most scores in 2022 compared to 2021, 2023 shows a marked improvement overall. The Trust has worked on and across all staff survey themes through dedicated cultural and services improvement plans. It should be noted that despite continuous service pressures the Trust’s score in relation to “Care of patients/service users is my organisations top priority” continues to improve against 2022 and above national trends.

**The Trust has taken the following actions to improve this percentage, and so the quality of its services by:**

For the last four years significant work has gone into transforming the culture and supporting staff on front line services of the Trust. The Trust is taking the following strategic direction to improve our overall scores:

- The implementation of a Leadership Development Strategy focused on increasing line manager core skills, developing a values based leadership programme centred on improving leadership influence on culture and implementation of structured career pathways and education opportunities for clinical and non-clinical staff. As a result of investment in leadership development the Trust has piloted and rolled out 13 cohorts across all professions priority areas and management groups in 2023.

- The continuation of a cultural transformation programme developed with our staff since August 2022 to improve employee experience resulted in high levels of staff engagement and voice: the Trust has since rolled out a culture transformation working group and Board. 2023 has seen the development of a culture change academy aimed at individuals, teams, leaders and the development of a network of culture change ambassadors.

- Proactive career planning within nursing, including expanding the apprenticeship framework to enrich nursing career opportunities and retain good staff.

- Improved recruitment strategy and actions to become an Employer of Choice.

- Implementation of an Equality, Diversity, and Inclusion action plan to strengthen our inclusion, diversity and equity. The Trust has launched 3 staff networks Black and Minority Ethnic (BME), Disability, LGBTQ+ in 2022 and launched the Women's network in 2023. A provision of educational programmes from 2023 onwards, ran with and through the staff networks, will support a more inclusive and equitable workforce and workplace.

- The Trust's two year health and wellbeing plan designed to build on progress made to date and embed effective leadership of our staff's health and wellbeing, introduced Schwartz rounds, growing a network of wellbeing champions and offering training in the field of Mental Health First Aid along with a review of our staff wellbeing spaces, improvement of rest areas, and implementation of financial wellbeing services and education, social wellbeing and career wellbeing in collaboration with organisational development and learning and education.

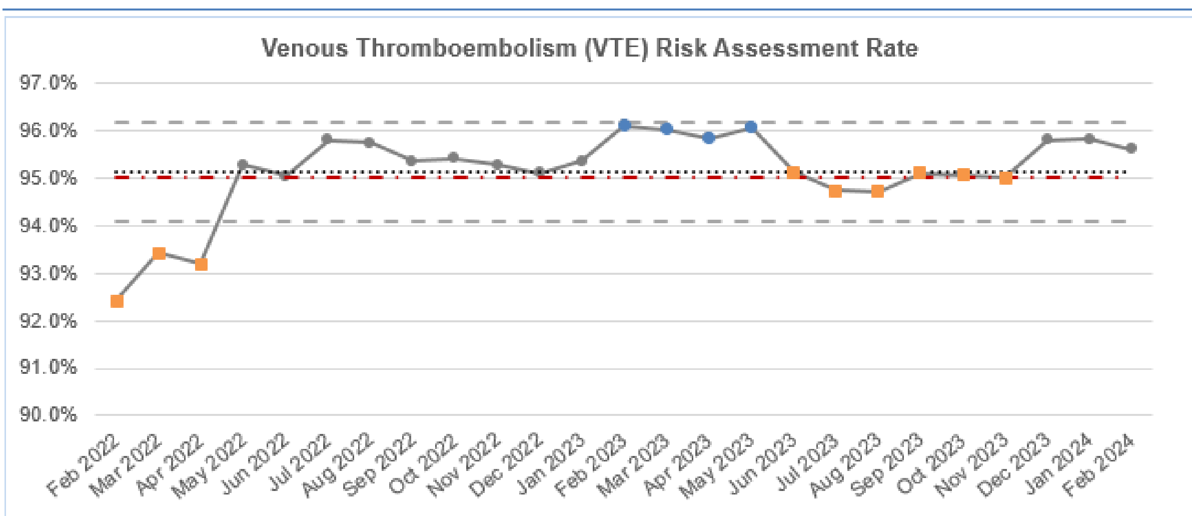
- The Trust aims to further develop this work in 2024 through leadership programme, culture programmes, coaching, mentoring and the development of a culture change academy aimed at individuals, teams, leaders, and a network of culture change transformation and the introduction of a dedicated People Promise Manager in May 2024.

## 2.4d Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

### Risk assessed for Venous Thromboembolism (VTE)

The national VTE data collection and publication was paused to release NHS capacity to support the response to the Covid-19 pandemic. National data collection remains

paused, so the below data only reflects local Trust performance data.




**Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:**

- The Trust reports on and oversees local VTE risk assessment compliance through the Trust's Performance Review meetings and in the Executive Governance reporting mechanisms. Compliance figures are also available at specialty level, allowing targeted support if indicated.

**The Trust has taken the following actions to improve this percentage, and so the quality of its services by:**

- The Trust completed the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system in November 2021. The system is having the desired effect in improving patient safety as built-in controls prompt doctors to undertake full VTE risk assessments in a timely manner, prior to prescribing or administering medications. Since the introduction of the EPMA system VTE risk assessment rate has significantly improved and remained above the Trust's 95% target since May 2022,

- The Trust's Quality Governance Group receives a highlight report in relation to VTE screening performance.

**Clostridium Difficile infection reported within the Trust**

The data made available to the Trust by NHS Digital regarding the rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust (hospital onset) amongst patients aged 2 or over is shown in the table below. *(Most recent data published by NHS digital on 6 October 2023).*

| Indicator | Trust value 2020/21 | Trust value 2021/22 | Trust value 2022/23 | National average 2022/23 | National lowest 2022/23 | National highest 2022/23 |
|---|---|---|---|---|---|---|
| The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period. | 7.9 | 5.1 | 8 | 18.3 | 0 | 73.3 |

**Source:** NHS Digital Quality Account Indicators Portal https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

**Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:**

The data shows that the Trust has maintained a position beneath the England average and is one of the best performing acute hospitals in Enagland which is a major achievement.

The definitions for reporting Clostridium difficile cases changed in April 2019 meaning cases detected after 2 days would be attributed as Hospital Onset Healthcare Associated (HOHA) as opposed to the previous guidance, which specified 3 days previously. Cases would also be classed as Community Onset Healthcare Associated (COHA) if the patient was an in-patient within the previous 4 weeks.

Due to success of considerable reduction of cases in previous years, the trajectory for the year 2023 - 2024 of 20 cases was extremely challenging. The Trust had a Clostridium difficile infection objective of no more than 20 cases and ended the year on 18 reported cases combining Hospital-onset healthcare associated and Community-onset healthcare associated cases. There were no significant lapses in practice/care detected from the post infection reviews undertaken. Despite exceeding the threshold, The Trust performed exceptionally well for Clostridium difficile rates for all England acute trusts based on 100,000 bed days and the best performing trust in the region and in the lowest quartile nationally.

**The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:**

- Capital and planning teams factored the need to increase isolation capacity in building schemes e.g. The new Integrated Acute Admission Unit and Same Day Assessment Unit at Diana Princess of Wales Hospital and Scunthorpe General Hospital.
- The Trust has an evidence-based Clostridium difficile policy and patient treatment care pathway.
- Multi-disciplinary team meetings are held for inpatient cases where required to identify any lessons to be learnt and post-infection review is conducted for hospital onset cases.
- For each case admitted to hospital, practice is audited by the infection prevention and control team based on the Department of Health Saving Lives' audit tools.
- Themes learnt from the Post-Infection Review (PIR) process are monitored by the

Infection Prevention & Control Committee and shared with relevant bodies.

- The bespoke IPC alert which informs the IPC team to previous cases of Clostridium difficile.

- GPs are sent an email to inform them of a patient's Clostridium difficile status again to help reduce the amount of antimicrobial use and prevent future Clostridium difficile cases; This is now incorporated into the patient discharge letter.

- The continuation of a rolling programme of antibiotic prescribing audits reviewed by the Infection Prevention & Control Group.

- PathLinks antimicrobial formulary reviewed with latest national standards.

- The Trust participated in the National Point Prevalence survey of healthcare associated infections antimicrobial use and antimicrobial stewardship in England. This will provide information and actions to improve antimicrobial prescribing and management. This can also have a positive patient outcome to minimize the acquisition of CDI.

- Updated antimicrobial Trust intranet site, the HUB, to make access to content easier for prescribers.

### Patient safety incidents

| Time frame | Trust number of patient safety incidents reported | Trust rate of patient safety incidents reported per 1,000 bed days | Trust number of patient safety incidents reported involving severe harm or death | Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days | Percentage of safety incidents that resulted in severe harm or death |
|---|---|---|---|---|---|
| April 2021 – March 2022 | 15,533 | 72.6 | 25 | 0.11 | 0.16% |
| April 2022 – March 2023* | 24,488 | 99.98 | 36 | 0.15 | 0.15% |
| April 2023 – March 2024* | 19,627 | 82.29** | 33 | 0.14 | 0.17% |

**Source:** NRLS Organisation data workbook for the period April 2021 – March 2022. *From April 2022 there has been no data published nationally therefore this has been calculated internally by the Trust. **Bed days data is not available for the month of March 2024 due to the Trust switching to a new Electronic Patient Record (EPR) system in February 2024. Bed days for March 2024 has therefore been calculated using an average of the bed days from April 2023 – February 2024.

### Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- A significant increase in incidents reported is noted for the reporting period April 2022 – March 2023 in comparison to the previous year (April 2021 – March 2022) and the subsequent year (April 2023 – March 2024). This was due to a requirement to report all Emergency Department 12-hour trolley waits on an individual basis. This was subsequently

changed to recording a daily summary of these types of incidents resulting in a reduction of incidents reported in April 2023 – March 2024.

**The Trust has taken the following actions to improve this number and/or rate, and so the quality of its services by:**

- The Trust continues to monitor incident rates locally and actively promotes and encourages staff to report all incidents including near misses as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicate a high level of safety awareness. This is particularly so when the high level of reporting is for no/low harm or near miss incidents. 98% of patient safety incidents reported in each of the timeframes shown in the table were in this category of harm levels.

- The Trust continues to monitor the data for understanding of key themes and sharing learning opportunities.

- The Trust continually works towards improving learning in the organisation and has a learning strategy in place.

- In December 2023 the Trust commenced transition to the new Patient Safety Incident Response Framework (PSIRF) as part of the new national initiative. The Trust has completed a number of proportionate learning responses focusing on areas where improvement will have the greatest impact as outlined in the Trust's Patient Safety Investigation Response Plan. Findings from these reviews are used to identify themes and trends across the organisation for learning and improvement purposes.

- The Trust oversees the identification and management of incident investigations weekly at the Learning Response Panel ensuring that the appropriate learning response is undertaken in line with the PSIRF and Patient Safety Incident Response Framework Policy and Plan. Incidents are also reviewed at a daily incident navigation meeting to actively determine the appropriate management of those incidents so that valuable learning can be identified and acted upon as early as possible to improve the quality of our services.

# PART 3: Review of Quality Performance

## 3.1 Performance against relevant indicators and performance thresholds

Performance against indicators that form the Oversight Framework (not already reported on within this document) are shown as follows for 2023/24.

| Indicator | Quarter 1 23/24 (Percentage) | | | Quarter 2 23/24 (Percentage) | | | Quarter 3 23/24 (Percentage) | | | Quarter 4 23/24 (Percentage) | | | Target | Full year average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | | |
| Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway | 64.49 | 65.07 | 63.91 | 63.16 | 61.87 | 61.24 | 61.85 | 61.46 | 60.48 | 61.50 | 60.58 | 60.47 | 92% | 60.47% (March 2024 snapshot) |
| A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge | 61.28% | 65.15 | 65.25 | 63.28 | 65.38 | 64.34 | 60.77 | 65.61 | 61.46 | 60.35 | 59.42 | 66.36 | 76% | 63.22% |
| All cancers: 62-day wait for first treatment from referral/screening | 54.73% | 68.23 | 61.54 | 55.94 | 48.54 | 50.00 | 51.97 | 43.67 | 50.70 | 49.44 | 52.11 | 70.89 | 85% | 54.81% |
| Maximum 6-week wait for diagnostic procedures | 38.52% | 35.79 | 35.31 | 37.04 | 36.49 | 31.49 | 26.78 | 25.04 | 26.37 | 22.03 | 16.47 | 15.47 | 1.0% | 28.9% |

## 3.2 Information on staff survey report

### Summary of performance – NHS staff survey

Each year the Trust encourages staff to take part in the national staff survey. The survey results give each health Trust a picture of how its staff think it's performing as an employer and as an organisation.

**Timeline**

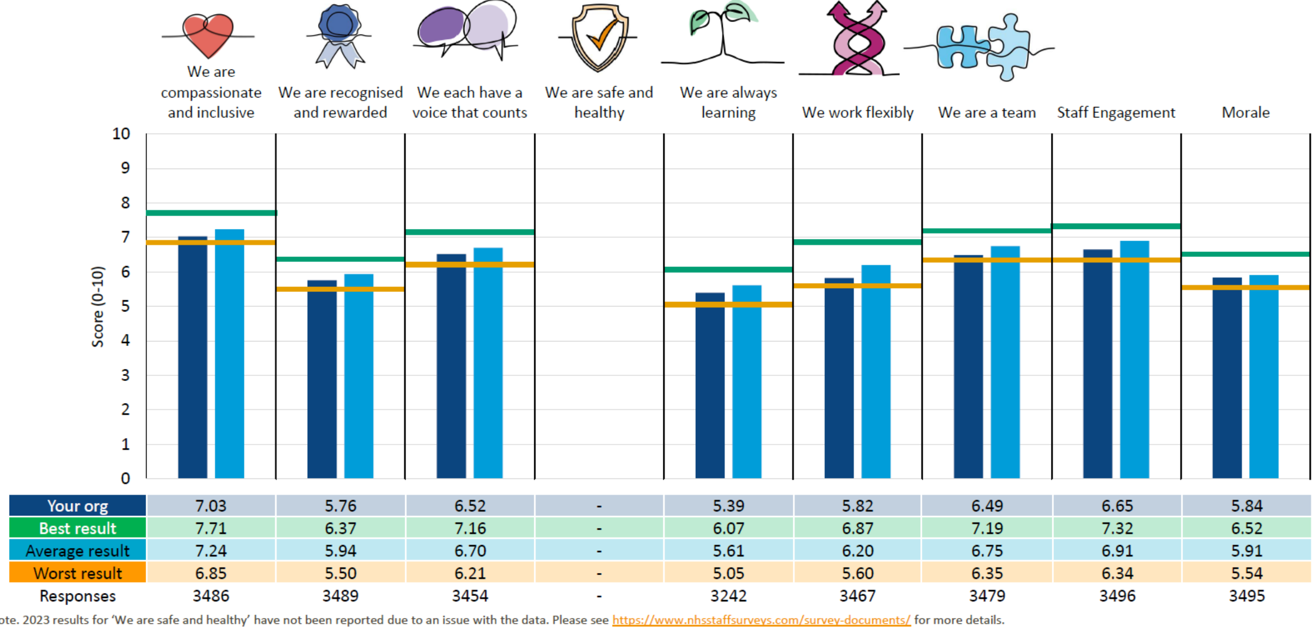
Survey Window: 2nd October 2023 to 24th November 2023
Embargoed Findings: Received – 28th February
2024 NHSEI Publication: 7th March 2024

**Key Facts**

Benchmark Comparators: 122 Acute & Acute Community Trusts
Benchmark Response Rate: 45% (-1 % on 2022 survey)
NLaG Response Rate: 48% (+13% on 2022 survey)
NLaG Survey Mode: Blended (3512 completed / +1097 on 2022)

**Staff Survey 2023 findings**

The 2023 survey questions are aligned to the seven themes of the People Promise.
Staff Engagement and Morale remain included as in previous years.
The chart below demonstrates Trust results in comparison to peer organisations.




| | We are compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| Your org | 7.03 | 5.76 | 6.52 | - | 5.39 | 5.82 | 6.49 | 6.65 | 5.84 |
| Best result | 7.71 | 6.37 | 7.16 | - | 6.07 | 6.87 | 7.19 | 7.32 | 6.52 |
| Average result | 7.24 | 5.94 | 6.70 | - | 5.61 | 6.20 | 6.75 | 6.91 | 5.91 |
| Worst result | 6.85 | 5.50 | 6.21 | - | 5.05 | 5.60 | 6.35 | 6.34 | 5.54 |
| Responses | 3486 | 3489 | 3454 | - | 3242 | 3467 | 3479 | 3496 | 3495 |

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

**Health and Well-Being**

Due to national technical issues in gathering data the Trust cannot fully evidence the impact of its actions on:

- Positive action being taken regarding health and wellbeing support.
- The uptake of staff working flexibly.

More guidance is available on the survey coordination centre

However, there are sufficient markers that indicate a positive outcome with regards to Health and Wellbeing for the Trust as follows:

**Health and Safety Climate**

Improvements in this particular theme will be felt by our staff and reduce the feeling of burnout with a focus on staffing which improved by +8.59% (q3i) as well as having sufficient resources and equipment (c+5.4% q3h) and calls for continued in investment in

this area.

Q3g I am able to meet all the conflicting demands on my time at work.

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 40.75% | 43.09% | 39.30% | 41.16% | 47.15% |
| Best result | 58.86% | 61.99% | 54.69% | 53.31% | 57.08% |
| Average result | 46.63% | 47.50% | 43.12% | 42.96% | 46.63% |
| Worst result | 36.05% | 38.27% | 34.26% | 32.24% | 37.52% |
| Responses | 2547 | 2379 | 2461 | 2355 | 3480 |

Q3h I have adequate materials, supplies and equipment to do my work.

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 50.85% | 56.50% | 52.84% | 50.09% | 55.47% |
| Best result | 74.53% | 74.54% | 72.96% | 69.73% | 72.97% |
| Average result | 54.19% | 58.54% | 55.33% | 53.52% | 56.88% |
| Worst result | 31.96% | 44.99% | 45.51% | 43.63% | 46.87% |
| Responses | 2551 | 2383 | 2480 | 2353 | 3488 |

Q3i There are enough staff at this organisation for me to do my job properly.

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 29.78% | 29.48% | 22.82% | 23.45% | 32.04% |
| Best result | 48.09% | 52.30% | 37.83% | 34.84% | 44.76% |
| Average result | 30.74% | 36.89% | 25.94% | 25.11% | 31.75% |
| Worst result | 20.78% | 25.99% | 18.06% | 17.19% | 22.75% |
| Responses | 2546 | 2388 | 2480 | 2356 | 3491 |

Q5a I have unrealistic time pressures.

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 22.61% | 22.70% | 20.85% | 21.33% | 25.61% |
| Best result | 31.33% | 33.42% | 29.43% | 29.80% | 33.29% |
| Average result | 21.94% | 24.12% | 22.39% | 22.31% | 25.08% |
| Worst result | 16.62% | 18.37% | 18.16% | 18.05% | 20.88% |
| Responses | 2537 | 2383 | 2478 | 2348 | 3483 |

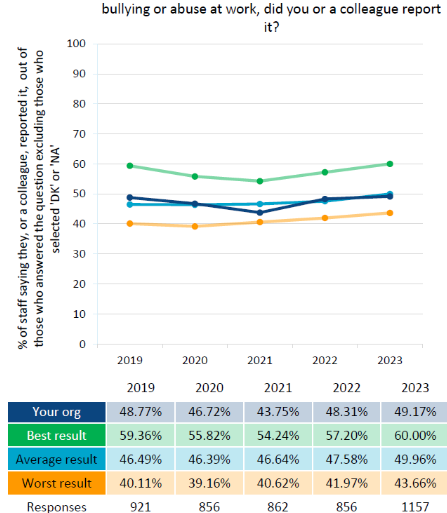
Q11a My organisation takes positive action on health and well-being.

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 47.84% | 44.98% | 48.79% |
| Best result | 73.93% | 71.57% | 72.85% |
| Average result | 56.44% | 55.65% | 56.95% |
| Worst result | 42.41% | 42.92% | 44.63% |
| Responses | 2426 | 2306 | 3479 |

Q13d The last time you experienced physical violence at work, did you or a colleague report it?

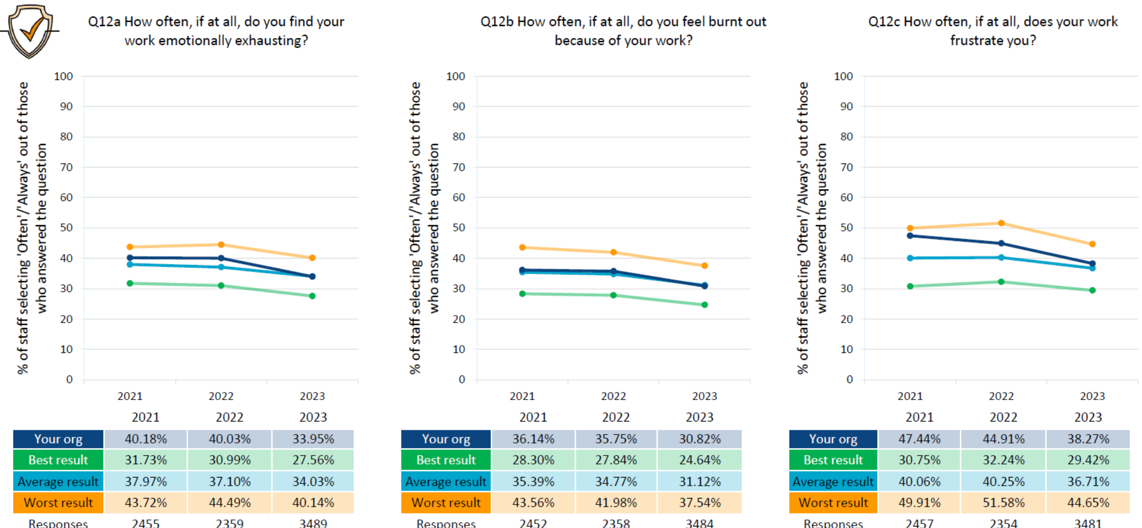
| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 64.47% | 61.69% | 63.61% | 65.68% | |
| Best result | 84.97% | 83.98% | 83.53% | 79.14% | |
| Average result | 68.03% | 67.86% | 66.62% | 68.43% | |
| Worst result | 53.29% | 56.69% | 55.14% | 57.21% | |
| Responses | 233 | 216 | 202 | 267 | |

Note. 2023 results for Q13d have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.




| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 48.77% | 46.72% | 43.75% | 48.31% | 49.17% |
| Best result | 59.36% | 55.82% | 54.24% | 57.20% | 60.00% |
| Average result | 46.49% | 46.39% | 46.64% | 47.58% | 49.96% |
| Worst result | 40.11% | 39.16% | 40.62% | 41.97% | 43.66% |
| Responses | 921 | 856 | 862 | 856 | 1157 |

## Burnout




Q12a How often, if at all, do you find your work emotionally exhausting?

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 40.18% | 40.03% | 33.95% |
| Best result | 31.73% | 30.99% | 27.56% |
| Average result | 37.97% | 37.10% | 34.03% |
| Worst result | 43.72% | 44.49% | 40.14% |
| Responses | 2455 | 2359 | 3489 |

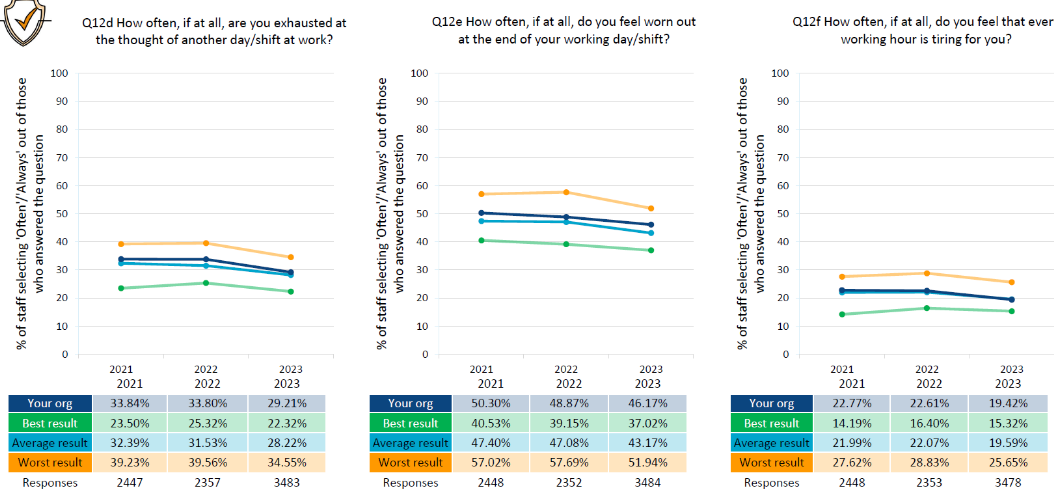
Q12b How often, if at all, do you feel burnt out because of your work?

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 36.14% | 35.75% | 30.82% |
| Best result | 28.30% | 27.84% | 24.64% |
| Average result | 35.39% | 34.77% | 31.12% |
| Worst result | 43.56% | 41.98% | 37.54% |
| Responses | 2452 | 2358 | 3484 |

Q12c How often, if at all, does your work frustrate you?

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 47.44% | 44.91% | 38.27% |
| Best result | 30.75% | 32.24% | 29.42% |
| Average result | 40.06% | 40.25% | 36.71% |
| Worst result | 49.91% | 51.58% | 44.65% |
| Responses | 2457 | 2354 | 3481 |

Generally we see an improvement in staff burnout throughout the Trust across all questions relating to burnout (-6.08% q12a; -4.93% q12b ; -6.64% q12c; -4.59% q12d ; -2.7% q12e; -3.19% q12f ; -1.82% q12g) which helps paint a more positive picture about work practices, better staffing, better work life balance as evidenced below and directly correlated to a reduction in work pressures and a better health and safety climate.




Q12d How often, if at all, are you exhausted at the thought of another day/shift at work?

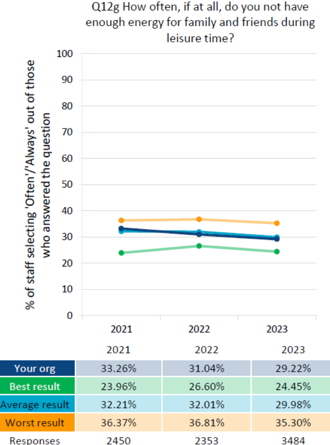
| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 33.84% | 33.80% | 29.21% |
| Best result | 23.50% | 25.32% | 22.32% |
| Average result | 32.39% | 31.53% | 28.22% |
| Worst result | 39.23% | 39.56% | 34.55% |
| Responses | 2447 | 2357 | 3483 |

Q12e How often, if at all, do you feel worn out at the end of your working day/shift?

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 50.30% | 48.87% | 46.17% |
| Best result | 40.53% | 39.15% | 37.02% |
| Average result | 47.40% | 47.08% | 43.17% |
| Worst result | 57.02% | 57.69% | 51.94% |
| Responses | 2448 | 2352 | 3484 |

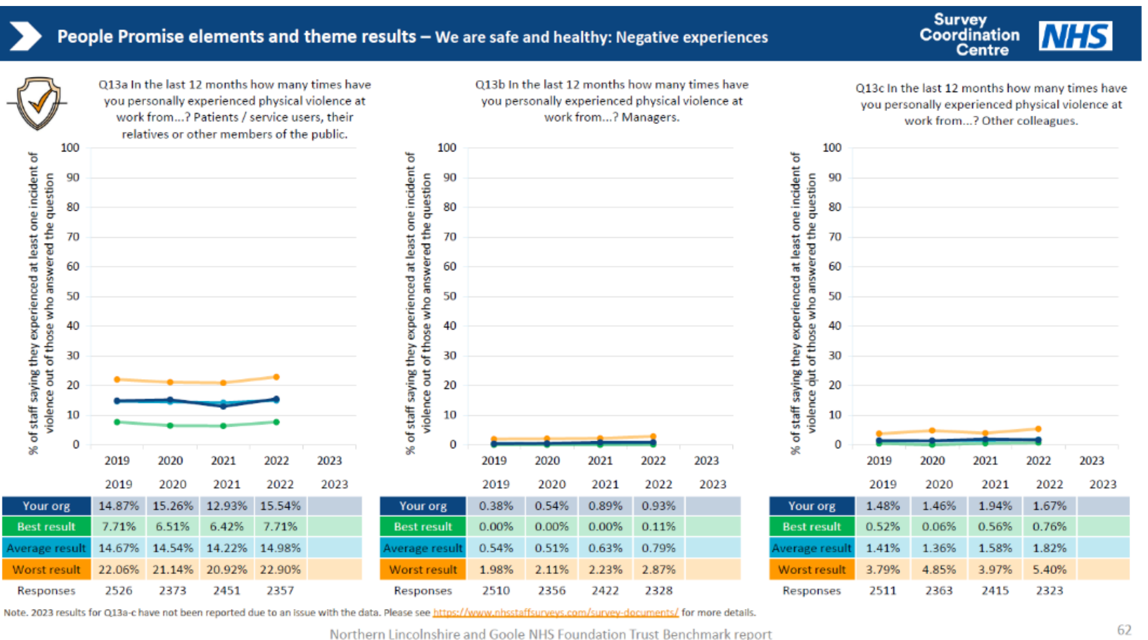
Q12f How often, if at all, do you feel that every working hour is tiring for you?

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 22.77% | 22.61% | 19.42% |
| Best result | 14.19% | 16.40% | 15.32% |
| Average result | 21.99% | 22.07% | 19.59% |
| Worst result | 27.62% | 28.83% | 25.65% |
| Responses | 2448 | 2353 | 3478 |




| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 33.26% | 31.04% | 29.22% |
| Best result | 23.96% | 26.60% | 24.45% |
| Average result | 32.21% | 32.01% | 29.98% |
| Worst result | 36.37% | 36.81% | 35.30% |
| Responses | 2450 | 2353 | 3484 |

## Negative experience




Q13a

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 14.87% | 15.26% | 12.93% | 15.54% | |
| Best result | 7.71% | 6.51% | 6.42% | 7.71% | |
| Average result | 14.67% | 14.54% | 14.22% | 14.98% | |
| Worst result | 22.06% | 21.14% | 20.92% | 22.90% | |
| Responses | 2526 | 2373 | 2451 | 2357 | |

Q13b

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 0.38% | 0.54% | 0.89% | 0.93% | |
| Best result | 0.00% | 0.00% | 0.00% | 0.11% | |
| Average result | 0.54% | 0.51% | 0.63% | 0.79% | |
| Worst result | 1.98% | 2.11% | 2.23% | 2.87% | |
| Responses | 2510 | 2356 | 2422 | 2328 | |

Q13c

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 1.48% | 1.46% | 1.94% | 1.67% | |
| Best result | 0.52% | 0.06% | 0.56% | 0.76% | |
| Average result | 1.41% | 1.36% | 1.58% | 1.82% | |
| Worst result | 3.79% | 4.85% | 3.97% | 5.40% | |
| Responses | 2511 | 2363 | 2415 | 2323 | |

Note. 2023 results for Q13a-c have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

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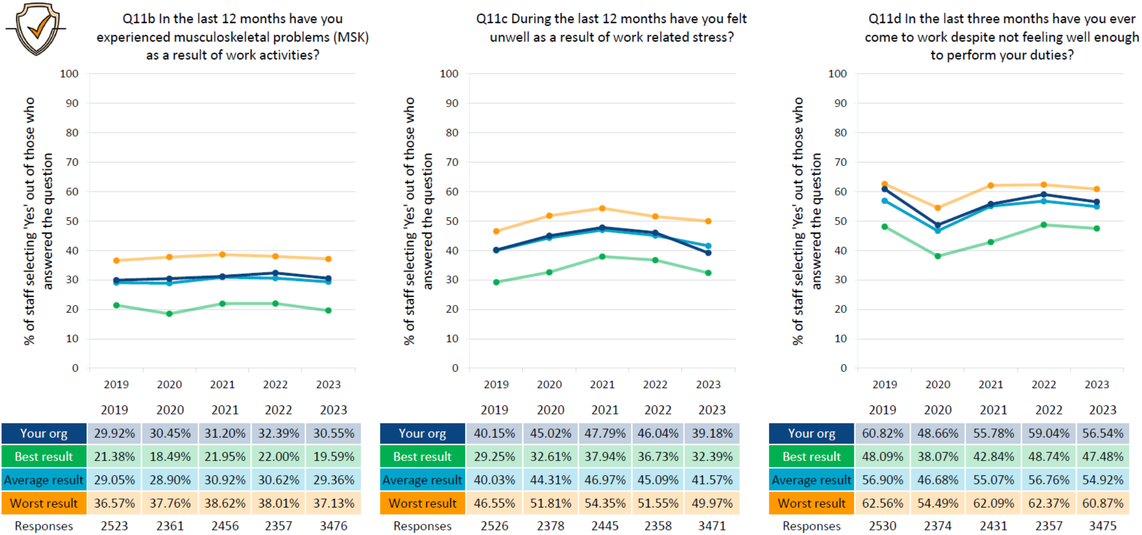
No data was available to evidence whether there was a reversal of the trend regarding physical violence, however we see a marked improvement this year compared to 2022 regarding MSK (-1.84% q11b), stress (-6.86% q11c) and staff not feeling compelled to come to work if they are feeling unwell (-2.5% q11d).




Q11b In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 29.92% | 30.45% | 31.20% | 32.39% | 30.55% |
| Best result | 21.38% | 18.49% | 21.95% | 22.00% | 19.59% |
| Average result | 29.05% | 28.90% | 30.92% | 30.62% | 29.36% |
| Worst result | 36.57% | 37.76% | 38.62% | 38.01% | 37.13% |
| Responses | 2523 | 2361 | 2456 | 2357 | 3476 |

Q11c During the last 12 months have you felt unwell as a result of work related stress?

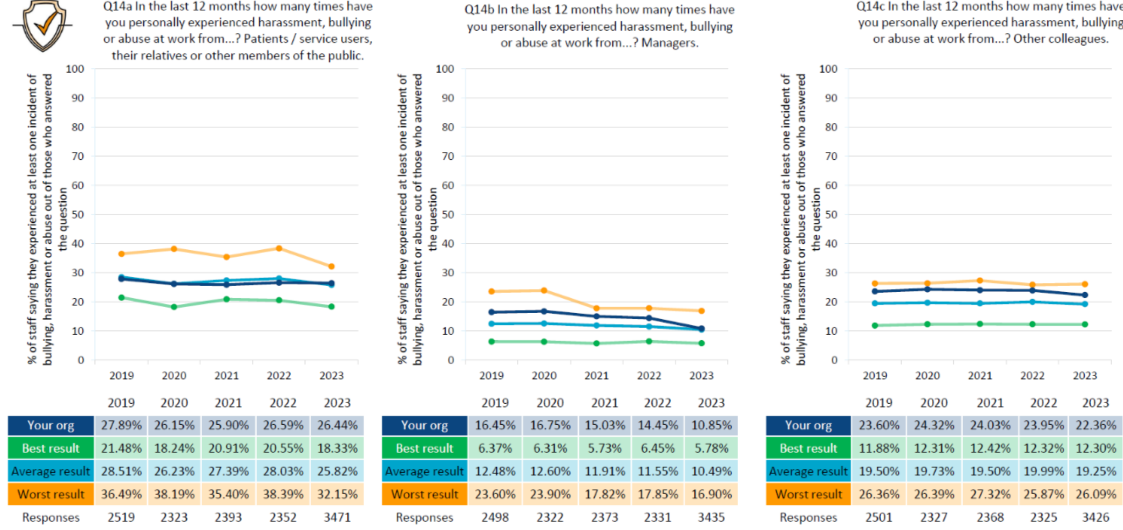
| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 40.15% | 45.02% | 47.79% | 46.04% | 39.18% |
| Best result | 29.25% | 32.61% | 37.94% | 36.73% | 32.39% |
| Average result | 40.03% | 44.31% | 46.97% | 45.09% | 41.57% |
| Worst result | 46.55% | 51.81% | 54.35% | 51.55% | 49.97% |
| Responses | 2526 | 2378 | 2445 | 2358 | 3471 |

Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 60.82% | 48.66% | 55.78% | 59.04% | 56.54% |
| Best result | 48.09% | 38.07% | 42.84% | 48.74% | 47.48% |
| Average result | 56.90% | 46.68% | 55.07% | 56.76% | 54.92% |
| Worst result | 62.56% | 54.49% | 62.09% | 62.37% | 60.87% |
| Responses | 2530 | 2374 | 2431 | 2357 | 3475 |

Although no improvement was markedly noticed regarding harassment, bullying and abuse from patient towards staff, there is a marked reduction in q14b (c-4%) and q14c (c-1.5%).

The introduction of training programmes on civility and respect in 2023 through 2024 for colleagues as well as the leadership and management development programme are hoped to have positive impact on fostering a culture of respect and an environment where people are treated with dignity systematically.




Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 27.89% | 26.15% | 25.90% | 26.59% | 26.44% |
| Best result | 21.48% | 18.24% | 20.91% | 20.55% | 18.33% |
| Average result | 28.51% | 26.23% | 27.39% | 28.03% | 25.82% |
| Worst result | 36.49% | 38.19% | 35.40% | 38.39% | 32.15% |
| Responses | 2519 | 2323 | 2393 | 2352 | 3471 |

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 16.45% | 16.75% | 15.03% | 14.45% | 10.85% |
| Best result | 6.37% | 6.31% | 5.73% | 6.45% | 5.78% |
| Average result | 12.48% | 12.60% | 11.91% | 11.55% | 10.49% |
| Worst result | 23.60% | 23.90% | 17.82% | 17.85% | 16.90% |
| Responses | 2498 | 2322 | 2373 | 2331 | 3435 |

Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.

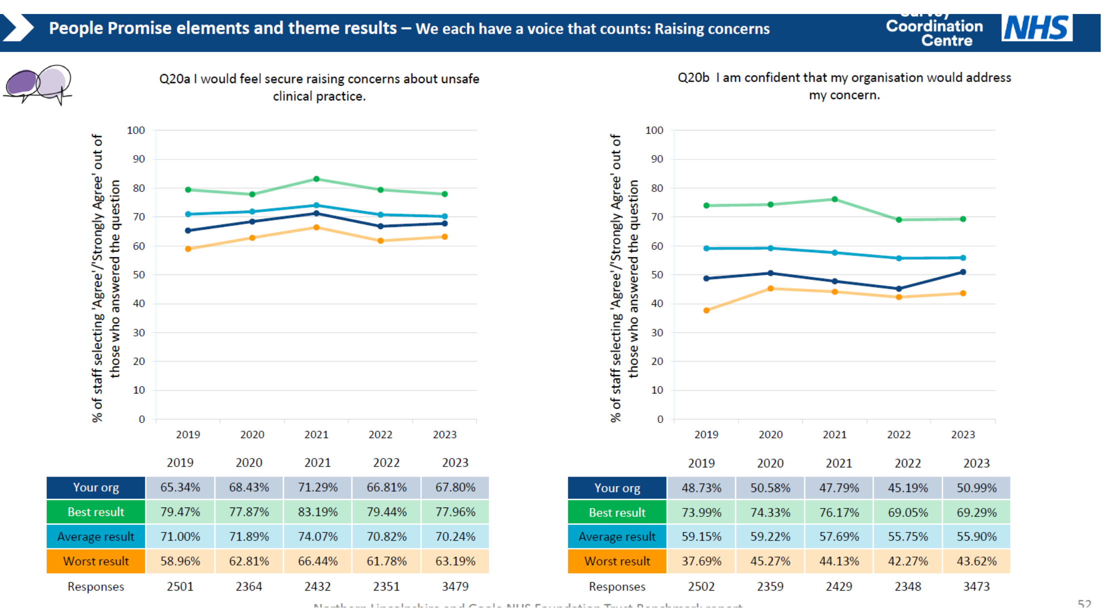
| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 23.60% | 24.32% | 24.03% | 23.95% | 22.36% |
| Best result | 11.88% | 12.31% | 12.42% | 12.32% | 12.30% |
| Average result | 19.50% | 19.73% | 19.50% | 19.99% | 19.25% |
| Worst result | 26.36% | 26.39% | 27.32% | 25.87% | 26.09% |
| Responses | 2501 | 2327 | 2368 | 2325 | 3426 |

The Trust has retained a fairly consistent score on the value managers placed on staff health and wellbeing. This is largely due to a comprehensive and proactive pandemic response action plan implemented in 2020 and retained and enhanced to support managers and staff through the challenges of the pandemic.

The Trust are committed to further work on health and wellbeing, as set out in our two-year health and wellbeing plan, and our Trust's participation in the NHSE Health and Wellbeing Trailblazer Pilot. The Trust is noted for its strategic perspective in the pilot, focusing on long term improvement of staff wellbeing and line manager capability to proactively support their staff. Further work is mapped to strengthen this including:

- The support of staff psychological wellbeing with skills training and sessions in Schwartz Rounds and a series of pop-up wellbeing Hubs planned for 2023/2024 to continue well into 2024/25
- Introduction of health and wellbeing activities
- Supporting staff burnout required given Q11d and staff continuing to work when unwell is increasing.

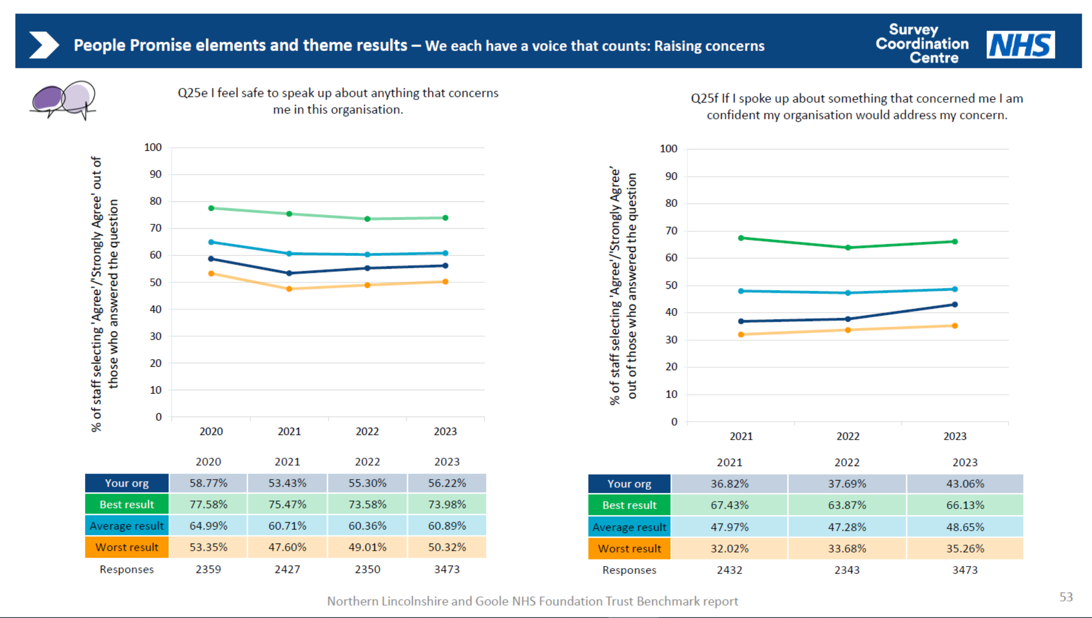
## Safety Culture




| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 65.34% | 68.43% | 71.29% | 66.81% | 67.80% |
| Best result | 79.47% | 77.87% | 83.19% | 79.44% | 77.96% |
| Average result | 71.00% | 71.89% | 74.07% | 70.82% | 70.24% |
| Worst result | 58.96% | 62.81% | 66.44% | 61.78% | 63.19% |
| Responses | 2501 | 2364 | 2432 | 2351 | 3479 |

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 48.73% | 50.58% | 47.79% | 45.19% | 50.99% |
| Best result | 73.99% | 74.33% | 76.17% | 69.05% | 69.29% |
| Average result | 59.15% | 59.22% | 57.69% | 55.75% | 55.90% |
| Worst result | 37.69% | 45.27% | 44.13% | 42.27% | 43.62% |
| Responses | 2502 | 2359 | 2429 | 2348 | 3473 |

Since 2018 significant progress has been made relating to staff feeling secure raising concerns about unsafe clinical practice (+8.9% since 2017 in 2021). Although we saw in 2022 there was a loss of confidence in raising concerns and addressing these the Trust has reversed the trend in 2023 to above pre-pandemic levels (+1% q20a; +5% q20b in 2023 compared to 2022).




Q25e I feel safe to speak up about anything that concerns me in this organisation.

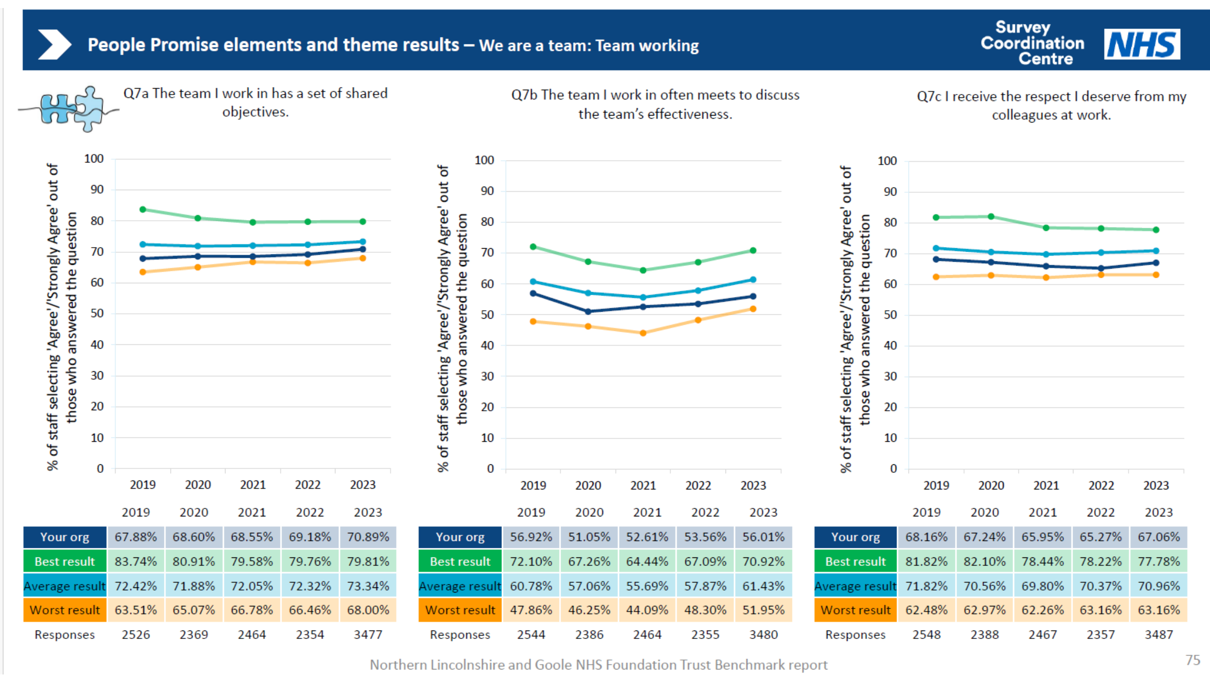
| | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Your org | 58.77% | 53.43% | 55.30% | 56.22% |
| Best result | 77.58% | 75.47% | 73.58% | 73.98% |
| Average result | 64.99% | 60.71% | 60.36% | 60.89% |
| Worst result | 53.35% | 47.60% | 49.01% | 50.32% |
| Responses | 2359 | 2427 | 2350 | 3473 |

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.

| | 2021 | 2022 | 2023 |
|---|---|---|---|
| Your org | 36.82% | 37.69% | 43.06% |
| Best result | 67.43% | 63.87% | 66.13% |
| Average result | 47.97% | 47.28% | 48.65% |
| Worst result | 32.02% | 33.68% | 35.26% |
| Responses | 2432 | 2343 | 3473 |

Whereas 2021/22 saw a decrease in staff feeling they are able to speak up about anything that concerns them in the organisation there has been a marked improvement with the introduction of our FTSU Guardian and the Trust taking a proactive approach to improve on this as part of the Culture Transformation programme and Just and Learning Culture.

## Team Working




Q7a The team I work in has a set of shared objectives.

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 67.88% | 68.60% | 68.55% | 69.18% | 70.89% |
| Best result | 83.74% | 80.91% | 79.58% | 79.76% | 79.81% |
| Average result | 72.42% | 71.88% | 72.05% | 72.32% | 73.34% |
| Worst result | 63.51% | 65.07% | 66.78% | 66.46% | 68.00% |
| Responses | 2526 | 2369 | 2464 | 2354 | 3477 |

Q7b The team I work in often meets to discuss the team's effectiveness.

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 56.92% | 51.05% | 52.61% | 53.56% | 56.01% |
| Best result | 72.10% | 67.26% | 64.44% | 67.09% | 70.92% |
| Average result | 60.78% | 57.06% | 55.69% | 57.87% | 61.43% |
| Worst result | 47.86% | 46.25% | 44.09% | 48.30% | 51.95% |
| Responses | 2544 | 2386 | 2464 | 2355 | 3480 |

Q7c I receive the respect I deserve from my colleagues at work.

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 68.16% | 67.24% | 65.95% | 65.27% | 67.06% |
| Best result | 81.82% | 82.10% | 78.44% | 78.22% | 77.78% |
| Average result | 71.82% | 70.56% | 69.80% | 70.37% | 70.96% |
| Worst result | 62.48% | 62.97% | 62.26% | 63.16% | 63.16% |
| Responses | 2548 | 2388 | 2467 | 2357 | 3487 |

We see a continuous improvement in scores since last year as an indication that some improvements have been made and felt by our staff. In addition to the Trusts implementing

the Leadership Development Strategy last year more Teamworking and Line management skills have been put into action to achieve higher levels of staff engagement. Our core leadership skills programme of work supports improvement in this theme.

**Next Steps**

Continue to deliver on cultural and leadership objectives aligned to Trust priorities and Leadership Development Strategy. These are overseen by the Culture Transformation Board and the Workforce Committee.

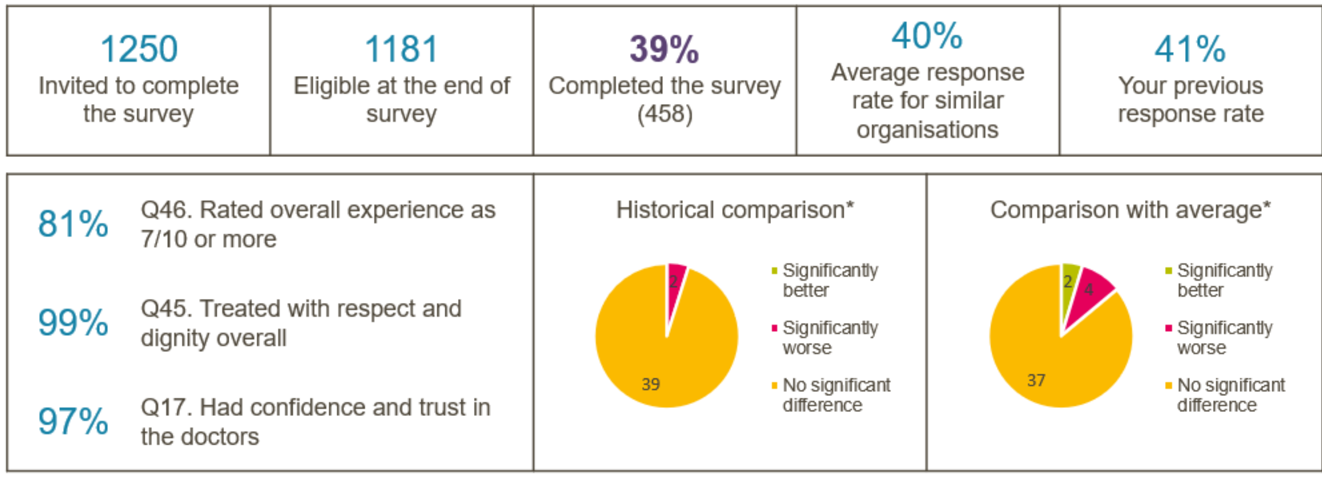
## 3.3 Information on patient survey report

The national survey programme provides a year-on-year review of person-centred validated questions and responses. This data allows the Trust to monitor internal progress and benchmarking. During 20223/24 the Trust implemented a comprehensive action plan based on the 2022 national inpatient survey (2023 survey results are still being collated nationally), of which the headlines are detailed below.

The 2022 National Adult Inpatient Survey for Northern Lincolnshire and Goole NHS Foundation Trust shows the sustaining of internal improvement, which was largely made during the period relating to the 2020 to 2021 survey dates.

The survey was completed across all adult inpatient areas during November 2022 39% inpatients completed a survey. 98% of those who responded were White British, with 1% respondents Asian or Asian British. There was a fairly even split of those identifying as male or female, with the majority of responses completed by those over 66 year of age.

A total of 61 questions were asked in the 2022 survey, of these 50 can be positively scored, with 41 of these which can be historically compared.




There are many positives within the report which should be celebrated.

**Positive headlines are:**

- ✓ 97% rated room fairly clean
- ✓ 96% patients asked said they got enough to drink
- ✓ 95% doctors answered questions clearly
- ✓ 97% patients had confidence and trust in doctors
- ✓ 98% of nurses answered questions clearly
- ✓ 97% nurses included patients in conversations
- ✓ 100% patients had confidence and trust in nurses
- ✓ 99% patients overall were treated with dignity and respect

The charts below show the top & bottom 5 scored questions compared to the picker average and also the Trust most improved and declined scores.

| Top 5 scores vs Picker Average | Trust | Picker Avg |
|---|---|---|
| Q12. Food was very good or fairly good | 74% | 69% |
| Q14. Able to get food outside of meal times | 78% | 75% |
| Q9. Got enough help from staff to wash or keep clean | 93% | 91% |
| Q15. Got enough to drink | 96% | 94% |
| Q47. Asked to give views on quality of care during stay | 15% | 13% |

| Bottom 5 scores vs Picker Average | Trust | Picker Avg |
|---|---|---|
| Q34. Family or cares involvement in discussions about leaving the hospital | 52% | 60% |
| Q51. Condition(s) taken into account during your care and treatment whilst in hospital | 81% | 87% |
| Q39. Given information about medicine at discharge | 81% | 86% |
| Q33. Felt involved in decisions about discharge from hospital | 71% | 76% |
| Q7. Staff explained reasons for changing wards at night | 76% | 81% |

| Most improved scores | Trust 2022 | Trust 2021 |
|---|---|---|
| Q14. Able to get food outside of meal times | 78% | 71% |
| Q35. Staff discussed need for additional equipment or home adaptation after discharge | 83% | 77% |
| Q32. Explained how well procedure had gone | 83% | 79% |
| Q31. Questions before procedure were answered well | 95% | 92% |
| Q47. Asked to give views on quality of care during stay | 15% | 12% |

| Most declined scores | Trust 2022 | Trust 2021 |
|---|---|---|
| Q2. Did not mind waiting as long as did for admission | 59% | 73% |
| Q10. Able to take own medication when needed to | 84% | 90% |
| Q37. Given information about what they should or should not do after leaving hospital | 76% | 80% |
| Q12. Food was very good or fairly good | 74% | 78% |
| Q46. Rated overall experience as 7/10 or more | 81% | 85% |

What we know is that our admission and discharge processes are two of the biggest challenges, not only in our NHS, but nationally.

An overarching action plan is now in place based on the 2022 survey findings.

Divisional ownership of the actions will be monitored quarterly via Divisional Patient Experience Reviews and Patient Experience Group meetings, any escalations will be through Quality Governance Group, actions will only be closed when suitable monitoring evidences improvement.

Due to the time span of national surveys, they are, in effect, always year behind by the time results are analysed and shared, the Trust conducts its own ongoing inpatient survey

programme. The INSIGHTS local survey programme surveys 10 patients on each adult inpatient ward monthly and monitors this feedback. It remains the Trust's commitment to listen and act on patient feedback and prioritise actions that matter to patients most.

## 3.4 Quality Improvement Journey

The Quality Improvement (QI) program for the trust has continued to develop in year with over 1000 staff trained at different levels in QI methodologies by the QI Academy during 23/24. This includes 458 Foundation Level Doctors from across the Integrated Care System at "Applying QI" level, where they are able to apply their QI skills by delivering a Quality Improvement Project (QIP). 32 Trust staff (and 18 Integrated Care Board staff member) have been trained in Leading & Coaching QI, enabling staff to not only enact their QI skills but lead larger programmes of change. 115 Quality Improvement Projects (QIPs) have been registered during the year with over 40 of these demonstrating measurable improvement so far with a further 42 at the planning and testing phase with the remainder in the earlier stages of development.

In addition, the Trust has run several trust wide QI collaborative events with measurable outcomes involving 50 clinical areas from across the trust. These include the QI collaborative which focused on increasing timely assessment and reassessment of patients pain to ensure the highest levels of care have been provided. This saw excellent engagement with clinical teams resulting in moving the trust position from 20% of pain assessments completed electronically in May 2023 up to a sustained position of over 95% from July 2023 until the project was handed over to business as usual in November 2023. Other benefits were also realised including saving Pain CNS time on a daily basis equal to 237 hours per year. Also, with the move to electronic assessment this saved £3,714 in printing costs.

Other key work within the year was in relation to the successful implementation of a service redesign within Maternity Triage services. The Ockenden report outlines a number of recommendations in relation to how maternity services should conduct triage for pregnant women with medical related concerns who are 16 week plus. These recommendations outline the need to follow a recognised model of triage to priorities timely assessment, i.e. the Birmingham Symptom Specific Obstetric Triage System (BSOTS). This Quality Improvement Project aim is to Implement a fully operational Maternity Triage Service across the whole of the Maternity Service in NLAG, that utilises a Nationally recognised Triage Model (BSOTS). In order to enhance the patient experience and care. The first phase of this work related to a single point of access triage phone line which over the year answered 10436 calls from concerned women. In addition to the patient experience benefits this also released nursing time to care on the wards of 20hrs per week or 1040 per year. The second phase of this work focused on face to face triage post initial phone assessment and in the first 5 months of opening saw 2485 women with positive feedback from patients surveyed.

The trust held its second QI conference with over 250 attendees which included regional speakers along with many examples of QI work from across the organisation. This was a great opportunity for the organsiation to celebrate its improvement journey and its staff. For the first time awards were also presented to staff who had promoted and led improvement within their areas.

The Trust will continue to build on its strong QI foundations to deliver outstanding quality of care to our patients in 2024/25. Reviewing with our HUTH colleagues what learning can we share as we look to build a culture of QI across the group.

# Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

## Annex 1.1: Statements from Commissioners

**Feedback from:**
**North East Lincolnshire Place - Humber and North Yorkshire Integrated Care Board (ICB) and Lincolnshire ICB**

The Humber & North Yorkshire Integrated Care Board (ICB) welcome the opportunity to review and comment on Northern Lincolnshire and Goole NHS Foundation Trust's Quality Report for 2023/24 and this response also includes reflections from Lincolnshire ICB.

We recognise the ambitions of the Trust, commitment and hard work of the workforce to deliver good quality care throughout the past year and we would like to say thank you to all staff and volunteers across NLaG. It is extremely positive to see so many achievements highlighted within the report, and we welcome the informative and illustrative content celebrated within the opening pages of the Quality Account. The patient and family narrative conveying Carol's story and the partnership working between the Trust and family is commendable. The approach to learn and implement changes that will positively impact other patient journeys from a family's experience is excellent practice.

The ICB's are supportive of the Trust's Quality Priorities for 2024/25. The continued focus on driving improvement in the delivery, experience and outcomes associated within End of Life, deteriorating patients, sepsis, medication safety and mental capacity is welcomed by the ICB. Further concentration on these areas will assist with embedding changes and continued focus to help support the realisation of the Trust's objectives to make sustained improvements.

The Quality Account candidly outlines challenges in performance and the associated experience of care, recognising those areas where further improvements are required. As a whole system we will continue to work in collaboration with NLaG to support improvements in key areas such as waiting times and flow through the Emergency Departments to improve the overall experiences and quality of care for our population.

The ICB would also like to congratulate the Trust for the work which is being undertaken in research. We note the partnership work planned with the Research Department at the Hull University Teaching Hospital and we will look forward to hearing more about this in 2024/2025.

There have been significant national changes to quality associated programmes that have required local implementation during this Quality Account period, one of which being the implementation of the National Patient Safety Incident Response Framework. The Trust have worked closely with ourselves, involving the ICB in their implementation of the Framework and sharing resources, knowledge and experience with other healthcare providers.

Since the last Annual Quality Account, the Trust have formally exited the Recovery Support Programme (previously known as special measures). This is a significant achievement and alongside the Improved CQC ratings demonstrates continuous improvements.

The ICB remain committed to working with NLaG and wider system partners to improve the quality and safety of services available for the population of the patients served by the Trust in order to improve patient experience and patient outcomes.

## Annex 1.2: Statement from Healthwatch organisations

**Feedback from:**
**Healthwatch North East Lincolnshire**
**Healthwatch North Lincolnshire**
**Healthwatch East Riding of Yorkshire**

**Healthwatch response to the Annual Quality Accounts 2023/2024**

Healthwatch North Lincolnshire, Healthwatch North East Lincolnshire and Healthwatch East Riding of Yorkshire welcome the opportunity to make a statement on the Quality Account for Northern Lincolnshire and Goole NHS Foundation Trust and have agreed to provide a joint statement.

The three local Healthwatch organisations recognise that the Quality Account report is a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public about the quality of service they provide. The following is the joint response from Healthwatch North Lincolnshire Healthwatch North East Lincolnshire, and Healthwatch East Riding of Yorkshire.

Healthwatch are pleased to see that the Northern Lincolnshire & Goole NHS Foundation Trust have now exited the recovery program. The trust has recognised and evidenced that that there are still further improvements to be made and have a robust action plan in place that will remain a key focus for 2024/25.

The summary clearly sets out what you have achieved during 2023/24 against your 5 priority areas and what still needs working on, and where progress has been made. The Trust has also clearly indicated what the priorities will be for 2024/25 and how you hope to achieve them.

Healthwatch carried out research on 2022/23 to ascertain what service users and their families thought about the End of Life pathway, what worked for them and what needed to improve. Recommendations were made by Healthwatch North and North East Lincolnshire. We are pleased that the trust has been responsive to our recommendations around the development of communication and the Bluebell model. The Trusts expansion of the palliative and end of life care team is very much welcomed alongside the implementation of the seven-day specialist palliative care service. We are also pleased to see the significant increase in the prescription of anticipatory medications which is allowing the residents of

North Lincolnshire to experience dignified, pain free deaths.

Healthwatch are disappointed to see the figures relating to the percentage of Mental Capacity Assessments that meet legal requirements. Although there has been some improvement within this area, the figures are still low and quite rightly are again placed on the quality priority planning for 2024/25.

Patients across Northern Lincolnshire have experienced lengthy waits in both emergency departments to be seen, treated, admitted or discharged. You have been unable to meet set targets and have recognised that this is unfortunately not good enough. However the new developments consisting of the Integrated Acute Assessment Units (Grimsby) and Same Day Emergency Care Provision (Scunthorpe) are now open and are supporting to provide extra patient care in comfortable and up to date surroundings.

We at Healthwatch are pleased to see the personal account of Carol – As told by her daughter and the development of Carols Campaign. This story evidenced that Carols family have been listened too and action has been taken with regards to their concerns. The trust has committed to work in partnership with her daughter and will continue to provide person centered care when it is needed most.

“A year in numbers” and “proud moments” of 2023/24 are a welcome addition to the account. This supports patient accessibility to information and aides public understanding of the trusts progress and achievements.

We would like to thank all your staff for the hard work they have put in during 2023/24 to achieve a better service for the people of North Lincolnshire.

Tracy Slattery
Delivery Manager
Healthwatch North East Lincolnshire

Lucy Wilkinson
Delivery Manager
Healthwatch North Lincolnshire

James Dennis
Delivery Manager
Healthwatch East Riding of Yorkshire

## Annex 1.3: Statement from local council overview and scrutiny committees (OSC)

**Feedback from:**
**Lincolnshire – Health Scrutiny Committee for Lincolnshire**
**Awaiting feedback**

**Feedback from:**
**East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee**
**Awaiting feedback**

**Feedback from:**
**North Lincolnshire Council – Health, Integration and Performance Scrutiny Panel**

North Lincolnshire Council's Health, Integration and Performance Scrutiny Panel welcomes the Trust's Annual Quality Account, and supports the aims and priorities outlined within.

We look forward to meeting regularly with Trust representatives throughout the forthcoming year to discuss both the Account and the performance and delivery of local services.

Cllr D Robinson, Chairman, Health, Integration and Performance Scrutiny Panel

**Feedback from:**
**North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel**
**Awaiting feedback**

## Annex 1.4: Statement from the Trust's Council of Governors

The Council of Governors is pleased to have been given the opportunity to comment on the Trust's Quality Account for 2023/24 which demonstrates a continuation in the significant quality improvements that have been achieved over recent years through the efforts of NLaG staff at all levels of the organisation.

Throughout the year governors continued to prioritise seeking robust assurance regarding the quality and safety of all hospital and community services provided by the Trust in the context of our duty to hold Non-Executive Directors (NEDs) to account for the performance of the Trust Board. We received regular reports at Council of Governors meetings on progress in implementing the Trust's quality priorities. We were represented at meetings of the Quality & Safety Committee in an observer capacity and NED chairs made themselves available to brief bi-monthly Governor Assurance Group meetings on committee highlights and to answer our searching questions.

Governors are pleased to see the progress that has been made against many of the Trust's 2023/24 quality priorities. Maintenance of a consistent downward in-hospital mortality trajectory has been particularly impressive although more work is required with integrated care system place partners to drive improvements to out of hospital mortality rates. In this context it is particularly pleasing to see the emphasis that has been placed on improving the quality of palliative and end of life care which is the one area of NLaG service provision still rated 'inadequate' by the Care Quality Commission.

The Council of Governors supports the decision to seek to embed and build upon improvements to the five 2023/24 quality priorities rather than identifying a new set of priorities for 2024/25. In our role as representing the interests of our trust members and service users we intend to seek feedback to inform the selection of a fresh set of quality priorities for 2025/26.

## Annex 1.5: Response from the Trust to stakeholder comments

The Trust are grateful to stakeholders for their views and comments on the Quality Account for the period 20223/24.

# Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2023/24 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2023 to March 2024
    - Papers relating to quality reported to the board over the period April 2023 to March 2024
    - Feedback from commissioners
    - Feedback from governors
    - Feedback from Local Healthwatch organisations
    - Feedback from Overview and Scrutiny Committees
    - Latest national inpatient survey 2022
    - Latest national staff survey 2024
    - CQC inspection report published 2 December 2022
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the quality report is routinely quality checked to ensure it is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality report is routinely quality checked to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

………………… Date......................................................Chair

………………… Date...................................................... Chief Executive

# Annex 3: Glossary



**Ceiling of Care:** The course of treatment considered to be the predetermined highest level of intervention deemed appropriate by a medical team, aligning with patient and family wishes, values and beliefs. These crucial early decisions aim to improve the quality of care for patients in whom they are deemed appropriate.

**Clostridium Difficile (C. Difficile):** A species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora are wiped out by antibiotics.

**CQUIN or Commissioning for Quality & Innovation Framework:** The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

**Deteriorating Patient:** Sometimes, the health of a patient in hospital may get worse suddenly. There are certain times when this is more likely, for example following an emergency admission to hospital, after surgery and after leaving critical care. However, it can happen at any stage of an illness. It increases the patient's risk of needing to stay longer in hospital, not recovering fully or dying. Monitoring patients regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems.

**Electronic Palliative Care Coordination system EPaCCs:** Single shared record for preferred place of care and advanced decisions.

**EPMA** stands for Electronic Prescribing and Medicines Administration and is the digital prescribing system used by Medics and Pharmacists at the Trust.

**Family and Friends Test (FFT):** From April 2013, all patients will be asked a simple question to identify if they would recommend a particular A&E department or ward to their friends and family. The results of this friends and family test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback.

**Harm:**

- **Catastrophic harm:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
- **Severe harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- **Moderate harm:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Locally defined as extending stay or care requirements by more than 15 days; Short-term harm requiring further treatment or procedure extending stay or care requirements by 8 - 15 days
- **Low harm:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Locally defined as requiring observation or minor treatment, with an extended stay or care requirement ranging from 1 – 7 days
- **None/ 'Near Miss' (Harm):** No obvious harm/injury, Minimal impact/no service disruption.

**Mortality Data: - How is it measured?**

There are two primary ways to measure mortality, both of which are used by the Trust:

1. Crude mortality – expressed as a percentage, calculated by dividing the number of deaths within the organisation by the number of patients treated,
2. Standardised mortality ratios (SMR). These are statistically calculated mortality ratios that are heavily dependent on the quality of recording and coding data. These are calculated by dividing the number of deaths within the Trust by the expected number of deaths. This expected level of mortality is based on the documentation and coding of individual, patient specific risk factors (i.e. their diagnosis or reason for admission, their age, existing comorbidities, medical conditions and illnesses) and combined with general details relating to their hospital admission (i.e. the type of admission, elective for a planned procedure or an unplanned emergency admission), all of which inform the statistical models calculation of what constitutes expected mortality.

As standardised mortality ratios (SMRs) are statistical calculations, they are expressed in a specific format. The absolute average mortality for the UK is expressed as a level of 100.

Whilst '100' is the key numerical value, because of the complex nature of the statistics involved, confidence intervals play a role, meaning that these numerical values are grouped into three categories: "Higher than expected", "within expected range" and "lower than expected". The statistically calculated confidence intervals for this information results in SMRs of both above 100 and below 100 being classified as "within expected range".

**Summary Hospital-level Mortality Indicator (SHMI)**: The SHMI is a measure of deaths following hospital treatment based on all conditions, which occur in or out of hospital within 30 days following discharge from a hospital admission. It is reported at Trust level across the NHS in England using standard methodology.

**National Confidential Enquiry into Patient Outcome and Death (NCEPOD):** NCEPOD promote improvements in healthcare and support hospitals and doctors to ensure that the highest possible quality of safe patient care is delivered. NCEPOD use critical senior and appropriately chosen specialists to critically examine what has actually happened to the patients.

**National Early Warning Score (NEWS2):** Nationally defined way of monitoring patients' observations to determine if there are signs of deterioration over time. Sometimes referred to as Early Warning Scores each Trust will have an agreed policy to act on NEWS scores escalating care were appropriate. In some cases, NEWS escalation will not occur, for example when a patient is receiving end of life care, such decisions will be agreed with patients and their families.

**Patient Advice & Liaison Service (PALS):** The PALS service offers confidential advice, support and information on health-related **matters. They provide a point of contact for patients, their families and their carers.**

**Patient Reported Outcome Measures (PROMS):** Patient Reported Outcome Measures are questionnaires that ask patients about their health before and after an operation. This helps to measure the results or outcome of the operation from the patient's point of view. This outcome is known as the 'health gain'. All NHS patients undergoing planned hip replacement, knee replacement, varicose vein or groin hernia surgery procedures are invited to fill in PROMs questionnaires.

**A Recommended Summary Plan for Emergency Care and Treatment (ReSPECT):** Provides a summary for a person's clinical care and treatment in a future emergency in which they do not have capacity to make or express choices.

**Same Day Emergency Care (SDEC):** Same Day Emergency Care is one of the many ways the Trust is working to provide the right care, in the right place, at the right time for patients. It aims to benefit both patients and the healthcare system by reducing waiting times and unnecessary hospital admissions.

**Sepsis:** A medical condition that is characterised by a whole body inflammatory state and the presence of a known infection.

**Venous Thromboembolism (VTE):** VTE is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes

# Annex 4: Mandatory Performance Indicator Definitions

No external audit of indicators included in the report has been required as part of the 2023/24 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

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# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)099**

| **Name of the Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | Thursday 13 June 2024 |
| **Director Lead** | N/A |
| **Contact Officer/Author** | Sue Liburd, Non-Executive Director<br>Stuart Hall, Non-Executive Director |
| **Title of the Report** | **Maternity & Neonatal Safety Champion's Report** |
| **Executive Summary** | This report sets out the activities undertaken by the Non-Executive Maternity & Neonatal Champions to provide assurance to the Board in the provision of high quality, safe maternity, and neonatal clinical care.<br><br>The Maternity & Neonatal Safety Champions continue to be proactive in engaging with staff across NLaG and HUTH. This activity is specifically documented in detail in the individual maternity reports produced by the Maternity teams and is summarised in this report.<br><br>The report sets out matters of risk to escalate which include:<br>• The Champions for both Trusts are pleased to note the appointment of a Group Director of Midwifery who will commence in post on 10 June 2024. However, there is still some instability in senior leadership roles where interim arrangements are in place.<br>• This will complement the consistency of governance procedures across both sites which is making progress. |
| **Background Information and/or Supporting Document(s)** (if applicable) | The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that:<br><br>• High quality clinical care;<br>• Maternity & neonatal service & facilities;<br>• Workforce numbers;<br>• Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback);<br>• Effective team working are all in place. |
| **Prior Approval Process** | N/A |
| **Financial implication(s)** (if applicable) | N/A |

| | | |
|---|---|---|
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/A | |
| **Recommended action(s) required** | ☐ Approval<br>☐ Discussion<br>✓ Assurance | ✓ Information<br>✓ Review<br>☐ Other – please detail below: |

# Maternity & Neonatal Safety Champion's Report
# For April and May 2024

**Executive summary:**

The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that:

- High quality clinical care;
- Maternity & neonatal service & facilities;
- Workforce numbers;
- Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback);
- Effective team working are all in place.

This report has been developed to enable the Maternity & Neonatal Safety Champions for the two trusts to report on and provide assurance to the relevant committees and the boards in respect of the above areas. Where required, the report will include risks & concerns requiring escalation as well as good practice, improvement and innovation.

**Activities undertaken this month:**

Activities undertaken in April and May have included the standard programme of walk rounds, service level meetings, and meetings with service leaders including the Head of Midwifery for the respective Trusts.

In addition, across both organisations the Champions have attended the following:

**HUTH**

- 17 April: MSSP Maternity Improvement Advisor meeting
- 19 April: Maternity and neonatal safety champion meeting
- 23 April: Maternity safety support programme event
- 8 May: Maternity assurance visit
- 15 May: MSSP Maternity Improvement Advisor meeting
- 22 May: Maternity Safety Walkabout

**NLAG**

- 12 April - NHSE Midlands Maternity NED Network
- 24 Apr: Maternity & Neonatal Safety Champions Walk round at Scunthorpe General Hospital
- 7 May: HNY LMNS PQSAG meeting
- 10 May: NNEL MNVP quarterly meeting
- 17 May: Safety Champions (CNST requirements review)
- 29 May: Maternity & Neonatal Champions Walk round at Diana, Princess of Wales Hospital
- In April, the planned NLAG Maternity Transformation Improvement Group was stood down due to staff unavailability

| Learning Lessons: | Service User Voice Feedback: | Staff Experience & Feedback: |
|---|---|---|

| | | |
|---|---|---|
| The importance of training our staff to give them the skills to perform their roles safely and to the best of their ability is where there is some variability across the Trusts particularly with regards to safeguarding. The Champion for HUTH welcomes the marked improvement in our training compliance above target in majority of specialties and is championing the need for long term planned and sustainable provisions that facilitate staff having enough time to fulfil their responsibilities. | At HUTH, it has been positive to hear of the positive feedback that service users gave to external visitors in the past month. This included Donna Ockenden and Professor Donald Peebles visit on 30 April 2024 and Dame Ruth May's visit on 23 May 2024 in her capacity as Chief Nursing Officer for England.<br><br>Service User feedback remains largely positive, although it is felt that there is more work to do on the North Bank to capture compliments and wider feedback.<br><br>Both trusts have received the 2023 Maternity Survey results and are putting actions in place to learn and improve for future surveys, which Champions will be a part of with other stakeholders. | The Safety Champion for HUTH reports a positive response in relation to the BadgerNet role out and for the training received as part of implementation in February.<br><br>However, as part of the maternity champions visit there were some concerns regarding the real-time functionality of Badgernet with some historical records being displayed. This has been escalated. The learning from HUTH implementation is being taken into consideration ahead of the implementation at NLAG planned for September 2024.<br><br>At HUTH Internationally Educated Midwives (IEM), now have a monthly catch up with the HoM / Recruitment Retention lead. This bespoke confidential space provides support to our IEMs. Feedback so far have helped improve some areas of induction e.g. support with planning / booking leave etc. |

**Good practice, improvements & innovation to share:**

The Champions have reported a reduction in midwifery vacancies across the group, although still high, in addition to turnover markedly reducing.

The HUTH Champion has positively noted the additional delivery groups in place at a Group Level to oversee the delivery of MIS Year 6 and remaining HUTH CQC actions. This will allow time for richer discussion on wider action plans on 3 year delivery plan, MNVP feedback and CQC survey actions at the Maternity Transformation and Assurance Committee (MTAC).

The Champions are pleased to note these delivery groups are cross group and the HUTH safety champion is pleased to see that the MTAC will incorporate MNVP participation. This will help address the feedback from ICB membership of the MNVP during May 2024 of the need to increase the timeliness of implementation of 15 steps visit feedback.

**Risks & concerns to escalate:**

The Champions for both Trusts are pleased to note the appointment of a Group Director of Midwifery who will commence on 10 June 2024 and bring leadership across the Group's sites.

In the interim, this has created some uncertainty for staff and leadership and has been flagged as a risk at the Quality and Safety Committees-in-Common. It is noted there is Improvement Support now in place on the North Bank (HUTH), but other senior posts require substantive recruitment where posts are filled by interim.

The Champions are conscious that both HUTH and NLAG have attended an ICB meeting in March to review and prioritise planned investments for 2024/25 given the funding pressures and were keen to see progression with the HUTH requirement for prioritise in respect of sustaining triage and leadership, and at NLAG to embed roles funding non-recurrently through Ockenden funding. The Champions note that an outcome has not been determined by the ICB with system colleagues as of yet.

**Activities planned next month:**

The following activities are planned during the month:

**HUTH**

- 14 June: Maternity and neonatal safety champions visit
- 20 June: MNSI visit
- 25 June: HNY LMNS Delivery Board

**NLAG**

- 25 June HNY LMNS Delivery Board
- 26 June Maternity & Neonatal Safety Champions Walk round at Scunthorpe General Hospital

The Champions are keen to introduce a joint visit to further the opportunities available to the Group.

**Stuart Hall**
**Non-Executive Director Maternity & Neonatal Safety Champion (HUTH)**

**Sue Liburd**
**Non-Executive Director Maternity & Neonatal Safety Champion (NLAG)**

***6 June 2024***

**Trust Boards-in-Common Front Sheet**

**Agenda Item No: BIC(24)100**

| **Name of the Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | Thursday 13 June 2024 |
| **Director Lead** | Amanda Stanford, Group Chief Nurse |
| **Contact Officer/Author** | Rukeya Miah, Head of Midwifery HUTH<br>Nicola Foster, Head of Midwifery NLAG |
| **Title of the Report** | Maternity & Neonatal Safety Assurance Reports |
| **Executive Summary** | Teams from both Trusts have increasingly started working collaboratively. The Group Director of Midwifery is due to commence in post on 10 June 2024 and our Group Maternity Transformation and Assurance Committee will first meet on 21 June 2024.<br><br>Teams have been working collaboratively as part of a Year 6 Maternity and Perinatal Incentive Scheme (MIS) Delivery Group since 17 May 2024. There are also Delivery Groups feeding into the overarching committee for HUTH CQC plan delivery and a Groupwide Three Year Plan delivery group.<br><br>The individual Trust reports contain the following updates:<br><br>**Hull University Teaching Hospitals NHS Trust**<br><br>**1. Workforce**<br>The Trust is continuing to work as a system with the LMNS and ICB to action the output from the Birthrate+ refresh review as described in Section 1. This considered the implementation of the new maternity triage service and recommended a total clinical whole time equivalent of **197.48 WTE** registered midwives and band 3/4 maternity support workers, excluding the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services.<br><br>The final refreshed report identified a total budget of 221.17wte for clinical/managerial/specialist roles. The clinical establishment is funded to 197.48wte but there is a gap in specialist roles.<br><br>Separately, the Trust is receiving support from its Maternity Improvement Advisor who has recommended a further Birthrate plus review with the undertaking of a full assessment as opposed to the “refresh” undertaken. This will be undertaken in tandem with a review at Northern Lincolnshire and Goole NHS Foundation Trust in the summer under the guidance of the Group Director of Midwifery who commences in post on 10 June 2024. Midwifery workforce continues to be extremely challenging and there were 19 occasions from 1/1/2024 – 31/5/2024 when the labour ward coordinator was not supernumerary.<br><br>**2. Patient Experience**<br>HUTH has a well established MNVP forum and is working through the action plan from the 15 steps in maternity visit undertaken. The local Healthwatch organisations have undertaken a targeted review of HRI maternity services between October 2023 and January 2024 and reported |

in their conclusion that ‘there has been many improvements made by the staff of HRI to improve patient experience following the CQC report published in 2023’

### 3. Assurance – Maternity and Perinatal Incentive Scheme Year 6 Update

The service has the pertinent updates to appraise Trust Board to satisfy requirements of reporting and escalate any key risks:

**Perinatal Mortality Review Tool (PMRT) for Q4 (Safety Action 1)**

a) There were 4 eligible baby deaths in the Trust, in 100% of the cases the MBRRACE-UK perinatal surveillance was commenced within 7 days and completed within one calendar month

b) The parents’ perspective was sought in both cases occurring in Q4, achieving 100% compliance with the standard.

c) 100% of the cases in Q4 when babies were born and died in the Trust, have been commenced within the standard of 2 months. All three cases are still under review. 6 of the cases in which the babies deaths occurred within Q3 (October – December 2023) the reviews have been completed and reported upon which maintains a 100% compliance. Learning has been shared from the mortality reviews with all staff achieving all of the MIS standards for Safety Action 1.

**Maternity Service Data Set (MSDS) (Safety Action 2)**

Due to the implementation of BadgerNet there has been a risk raised by the digital team regarding the external submission of the data quality submission for MSDS MIS year 6 standards.

There has been ongoing meetings with the internal digital team and the LMNS to support the MSDS submission for safety action 2. The LMNS on the Trust Behalf wrote to NHS Resolution 22 April to explain the concerns with the data quality when implementing BadgerNet. NHS Resolution have responded to the LMNS to confirm a likely mitigation and re-review in September or October.

**Saving Babies Lives Version 3 Update (Safety Action 6)**

The Trust have been undertaking quarterly meetings with the LMNS/ICB and submitting evidence via the Futures platform. HUTH have been making steady progress to implementing the SBLV3 and for Q3 was verified at 69% overall compliance. The areas of concern is Element 4 (Fetal Monitoring) and when triangulating learning from recent MNSI cases, PMRT mortality reviews and ATAIN review triangulation.

The Q4 data submission deadline for LMNS verification was 3 June 2024, and the Trust attended a system wide meeting accordingly.

**Training Data HUTH (Safety Action 8)**

Safety action 9 (SA8) identifies that 90% attendance in each relevant staff group should attend:

- Fetal monitoring training;
- Multi-professional maternity emergencies training; and
- Neonatal Life Support Training.

This was an area of non compliance for HUTH in Year 5.

HUTH are on track to achieve the 90% compliance for MIS year six, all managers are informed of any non- attendance and staff cannot be

cancelled without the Medical Director being informed.

## 4. Feedback

Safety Champions undertake a monthly walk round across the maternity and neonatal services alternating the venue each time. This provides an opportunity for the Safety Champions to speak with staff to understand concerns and safety issues they may have and to provide the 'floor to board' communication. There are close links to the Maternity and Neonatal Voices Partnership (MNVP) to ensure the voices of birthing people are represented.

## 5. Quality Improvements

**Transitional Care Service – Quality Improvements (SA3)**

The transitional care services at HUTH are currently provided on the postnatal ward and consist of five cots. There is a current admission criteria in place from 34 and 36+6 weeks gestation and is alignment with the national BAPM transitional care framework.

The services have had several meetings and have identified several QI projects to help support the reduction in admissions or length of stay into TC, this will be finalised at the MIS delivery Group by the 21 June 2024.

## 6. Serious Incident Reporting

**Maternity and Neonatal Safety investigations (MNSI) and Patient Safety Incidents (SA9/SA10)**

There are 4 MNSI cases that have been reported from Jan – May 2024, all cases have been reported correctly, the women informed and DoC completed.

MNSI have raised concerns with the HUTH maternity services in relation to the recent four cases as they relate to CTG incidents/escalation and communication. An action plan is under development by the Clinical Director and Head of Midwifery. A further action is for the Trust in collaboration with the LMNS to undertake a peer review of all four cases and the Terms of Reference of the review have been agreed.

There is a planned MNSI visit on the 20 June 2024 with the maternity and neonatal service.

There are three ongoing PSII cases.

## 7. Sustainability Reporting

The new maternity triage continues to have a positive impact on the care women receive with some key metrics significantly improving, such as:

- Average Time to be seen – 10 minutes (at the beginning 1hr 30mins)
- Average time in department – less than one hour – this time last year some women were waiting longer than 6 hours (at the beginning Average was 3hrs)
- In the period from 1 January 2024 performance is 90.9%. At the point of time in March 2023 when the Trust started to capture the data electronically post CQC inspection it was less than 60%.

## 8. External Visits

Donna Ockenden/Professor Donald Peebles NHS England 30th April 2024
Dame Ruth May Chief Nursing Officer for England 23 May 2024

**Northern Lincolnshire and Goole NHS Foundation Trust**

### 1. Workforce

Midwifery vacancy rate remains a challenge. There are now 11 international midwives that have joined the maternity service, the final 4 are in clinical areas in a supernumerary currently. Newly qualified midwives and recently recruited midwives are positively impacting on midwifery vacancies.

### 2. Patient Experience and Service User Feedback

The Maternity Service continues to receive relatively low numbers of new complaints and PALS concerns.  Maternity and Neonatal Maternity Voices Partnership (MNVP) Lead and maternity services co-produce within maternity services.  Service user feedback through FFT highlights a theme of dissatisfaction around long waiting times. A capacity and demand review has taken place within the division.

### 3. Maternity and Perinatal Incentive Scheme Year 6 Update

Assurance and monitoring will be continued for Year 6 and CNST meetings have commenced. The Trust has attended weekly Groupwide delivery group meetings with HUTH since 17 May 2024 to ensure consistency.

The service has the pertinent updates to appraise Trust Board to satisfy requirements of reporting and escalate any key risks:

**Perinatal Mortality Review Tool (PMRT) for Quarter 4 (Safety Action 1)**

A) There were 4 eligible baby deaths in the Trust, 100% were notified to MBRRACE-UK within seven working days and surveillance completed within one calendar month.
B) The parents' perspective was sought in all 4 cases in Q4, demonstrating 100% compliance against the standard.
C) 3 cases (75%) met the standard. Non-compliance was declared in 1 case as the MDT reviewed was delayed due to representative issues from the outside trust, impacting the timeliness of the MDT review meeting taking place. This case was declared as part of the MIS year 5 submission with a request for mitigating circumstances to be considered and approved.

**Maternity Service Data Set (MSDS) (Safety Action 2)**

The Trust is scheduled to implement BadgerNotes in September 2024. From the implementation plans, it is not anticipated that this will be a risk to NLAG at this stage.

**Saving Babies Lives Version 3 Update  (Safety Action 6)**

The Trust has a verified position by the LMNS of 81% for Quarter 3. The Q4 data submission deadline for LMNS verification was 3 June 2024, and the Trust attended a system wide meeting accordingly.

### 4. Quality Improvement

Current ongoing Quality Improvement (QI) projects within maternity services include Neonatal Thermoregulation and Antenatal clinic/Antenatal Day Unit.

### 5. Maternity Safety Champions

Locally there are embedded monthly walk arounds across the maternity and neonatal services by the Safety Champions alternating the site venue each time is also a Shout Out Wednesday event each month

| | |
|---|---|
| | which enables escalation by all staff of any safety concerns as well as the safety mailboxes open to all. An improvement plan is collated ensuring learning and improvement opportunities are captured and progress monitored.<br><br>**6. External Visits**<br>No external visits to report. |
| **Background Information and/or Supporting Document(s)** (if applicable) | NA |
| **Prior Approval Process** | NA |
| **Financial implication(s)** (if applicable) | NA |
| **Implications for equality, diversity and inclusion, including health inequalities (if applicable)** | NA |
| **Recommended action(s) required** | ☐ Approval ☐ Information<br>☐ Discussion ☐ Review<br>✓ Assurance ☐ Other – please detail below: |

## Hull University Teaching Hospitals NHS Trust Maternity & Neonatal Oversight Report – June 2024 (Jan – May Data)

### 1. Workforce/Staffing

The Service has previously provided a detailed paper to Board in respect of the Birthrate Plus establishment tools which were refreshed in December 2023.

The refreshed report considered the implementation of the new maternity triage service and recommended a total clinical whole time equivalent of 197.48wte registered midwives and band 3/4 maternity support workers this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services.

The final refreshed report in December 2023 identified a total budget of 221.17wte for clinical/managerial/specialist roles. The clinical establishment is funded to 197.48wte but there is a gap in specialist roles and the services is covering a maternity triage workforce model that is not currently funded.

| Birthrate Plus | Total WTE Clinical Requirement | Specialist Roles/Managerial | Recommended overall Budget | Budget GAP |
|---|---|---|---|---|
| **Refresh December 2023** | 197.48wte | 23.70 wte<br><br>(10.24 in post, representing an uplift of 13.46 WTE) | 221.17wte | 20.13 wte<br><br>When compared to budget of 201.04wte |

The Trust is proactively working with the LMNS and ICB to evaluate specialist roles across its Group footprint and across the system footprint.

Separately, the Trust is receiving support from its Maternity Improvement Advisor who has recommended a further Birthrate plus review with the undertaking of a full assessment as opposed to the “refresh” undertaken. This will be undertaken in tandem with a review at Northern Lincolnshire and Goole NHS Foundation Trust in the summer under the guidance of the Group Director of Midwifery who commences in post on 10 June 2024.

The service has a number of key priorities for investment for 2024/25 planning together with measures to address capacity and demand issues in respect of theatre provision (growth in C-section rates) which include:

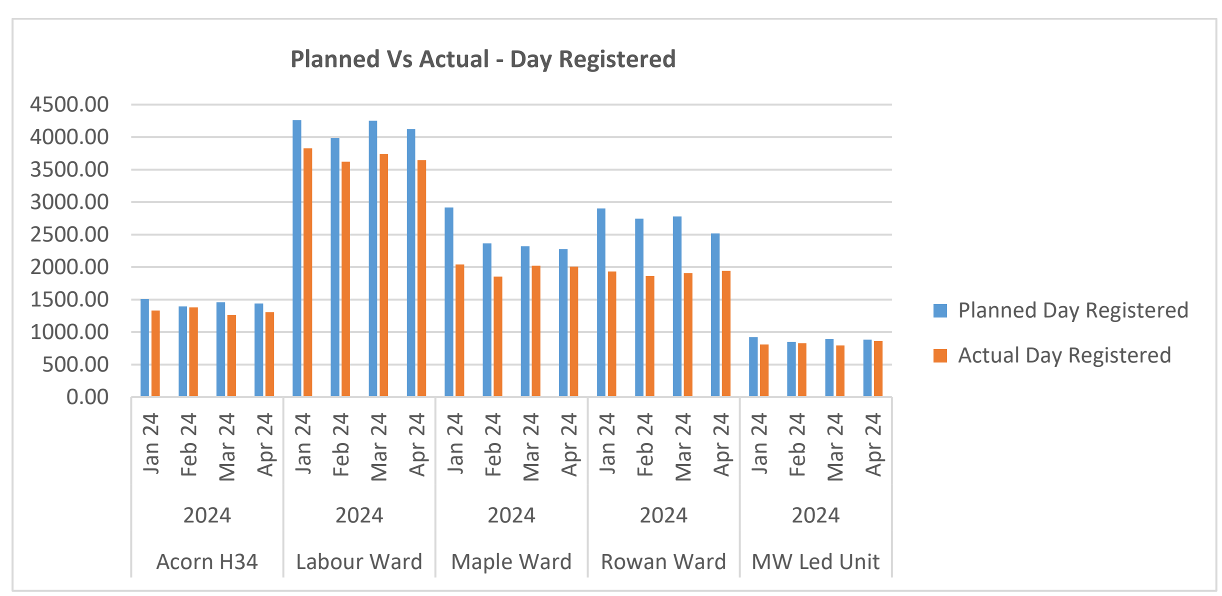
- Maternity Triage;
- Specialist midwifery roles and leadership roles including Governance Leads; and
- Staff training (ensuring the establishment provides for sufficient time for staff to complete their training).

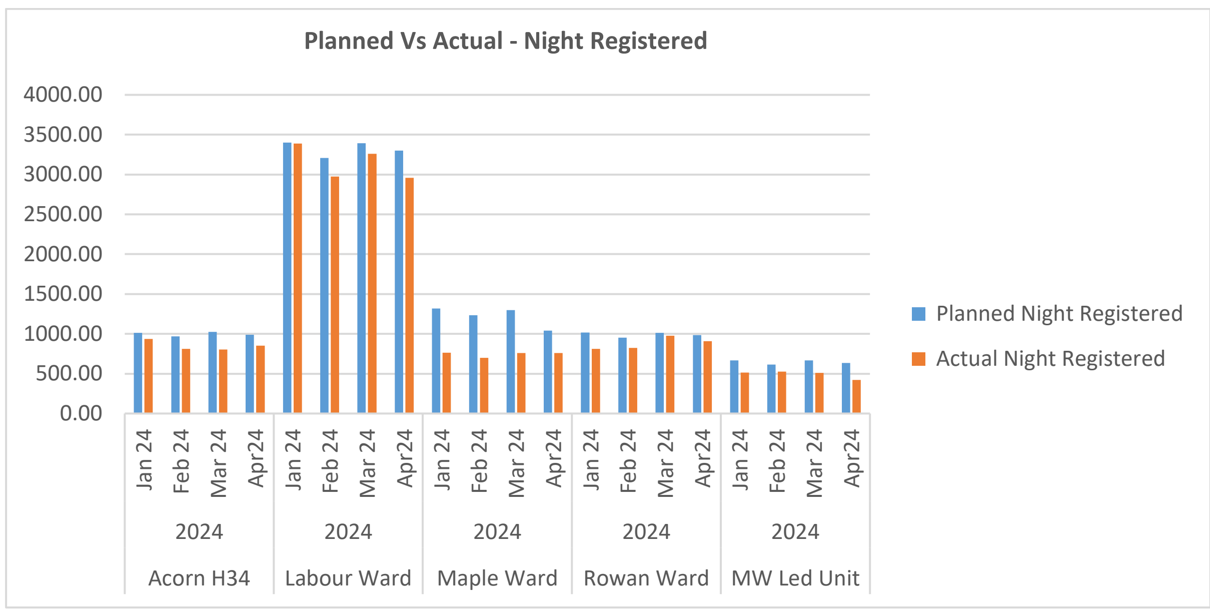
The plan was presented to ICB and LMNS on Monday 25 March 2024 at a meeting facilitated by the Executive Director of Nursing and Quality of Humber and North Yorkshire ICB, incorporating Executive Directors of Nursing and Midwifery or equivalent. The purpose of the meeting was to establish a system based approach to identify the key financial requirements/priorities for 24/25.

Safe midwifery staffing is reviewed and maintained by the operational matron 7 days a week in line with the regional Opel escalation framework and any issues escalated to the Head of Midwifery. Any staffing shortfalls are managed through the Safe Care meetings and through staff redeployment across the service to ensure safety is maintained. During periods of high acuity/activity requests are made regionally for mutual aid e.g. transfers out to other units as required maintaining safety.

Financal approval is key to supporting safe staffing levels in line with NICE and RCOG guidance this will support the service in sustainable service improvements.

**Care Hours per Patient Day (CHPPD) January – April 2024**




The care hours per patient day data demonstrates the ongoing midwifery workforce challenges of filling the midwifery rotas both during the day and on a night. The workforce challenges are due to ongoing high maternity leave/short term sickness and vacancy factor. There are 26 new midwives commencing in post October 2024 but will require a period of supernumerary status. The service continues to manage staffing on a daily to mitigate and manage the risk and DPI is agreed on a weekly basis.

**Red Flag Data**
Midwifery workforce continues to be extremely challenging and there were 19 occasions from 1/1/2024 – 31/5/2024 when the labour ward coordinator was not supernumerary and not providing 1:1 care and 5 times when they were not supernumerary but providing 1:1 care.

| | | | |
|---|---|---|---|
| RF10 | Labour Ward Coordinator not supernumerary – Providing 1:1 Care for a woman<br>Anytime when the coordinator is caring for a woman who requires 1:1 care and not able to maintain supernumerary status- the woman may be in labour (Cat I-V) or a high risk AN (A2) or PN (PD1) woman requiring 1:1 care due to her condition. | **5** | **10%** |
| RF11 | Coordinator unable to maintain supernumerary status- NOT providing 1:1 care<br>Any time when the coordinator is caring for a woman & not able to maintain supernumerary status- the women are not in labour & do not required 1:1 care- for example A1,PD2,PN,X. | **14** | **29%** |

## 2. Patient Experience / Service User feedback

The following section details the feedback received via Formal Complaints, Patient Advice and Liaison Service (PALS) concerns, Compliments and the Friends and Family Test (FFT).

**Formal Complaints and PALS Data**

| **Obstetrics** | **Jul -23** | **Aug -23** | **Sep -23** | **Oct -23** | **Nov -23** | **Dec -23** | **Jan -24** | **Feb-24** | **Mar -24** | **Apr -24** | **May -24** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of complaints open and ongoing | 8 | 7 | 9 | 9 | 9 | 7 | 12 | 9 | 15 | 17 | 19 |
| Number of complaints overdue | 2 | 1 | 4 | 6 | 4 | 3 | 5 | 3 | 4 | 7 | 7 |
| Number of complaints closed this month | 2 | 1 | 1 | 3 | 5 | 4 | 4 | 3 | 3 | 2 | 4 |
| Number of new complaints this month | 6 | 3 | 2 | 5 | 2 | 3 | 4 | 1 | 5 | 8 | 0 |
| | **Jul -23** | **Aug -23** | **Sep -23** | **Oct -23** | **Nov -23** | **Dec -23** | **Jan -24** | **Feb-24** | **Mar -24** | **Apr -24** | **May -24** |
| Number of PALS open | | | | | | | 5 | 8 | 17 | 13 | 5 |
| Number of PALS overdue | | | | | | | 3 | 6 | 15 | 13 | 5 |
| Number of PALS closed this month | 5 | 16 | 7 | 16 | 22 | 19 | 11 | 8 | 7 | 9 | 6 |
| Number of new PALS | 10 | 15 | 12 | 16 | 21 | 19 | 14 | 3 | 4 | 3 | 0 |
| | **Jul -23** | **Aug -23** | **Sep -23** | **Oct -23** | **Nov -23** | **Dec -23** | **Jan -24** | **Feb-24** | **Mar -24** | **Apr -24** | **May -24** |
| % of complaints closed within 40 working days (KPI 80%) | | | | | | | 25% | 50% | 33% | 50% | 50% |
| Average length of time to respond to complaints closed (working days) | | | | | | | 76 | 57 | 58 | 60 | 62 |
| % of PALS closed within 5 working days | | | | | | | 54.50% | 58.10% | 57.14% | 11.00% | 0.00% |

| **Children and Young People including Neonates** | **Jul -23** | **Aug -23** | **Sep -23** | **Oct -23** | **Nov -23** | **Dec -23** | **Jan -24** | **Feb-24** | **Mar -24** | **Apr -24** | **May -24** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of complaints open and ongoing | 4 | 1 | 1 | 2 | 4 | 3 | 2 | 1 | 2 | 2 | 2 |
| Number of complaints overdue | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 1 | 1 | 1 |
| Number of complaints closed this month | 3 | 3 | 0 | 1 | 2 | 0 | 2 | 1 | 0 | 0 | 0 |
| Number of new complaints this month | 3 | 0 | 2 | 0 | 1 | 1 | 3 | 0 | 0 | 0 | 0 |
| | **Jul -23** | **Aug -23** | **Sep -23** | **Oct -23** | **Nov -23** | **Dec -23** | **Jan -24** | **Feb-24** | **Mar -24** | **Apr -24** | **May -24** |
| Number of PALS open | | | | | | | 2 | 0 | 2 | 0 | 0 |
| Number of PALS overdue | | | | | | | 2 | 0 | 2 | 0 | 0 |
| Number of PALS closed this month | 4 | 8 | 7 | 11 | 7 | 9 | 11 | 2 | 0 | 4 | 2 |
| Number of new PALS | 9 | 5 | 13 | 9 | 6 | 10 | 13 | 0 | 2 | 5 | 0 |
| | **Jul -23** | **Aug -23** | **Sep -23** | **Oct -23** | **Nov -23** | **Dec -23** | **Jan -24** | **Feb-24** | **Mar -24** | **Apr -24** | **May -24** |
| % of complaints closed within 40 working days (KPI 80%) | | | | | | | 50% | 0% | 0% | 0% | 0% |
| Average length of time to respond to complaints closed (working days) | | | | | | | 33 | 0 | 0 | 0 | 0 |
| % of PALS closed within 5 working days | | | | | | | 72.70% | 100.00% | 0.00% | 25.00% | 0.00% |

**Obstetrics**

The Maternity Service at HUTH received no new complaints in May 2024, the total open and ongoing complaints is 19; seven of which, are overdue the 40 working day target. The main themes of the open and ongoing complaints are treatment, care, and comfort including privacy and dignity. Four complaints were closed, two of which were closed within the 40 working day target.

There were also no new PALS cases opened in May 2024. 6 PALS were closed, leaving 5 remaining open and ongoing PALS cases, all of which are overdue the 5 working day target. The main themes for the open cases are treatment, discharge and attitude.

**Children and Young People (including Neonates)**
The children and Young People Services at HUTH received no new complaints in May. The main themes of the open and ongoing complaints are communication, care and Comfort including privacy and dignity.

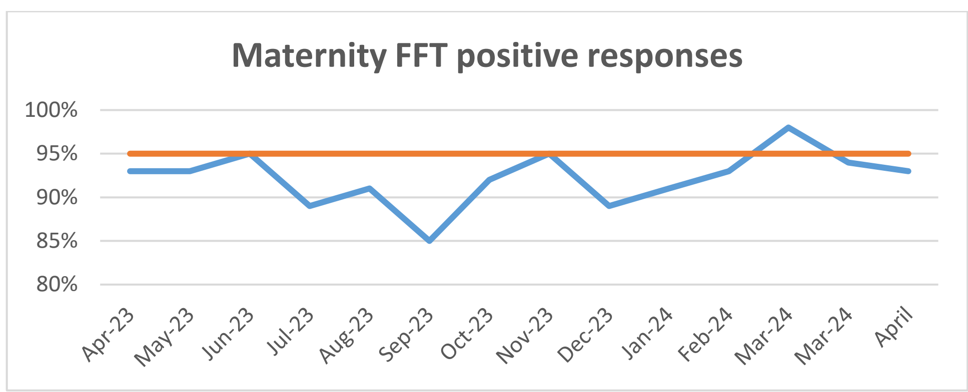
There were also no new PALS cases opened in May 2024, 2 PALS remaining open and Ongoing PALS cases, all of which are overdue the 5 working day target.

**Compliments**

Seven compliments were received for the Maternity Service in May 2024.

**Friends and Family Test (FFT)**

Maternity Services is an overall improving patient experience with FFT positive responses increasing, PALS and Complaints received remaining low and consistent, slight improvements noted in the National Maternity Patient Survey and FFT Birth Score remains at 100%. Periods of lower attainment (July, Sept and Dec 23) relate to Rowan Ward (Postnatal) and attributable to staff attitude themes. As part of the Maternity Assurance visit on 08 April 2024, the team visited Rowan Ward to gather live experiences; although there was a small amount of patients on the ward, they all reported positive experiences. This will continue to be monitored.




The local Healthwatch organisations have undertaken a targeted review of HRI maternity services between October 2023 and January 2024 and reported in their conclusion that ‘there has been many improvements made by the staff of HRI to improve patient experience following the CQC report published in 2023’ These included the improvements to triage made, but also rightly drew out the need to sustain our staffing models.

## 3. Assurance

**Perinatal Mortality Review Tool (PMRT – Q4 Data)**

This data reflects the late miscarriages, antepartum stillbirths and neonatal deaths.

An incident is reported via the MBRRACE system, following each death, and is independently reviewed to identify its avoidability and any learning. A quarterly review of all perinatal mortality is undertaken to identify themes, trends and learning opportunities.

The process for reporting any early pregnancy losses including pregnancies less than 20 weeks gestation, neonatal deaths regardless of gestation and including termination of pregnancies changed in March 2022. Any fetus showing signs of life following medical termination of pregnancy now requires a referral to coroner for further investigation. The reporting of this revised criteria will show an increase in early neonatal deaths from previous years reporting. This will be demonstrated in the table below. All cases are reported to MBRRACE.

The Maternity Service continues to use the Perinatal Mortality Review Tool (PMRT) to review deaths which meet the criteria for review, and to identify and share learning from these reviews to improve practice, safety, and patient care. The service will continue to use the reporting tool and meet the timescales identified in the technical guidance for the Maternity Incentive Scheme.

| Quarter 4 PMRT data | January 2024 – March 2024 | |
|---|---|---|
| Total Number of deaths | | 4 |
| Type of Mortality | Ante partum Stillbirths | 1 (known abnormality) |
| | Intrapartum Stillbirths | 0 |
| | Neonatal deaths | 3 (1- MNSI) |
| | Post Neonatal Death | 0 |
| Gestational age | <24 weeks | 5 through Datix but not PMRT eligible due to gestation |
| | 24-27 weeks | 1 |
| | 28-31 weeks | 0 |
| | 32-36 weeks | 1 |
| | 37-41 weeks | 1 |
| | >42 weeks | 0 |

| Details/Themes and Trends |
|---|
| a) There were 4 eligible baby deaths in the Trust, in 100% of the cases the MBRRACE-UK perinatal surveillance was commenced within 7 days and completed within one calendar month<br>b) The parents' perspective was sought in both cases occurring in Q4, achieving 100% compliance with the standard.<br>c) 100% of the cases in Q4 when babies were born and died in the Trust, have been commenced within the standard of 2 months. All three cases are still under review. 6 of the cases in which the babies deaths occurred within Q3 (October – December 2023) the reviews have been completed and reported upon which maintains a 100% compliance.<br>d) Quarterly report submitted as per standard and discussed with the Trust safety champion<br><br>1 case was MNSI reportable case; Term pregnancy at 41+1 weeks - Early Neonatal Death , presented with reduced fetal movements and fetal bradycardia on CTG in correct classification |

| Action Plan - PMRT | | | | |
|---|---|---|---|---|
| Issue | Action | Owner | Due Date | Progress |

| A woman did not receive steroids or antibiotics which may have affected the outcome for the baby | Develop guideline for Extreme Preterm SROM antibiotic therapy/repeating steroids pathway | Clinical Governance Midwife | July 2024 | Complete – working to BAPM7 guideline |
|---|---|---|---|---|
| A woman presented at community midwife with reduced fetal movements and was not referred | Any woman reporting reduced fetal movements I n community, consistent advise to be given and referred to antenatal triage | Clinical Governance Midwife | January 2024 | Complete – email reminder to all staff, reduced FM leaflet pushed through on BadgerNet |

**Progress Update/Learning Points**

The maternity service has worked closely with the HUTH digital team and LMNS to implement BadgerNet a fully digital record. It allows real-time recording of all events wherever they occur: in the hospital, the community, or at home. This includes both high risk (consultant-led) and low risk (midwife-led) pregnancy pathways. Based on a woman-centred care model, the BadgerNet Maternity system comes with a portal for women to view and access their own maternity records online.

The key feature of the system allows real time care planning to be undertaken, it enables women to submit conversations through the App and enables push notifications for essential information to be communicated to women. BadgerNet also allows for the digital plotting of fundal height so reducing human error.

Key points for Learning from PMRT are:

- Ensure to offer smoking cessation to all Family members
- Ensure CO monitoring is undertaken at ever contact
- Reminder to all staff to use Amnisure when SROM is suspected to aid confirmation
- Ensure women are offered adequate pain relief in labour regardless of the stage of labour

## Maternity Services Data Set Submission (MSDS) (MIS Safety Action 2)

Each month maternity services submit a data set to NHS Digital the purpose is to inform the Trust Board that at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. July 2024 data must contain a valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).

The CQUIN data set are:

- Babies who were born pre-term, Babies with a first feed of breastmilk,
- Proportion of babies born at term with an Apgar score <7 at 5 minutes,
- Women who had a postpartum haemorrhage of 1,500ml or more,
- Women who were current smokers at booking, Women who were current smokers at delivery,
- Women delivering vaginally who had a 3rd or 4th degree tear,
- Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section
- Caesarean section delivery rate in Robson group 1 women
- Caesarean section delivery rate in Robson group 2 women
- Caesarean section delivery rate in Robson group 5 women
- Babies breastfed at 6-8 weeks
- Babies readmitted to hospital <30 days after birth

Due to the implementation of BadgerNet there has been a risk raised by the digital team regarding the external submission of the data quality submission for MSDS MIS year 6 standards.

There have been ongoing meetings with the internal digital team and the LMNS to support the MSDS submission for safety action 2. The LMNS on the Trust behalf wrote to NHS Resolution on 22 April to explain the concerns with the data quality when implementing BadgerNet. NHS Resolution have responded to the LMNS. The Safety action lead at NHS England responded to confirm that:

*"The trust would likely be given a second opportunity to pass the criteria using September or October data. As they are transitioning systems they could also request an exemption providing they are demonstrating they are doing all they can to make sure the system is capturing the right data in future. More details about the exemption process will be circulated later in the year."*

The digital team are planning to continue running test MSDS submissions and will appraise the Trust Board of any risk to delivery safety action 2.

## Saving Babies Lives Version 3 (Progress Report)

To comply with safety action 6 of the MIS and as part of the Three Year Delivery Plan for Maternity and Neonatal Services the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by 1 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To meet the minimum requirement for CNST the Trust must demonstrate implementation of 70% of interventions across all 6 elements overall and implementation of at least 50% of interventions for each element.

In September 2023 the new national implementation tool was released which enables the Trust to track and evidence improvement as well as report on compliance with the requirements set out in the Care Bundle. The implementation tool and supplementary evidence are validated by the Local Maternity and Neonatal Service (LMNS), ensuring a more comprehensive process of assurance and better understanding of where improvement can be made across the LMNS. As part of the process, Maternity Services have been reporting to the local LMNS/ICB at quarterly assurance meetings following submission of evidence via the implementation tool on the NHS Futures platform.

The most recent assurance meeting took place in December 2023 and one of the recommendations was to ensure the Trust Board are sighted on the current position, therefore, the purpose of this report is to provide an overview of the current compliance for the 6 elements of the care bundle following submission of evidence for quarter 3 2023/24.

### Current Position – Overall Summary

The tables below provide a breakdown of the current position for all six elements of the Saving Babies Lives Care Bundle Version 3 following Quarter 3 submission along with the overall position for CNST compliance for Safety Action 6. It should be noted that the Quarter 4 submission deadline was 3 June 2024 and an away day was hosted on 3 June 2024 with LMNS to commence verification which will be updated in due course.

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (LMNS Validated) | % of Interventions Fully Implemented (LMNS Validated) | NHS Resolution Maternity Incentive Scheme |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Partially implemented | 60% | Partially implemented | 50% | CNST Met |
| Element 2 | Fetal growth restriction | Partially implemented | 90% | Partially implemented | 90% | CNST Met |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Partially implemented | 50% | CNST Met |
| Element 4 | Fetal monitoring in labour | Partially implemented | 40% | Partially implemented | 20% | CNST Not Met |
| Element 5 | Preterm birth | Partially implemented | 63% | Partially implemented | 67% | CNST Met |
| Element 6 | Diabetes | Fully implemented | 100% | Partially implemented | 83% | CNST Met |
| All Elements | TOTAL | Partially implemented | 73% | Partially implemented | 69% | CNST Not Met |

During the LMNS assurance meeting, progress made in Q3 was highlighted and improvement work to be undertaken was discussed. It was recognised that significant progress had been made in Elements 2 and 6. There has also been consistent progress made in all the other elements with an increase in the number of interventions now fully implemented. All those involved in the improvement work are to be congratulated on this.

Since the previous review, 5 out of 6 elements are now partially implemented to CNST MIS Yr5 requirements. Where Elements 3 and 4 remain at 50% and 20%, it was acknowledged that within the last quarter progress has been made on updating guidance and establishing the audits needed to meet the requirements within each of those elements.

A discussion highlighted that engagement with the digital Midwife and monitoring of the transition to BadgerNet would be needed to ensure data pulled from the system can be relied upon for audit data accuracy. Continuous feedback to inform any system updates should help support the SaBLCBv3 audit programme moving forward.

**Areas of non-compliance**

Element 1: Reducing smoking in pregnancy

| REF | Intervention | Comments/Actions | Current compliance 16/5/24 |
|---|---|---|---|
| 1.2 | Co testing offered at all other antenatal appointments (smokers) | Audit being conducted in SBL E1 badger net reports to establish if maternity staff are completing the required fields- identifying themes. On -going communication and training | On track |
| 1.3 | Whenever co testing is offered, it should be followed up by an enquiry about smoking status with the co result and smoking status recorded | Audit being conducted in SBL E1 badger net reports to establish if maternity staff are completing the required fields- identifying themes. On -going communication and training. | On Track |
| 1.4 | Instigate an opt out referral for all women who have an elevated Co level | Regional task and finish group to share learning; facilitate with improved outcomes | On track |
| 1.6 | Setting of 4 week quit dates<br><br>Successful implementation of the tobacco dependency treatment | Regional task and finish group to share learning; facilitate with improved outcomes Change lead conducting process mapping to improve engagement via set clinics | On track |
| 1.7 | Feedback is provided to the pregnant woman named maternity health care professional | Change of process; removal of paper referrals. TDTT have viewing access to badger net however awaiting full access to enable feedback via clinical notes. | On Track |
| 1.8 | All staff providing frontline maternity care should be have co competency training- required compliance 90% | Managers/Public Health Lead and link trainers have worked to increased compliance; Co competencies have been written into the preceptorship training. | Now fully compliant 91% |

Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction

| REF | Intervention | Comments/actions | Current compliance 16/5/24 |
|---|---|---|---|
| 2.4 | | Audit required however difficulties obtaining information- on going work with digital and business intelligence lead to obtain data | Not yet delivered |

Element 3: Raising Awareness of Reduced Fetal Movements

| REF | Intervention | Comments/actions | Current compliance 16/5/24 |
|---|---|---|---|
| 3.2b | | Re audit required to take into consideration the 2 weeks prior: guideline meeting 20/5/24 re RFM guideline, clarity on the definition of recurrent QI project Aqua programme | On track |

Element 4: Effective fetal monitoring during labour

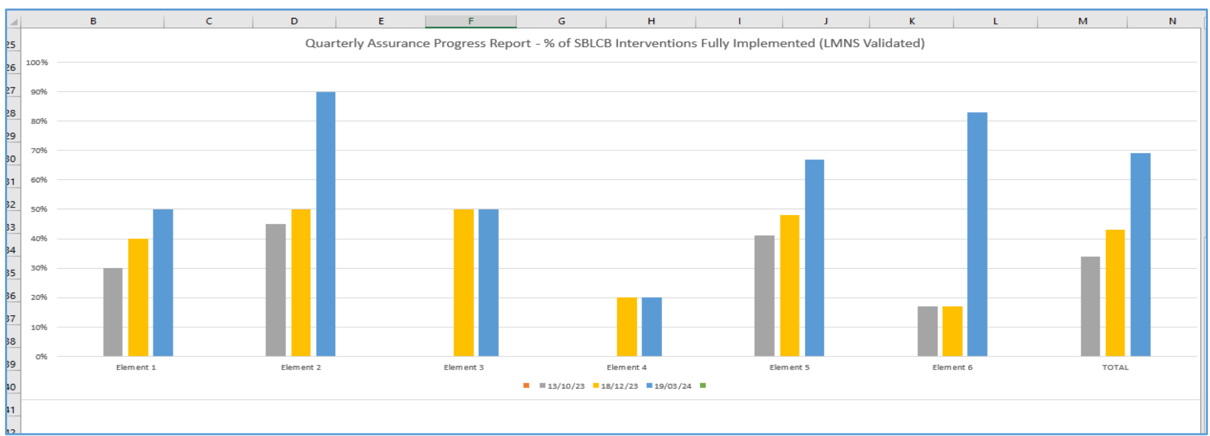
| REF | Intervention | Comments/actions | Current compliance 16/5/24 |
|---|---|---|---|
| 4.2 | Structured risk assessment | Focused QI report required | Not yet delivered |
| 4.3 | Hourly reviews | Focused QI report required | Not yet delivered |
| 4.4 | Buddy system | Focused QI report required | Not yet delivered |

Element 5: Reducing preterm birth

| REF | Intervention | Comments/action | Current compliance 16/5/24 |
|---|---|---|---|
| 5.1 | JD for neonatal pre term consultant, midwife and preterm nurse | Awaiting confirmation of funding | Not yet delivered |
| 5.2a&b | | BI report under development- | Not yet delivered |
| 5.2C | PMRT | QI focus | Not yet delivered |
| 5.2d | Pre term who die before discharge | Audit in progress | On track |
| 5.16 | Number of women who deliver pre term that have a discussion with the neonatal team regarding care options | Baseline audit in progress | On track |
| 5.17 | Number of relevant optimisation interventions | QI focus required | Not yet delivered |
| 5.26 | VTV | Baseline audit conducted | Delivered not yet evidenced |
| 5.27 | Caffeine | Baseline audit conducted | Delivered not yet evidenced |

Element 6: Management of pre-existing diabetes in pregnancy

| REF | Intervention | Action/'/comments | Current compliance as of 16/5/ 24 |
|---|---|---|---|
| 6.1 | On stop clinic (pre-existing diabetes | Audit conducted | Fully complaint |




## Conclusion

The Trust have been undertaking quarterly meetings with the LMNS/ICB and submitting evidence via the Futures platform. HUTH have been making steady progress to implementing the SBLV3 and for Q4 are at 70% overall compliance. The two areas of concern are learning from CTG recent MNSI incidents and a number of audits that are required to demonstrate compliance. The division continues to undertake multidisciplinary quality improvements and audit work and are aiming to provide assurance for the partial or non-complaint interventions for Quarter 1 and 2 submissions. The LMNS have mapped out the trajectories for HUTH and we should be 90% by March 2025 and 100% by March 2026.

| | Mar-24 | Interventions fully implemented | Mar-25 trajectory | Progress required | Interventions fully implemented | Mar-26 |
|---|---|---|---|---|---|---|
| **Element 1** | 50% | 5/10 | 80% | 3 | 8/10 | 100% |
| **Element 2** | 90% | 18/20 | 95% | 1 | 19/20 | 100% |
| **Element 3** | 50% | 1/2 | 100% | 1 | 2/2 | 100% |
| **Element 4** | 20% | 1/5 | 80% | 3 | 4/5 | 100% |
| **Element 5** | 67% | 18/27 | 85% | 5 | 23/27 | 100% |
| **Element 6** | 83% | 5/6 | 100% | 1 | 6/6 | 100% |
| **Total** | **69%** | **48/70** | **90%** | **14** | **62/70** | **100%** |

## Mandatory Training (Safety Action 8)

Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. Safety action 8 (SA8) identifies that 90% attendance in each relevant staff group should attend:

1. Fetal monitoring training
2. Multi-professional maternity emergencies training
3. Neonatal Life Support Training

**NOTE**: This is an annual rolling total and per the MIS requirement HUTH have to achieve 90% by 31 November 2024. However, as part of our focused improvement across Maternity services we are striving to recover this to target and have sustained plans in place for 2024/25 and beyond having addressed staffing establishments and put booking in place.

*1. Fetal monitoring*

Our training provision consists of a fetal monitoring course that is physically attended by staff and complemented by K2 online training. The compliance for both is documented below, with K2 online training at 97% but fetal monitoring at 85.5%.

| 85.5% | ACTUAL IN MONTH COMPLIANCE | | | | |
|---|---|---|---|---|---|
| Fetal Monitoring | Total No. Staff require learning | Number required to achieve 90% | Non-compliance required to meet 90% | 21.5.24 | % compliance |
| Obstetric Specialist Nurses | 14 | 13 | 0 | 14 | 100.0% |
| Maple & Rowan Wards | 40 | 36 | 7 | 29 | 72.5% |
| Community Midwifery | 45 | 41 | 1 | 40 | 88.9% |
| Labour Ward and Delivery | 51 | 46 | 0 | 47 | 92.2% |
| ANC/ADU | 45 | 41 | 0 | 42 | 93.3% |
| Midwifery Led Unit | 17 | 16 | 3 | 13 | 76.5% |
| Obstetric Rotational Staff | 15 | 14 | 0 | 14 | 93.3% |
| Obs & Gynae Medical Staff | 48 | 44 | 8 | 36 | 75.0% |
| Parental Education | 1 | 1 | 0 | 1 | 100.0% |
| Grand Total | 276 | 252 | 19 | 236 | |

It should be noted that courses in the last week of May are not incorporated in the above verified system data.

Detailed trajectories have been shared at the MIS Year 6 Delivery Group with plans at each staff group level. The overall trajectory is are summarised as below:

| MAY | JUNE | JULY | AUG | SEP | OCT | NOV | DEC |
|---|---|---|---|---|---|---|---|
| 236 | 248 | 253 | 255 | 255 | 256 | 257 | 257 |
| **86%** | **90%** | **92%** | **92%** | **92%** | **93%** | **93%** | **93%** |

| 97.0% | ACTUAL IN MONTH COMPLIANCE | | | | |
|---|---|---|---|---|---|
| K2 | Total No. Staff require learning | Number required to achieve 90% | Non-compliance required to meet 90% | 21.5.24 | % compliance |
| Obs Consultant | 21 | 19 | 0 | 21 | 100.0% |
| Obs ST1 -7 | 21 | 19 | 0 | 21 | 100.0% |
| Midwives | 225 | 203 | 0 | 217 | 96.4% |
| Grand Total | 267 | 241 | 0 | 259 | |

| 76.3% | ACTUAL IN MONTH COMPLIANCE | | | | |
|---|---|---|---|---|---|
| Newborn Life Support (Neonatal Resus) | Total No. Staff require learning | Number required to achieve 90% | Non-compliance required to meet 90% | 21.5.24 | % compliance |
| Obstetric Specialist Nurses | 14 | 13 | 0 | 13 | 92.9% |
| Maple & Rowan Wards | 40 | 36 | 3 | 33 | 82.5% |

| | | | | | |
|---|---|---|---|---|---|
| Community Midwifery | 45 | 41 | 6 | 35 | 77.8% |
| Labour Ward and Delivery | 51 | 46 | 5 | 41 | 80.4% |
| ANC/ADU | 45 | 41 | 6 | 35 | 77.8% |
| Obstetric Rotational Staff | 15 | 14 | 8 | 6 | 40.0% |
| Midwifery Led Unit | 17 | 16 | 5 | 11 | 64.7% |
| Parental Education | 1 | 1 | 1 | 0 | 0.0% |
| Grand Total | 228 | 208 | 34 | 174 | |

Detailed trajectories have been shared at the MIS Year 6 Delivery Group with plans at each staff group level. The overall trajectory is are summarised as below:

| **Trajectory of Compliance** | **MAY** | **JUNE** | **JULY** | **AUG** | **SEP** | **OCT** | **NOV** | **DEC** |
|---|---|---|---|---|---|---|---|---|
| Total | 182 | 193 | 195 | 203 | 206 | 208 | 208 | 208 |
| % | **80%*** | **85%** | **86%** | **89%** | **90%** | **91%** | **91%** | **91%** |

It should be noted that courses in the last week of May are not incorporated in the above verified system data, which reflects why the end of May trajectory is higher than the attainment as at 21 May 2024.

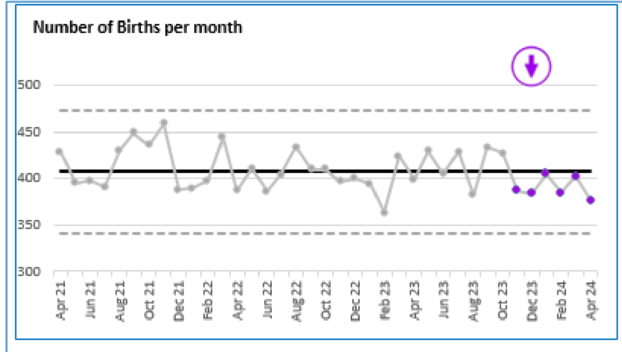
## Revised Perinatal Quality Surveillance

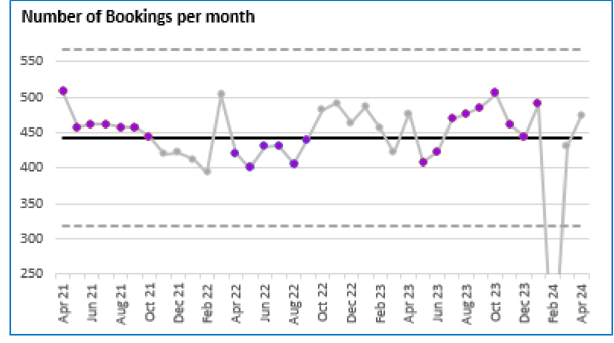
| CQC Maternity Ratings | Overall | Safe | Effective | Caring | Well-Led | Responsive |
|---|---|---|---|---|---|---|
| | Select Rating: | Select Rating: | Select Rating: | Select Rating: | Select Rating: | Select Rating: |
| | Inadequate | | | | | |
| **Maternity Safety Support Programme** | Yes | Yes Lesley Heelbeck ( NHSE) and Ruwan Wimalasundera | | | | |

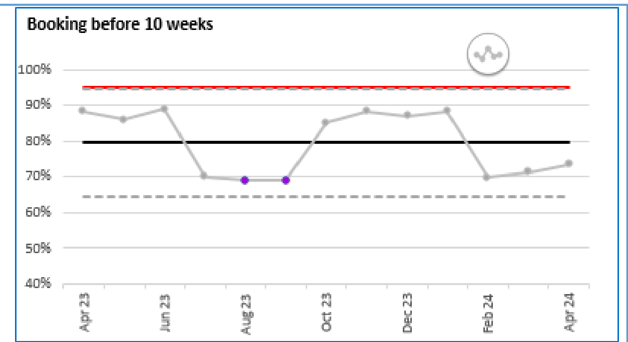
| | 2023 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Jan** | **Feb** | **March** | **April** | **May** | **June** | **July** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| 1. Findings of review of all perinatal deaths using the real time data monitoring tool | | | | | | | | | | | | |
| 2. Number of cases referred to MNSI/ENSR | 2 | 1 | 0 | 1 | 0 | | | | | | | |
| 3. Family's informed of referral to MNSI/ENSR | Yes | Yes | N/A | Yes | N/A | | | | | | | |
| 4. Findings of review of all cases eligible for referral to MNSI | Not yet published | Not yet published | N/A | Not yet published | N/A | | | | | | | |
| 5. Training compliance for all staff groups in maternity related to the core competency framework and CNST | | | | | | | | | | | | |
| 6. Minimum safe staffing in Maternity Services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively. | | | | | | | | | | | | |
| 7. The number of incidents logged graded as moderate or above and what actions are being taken | 3 PMRT and ATAIN reviews | 3 PMRT, ATAIN reviews, SOP update | 3 PMRT and ATAIN reviews | 6 Initial Incident Repose, After Action Reviews, PMRT, ATAIN reviews, update to guidelines and SOP | 4 Initial Incident Repose, After Action Reviews, PMRT, ATAIN reviews | | | | | | | |
| 8.Staff feedback from frontline champion and walk-abouts | | | | | | | | | | | | |
| 9. Service User Voice Feedback | | | | | | | | | | | | |
| 10. MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust | | | | | | | | | | | | |
| 11 .Coroner Reg 28 made directly to Trust | 0 | 0 | 0 | 0 | 0 | | | | | | | |
| 13. Progress in ATAIN Actions | | | | | | | | | | | | |
| 14. Progress in Implementation of Saving Babies Lives Care Bundle Version 3 | | | | | | | | | | | | |
| 15.Progress in achievement of CNST 10 | | | | | | | | | | | | |

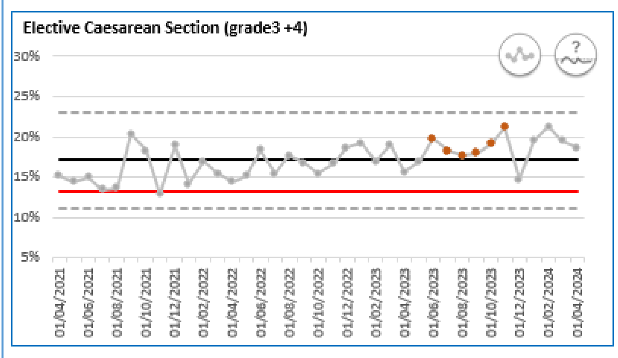
| | |
|---|---|
| (green) | Information included within the Body of the report |
| (amber) | Information will be included in August Board Report |

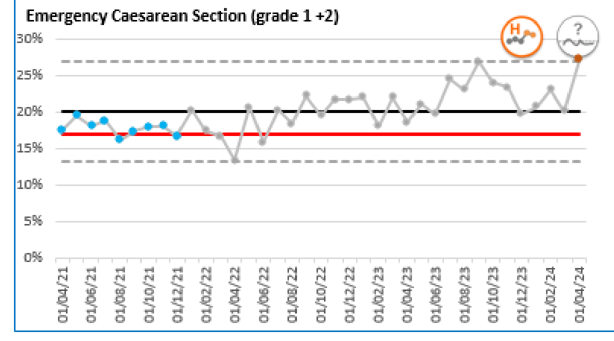
## Maternity Dashboard

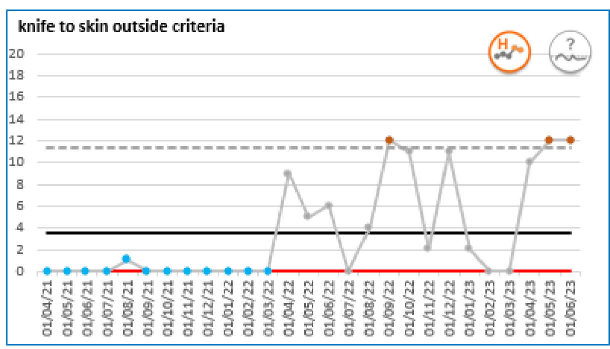


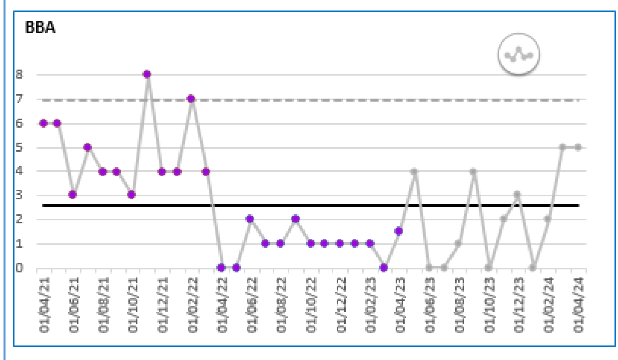



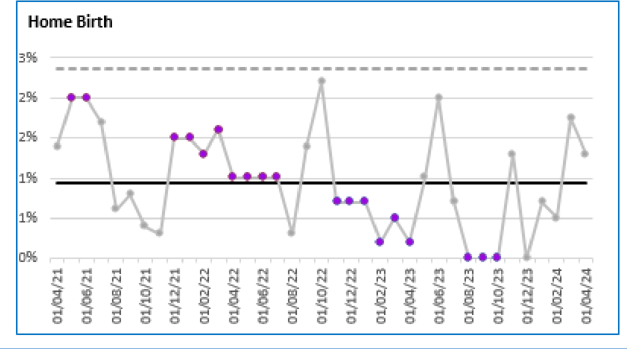



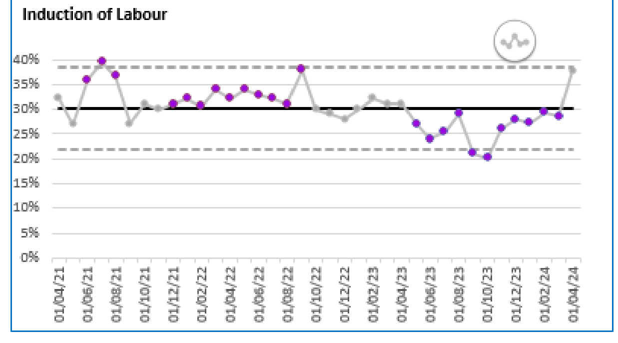



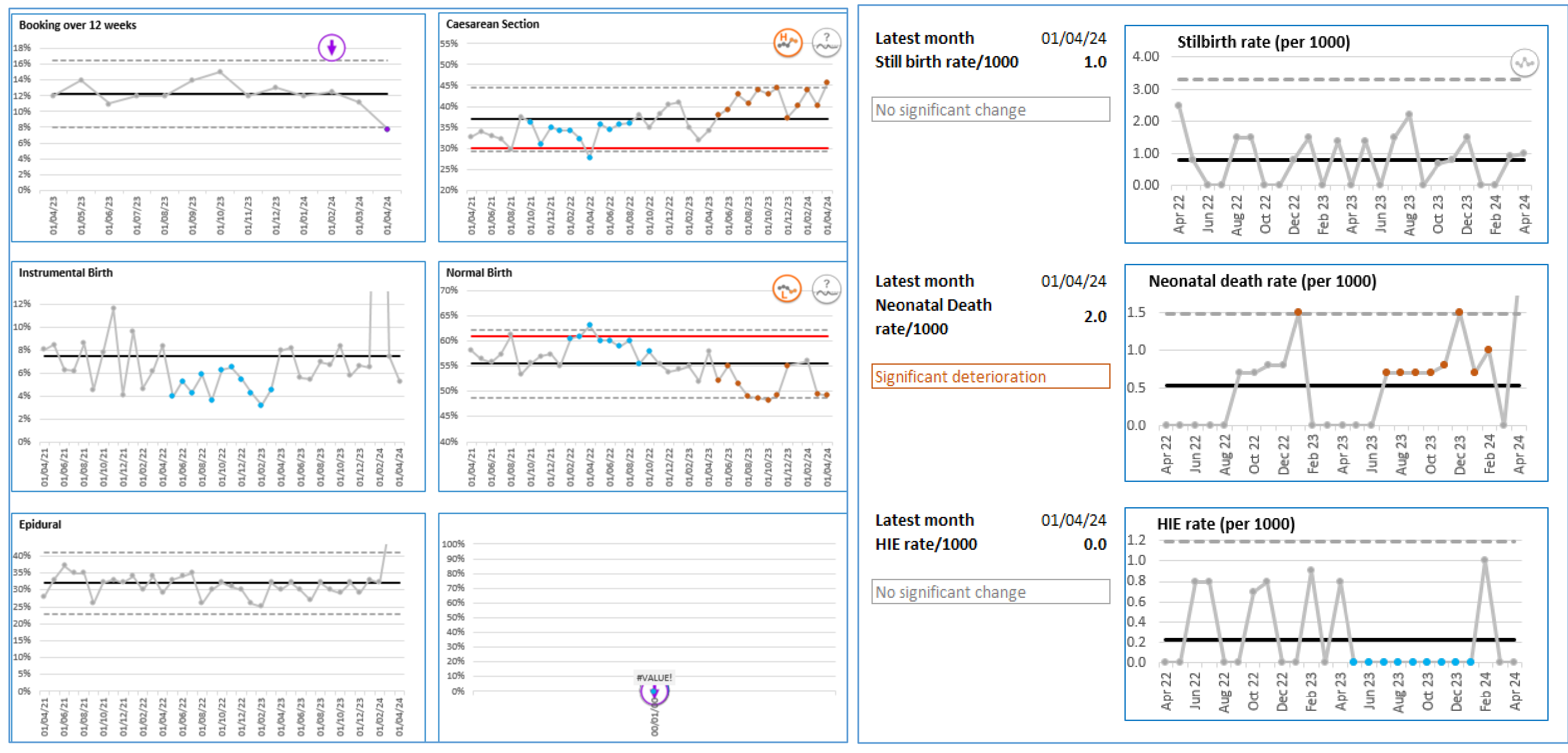






It is noted Booking before 10 weeks has had a slight deterioration since January 2024 linked to our BadgerNotes implementation. We are progressing to recover this to earlier levels of booking before 10 weeks, but note we remain above the regional and national performance on this metric.

## 4. Feedback

The Three-year delivery plan for maternity and neonatal services recognises that listening and responding to all women and families is an essential part of safe and high-quality care. Listening to women and families with compassion improves the safety and experience of those using maternity and neonatal services and helps address health inequalities.

Maternity and neonatal voices partnerships (MNVPs) ensure that service user voices are at the heart of decision-making in maternity and neonatal services. The ambition for MNVPs is set out in the Three-year delivery plan for maternity and neonatal services. HUTH has a well established MNVP forum and undertook a 15 steps visit in maternity in March 2023, with a follow up in September 2023. An action plan has been developed with members from the MNVP and has been monitored, with an update due to be presented at the Maternity Transformation and Assurance Committee on 21 June 2024.

The visit was made up of service users, MNVP leads, ICB representation from quality, patient safety and safeguarding, and Trust staff.

The following areas were visited:

- Women and Children's Hospital main entrance areas
- Antenatal Day Unit
- Scanning Department
- Labour and Delivery
- Rowan Ward
- Chapel

The group were unable to visit the Neonatal Intensive Care Unit (NICU) due to the ongoing building works, however detailed updates had been provided prior to the visit demonstrating positive progress. It was agreed that this area would be included on the next visit, or before, if the opportunity arose.

The community services were not visited due to the low number of actions; however no updates had been provided on these and we would request that these are reviewed.

Staff were welcoming in all the areas visited and it was positive to see that progress has been made on some of the actions, with a number agreeing to be recommended to be closed.

There were some areas where the service was not able to provide an update / timescale. For example the entrance area reception being staffed, signage, and the planned works to create an outside seating area. Staff stated they were not included in any discussions and could not provide any further information.

There are some areas where we feel there is the potential for further exploring if the actions can be made achievable and provide the following examples.

- **Scanning department** - is there an opportunity to review what is included in the appointment / invite letters for scans to support the main purpose of the scans?
- **Car parking**- In terms of the action about the dedicated parking / drop off area for women in labour, some in advanced labour.

The MNVP wold ask the service to review the actions from the 15 steps and provide a response to the MNVP correspondence as this will help to improve the 15-steps for maternity process in the future. The service are planning to meet with the MNVP/LMNS of the 7 June to develop a co-produce CQC maternity survey action plan. This will be shared with the MIS year six delivery group on the 14th June 2024.

## 5. Quality Improvements

### Transitional Care (TC) – Quality Improvements

Transitional care means 'in between care' and is for babies who need a little more nursing care and monitoring than the routine care that all babies receive on the maternity ward. It supports babies to stay with their mother rather than going to the Special Care Baby Unit. The transitional care services at HUTH are currently provided on the postnatal ward and consist of five cots. There is a current admission criteria in place from 34 and 36+6 weeks gestation and is alignment with the national BAPM transitional care framework.

In line with the MIS year six standards the service has collaborated with colleagues at NLAG to undertake a joint quality improvement project to decrease admissions and/or length of stay to TC.
The Group have still to confirm the joint QI project to help support the reduction in admissions or length of stay into TC, this will be finalised at the MIS delivery Group by the 21 June 2024.

## 6. Serious Incident Reporting

### Maternity and Neonatal Safety investigations (MNSI) and Patient Safety Incidents (SA9)

| Number of Moderate Harm incidents – Jan – March 2024 | 4 (MNSI reportable case) |
|---|---|
| **Rapid Review complete and Case referred to MNSI** | |

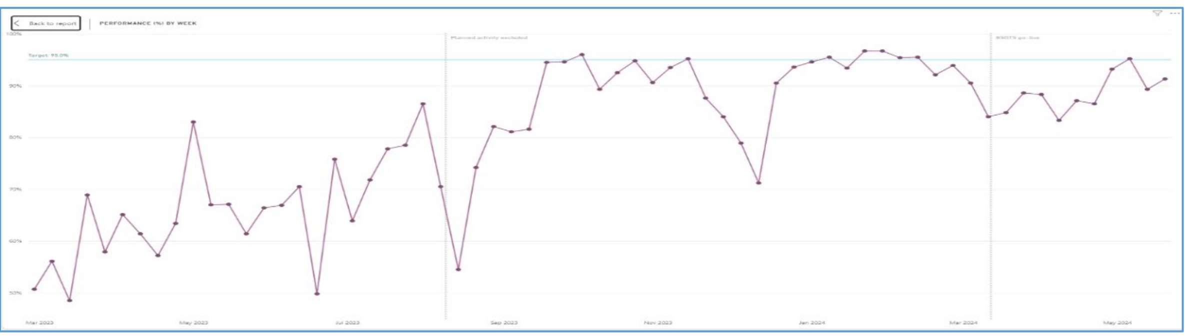
| PSII/Summary | Number of actions progressing within timescale | Number of actions complete |
|---|---|---|
| PSII/2023/16089<br><br>First pregnancy woman spoke little to no English. DNAS 28 week AN appointment resulting in a delay to obtaining 28 week bloods. Bloods were obtained Hb was noted to be 97g/l. Attended an antenatal appointment at 30+3 weeks, the fundal height measurement was incorrectly plotted. On correction at the review the correct plotting would have resulted in a referral for growth scan. The woman attended an antenatal appointment at 32+3, the fundal height measurement was incorrectly plotted on the 2nd occasion; referral for growth scan was indicated and not undertaken. At the 34+3 week appointment it was detected that the fundal height measurement was below the 10th Centile and a referral was made fora growth scan. On admission the woman complained of a mild headache auscultation of the foetal heartbeat was attempted but no heartbeat was heard; an intrauterine death was suspected and this was confirmed on ultrasound scan. The woman was transferred to the Labour Ward and gave birth to small baby | Final draft currently out for comments ready to be published<br><br>1 - Purchase set squares to assist in plotting on charts<br><br>2 - Update guideline to reflect this change in practice<br><br>3 - Update guideline to ensure the time frame to rearrange an appointment following DNA is clear. | All actions completed prior to completion of PSII |
| PSII/2024/19595 | PMRT complete but PSII not yet complete | All PMRT actions completed |

| | | |
|---|---|---|
| Pregnancy was risk assessed to be consultant led care. This woman had input with the RENEW team. Woman had a previous small for gestational age baby and a known smoker. Her carbon monoxide reading was 13, combined with previous SGA baby, was noted to require GAP scans throughout pregnancy.<br>Anaemia was identified at 28 weeks and 3 days gestation and it was documented ferrous sulphate was being taken by This woman at 31 weeks and 2 days. This woman was seen in the Antenatal clinic and induction of labour was booked for 40 weeks and 7 days.<br>At 40 weeks and 1 day This woman attended ADU and reported no fetal movements and on auscultation no fetal heart was found. | 1 - Highlight policy to refer all smokers for smoking cessation in PMRT and Community newsletters<br><br>2 - Reminder to all staff via PMRT newsletter that information on Fetal movements are provided and this is documented in the records. Providing written information to be included in the new electronic recorded for implementation 2024<br><br>3 - Reminder to all staff via PMRT newsletter that woman who report changed fetal movements >28 weeks are advised to attend maternity triage for an assessment and CTG | |
| PSII/2024/1363<br><br>Booked MLC care at the start of her pregnancy. She was identified to have Low PAPPa following her dating scan and screening. Known positive antibodies from booking bloods which were repeated at 28+2. Glucose tolerance test was negative for gestational diabetes. 32+3 woman attended the hospital with irregular tightening's and was found to have an abnormal CTG on admission so was transferred to labour ward. This woman remained comfortable but struggling to auscultate fetal heart rate effectively with concerning features. Steroids were given with the plan to deliver via caesarean section. No antibiotics or magnesium sulphate was given. This baby sadly passed away on NICU with cause of death being hypoplastic aortic arch with tight coarctation and prematurity and IUGR. | PMRT complete but PSII not yet complete<br><br>1 - Ongoing quality improvement project to improve pathway and accessibility of aspirin within the community.<br><br>2 - Preterm delivery and periprem passport not used. BAPM 7 and periprem passport usage now included on the mandatory training and within the new badger Net system.<br><br>3 - Reminder to all neonatal team to assigning roles of a scriber, so resuscitation can be reviewed. | Ongoing QI project still ongoing with good progress being made in making aspirin more accessible to women and review of fetal medicine process.<br><br>Actions 2 and 3 complete. |

## 7. Sustainability Reporting

Following the CQC visit there have been numerous improvements within the maternity service. The new maternity triage continues to have a positive impact on the care women receive with some key metrics significantly improving, such as:

- Average Time to be seen – 10 minutes (at the beginning 1hr 30mins)
- Average time in department – less than one hour – this time last year some women were waiting longer than 6 hours (at the beginning Average was 3hrs)
- Current Performance in the week commencing 20 May was 91.3% and for the period from 1 January 2024 is 90.9%. At the point of time in March 2023 when the Trust started to capture the data electronically post CQC inspection it was less than 60%)



It should be noted that the implementation of Badger Notes in March 2024 coincided with a slight reduction in performance to 83% which has started to recovery as the system has become embedded.

We are focused on securing the sustainability of the out of hours triage service and how this is staffed given the current midwifery workforce challenges.

## 8. External Visits

There have been two external visits at HUTH, Donna Ockenden visited with Professor Donal Peebles on the 30 April 2024. Dame Ruth May Chief Nursing Officer for England visited on the 23 May 2024. The verbal feedback received from both visits, which included time with service users, was very positive and Donna Ockenden is planning to return to the Trust in September 2024.

## 9. Conclusion

The oversight report highlights the work being undertaken within maternity services.

**Workforce/Staffing** - continues to be very challenging to maintain safe staffing levels with 19 occasions from 1/1/2024 – 31/5/2024 (14) times when the labour ward coordinator was not supernumerary and not providing 1:1 care and (5) times when they were not supernumerary but providing 1:1 care.

**Patient Experience –** On review of the complaint actions there are a number out of date for the service which requires dedicated focused attention.

**Assurance**

- Collaborative work continues with the maternity Improvement advisor
- Ongoing progress with progression of the outstanding CQC actions
- HUTH are undertaking a peer review with the LMNS on cluster cases reported to MNSI
- Ongoing progress made with the delivery on MIS year six which is monitored weekly through the Group MIS delivery group.

# NLAG Maternity & Neonatal Oversight Report – May 2024 (March 2024 data)

## 1 Workforce/Staffing

### Midwifery

The Trust has reported the following vacancies in the period:

| | Registered | Unregistered |
|---|---|---|
| DPOW | 11.78 WTE | 3.4 WTE |
| SGH | 9.47 WTE | 0.0 WTE |

Midwifery staffing is reviewed daily (weekdays) and a weekend plan cascaded widely. Maternity OPEL (Operational Pressures Escalation Levels) are reported internally and regionally, ensuring escalation as per the Staffing Escalation policy and to request or support with regional mutual aid as required to maintain safety. Mutual aid, escalation and provision currently under review by the Local Maternity and Neonatal System (LMNS) and the regional maternity team and a Yorkshire and Humber OPEL and mutual aid daily (weekday) meeting trial has commenced 15 April (extended until 17 May).

Assurance that safety was maintained within the maternity units is supported by the Midwife to Birth ratio data which was DPOW 1:21.74 and SGH 1:19.66. Although the vacancy factor is high, the ability to cover shifts shows positively in the ratios (expected ratio 1:28).

Maternity Wards Fill Rates and CHPPD Mar 2024

| Ward name | Fill Rate % | Change | Substantive Fill Rate % | Change | CHPPD | Change |
|---|---|---|---|---|---|---|
| **Blueberry/Holly DPoW** | **103.4%** | **▲ 3.7%** | **78.7%** | **▼ -1.2%** | **12.4** | **▲ 0.22** |
| Registered Nurses and Midwives | 111.2% | ▲ 6.9% | 85.2% | ▲ 2.3% | 8.7 | ▲ 0.26 |
| Care Staff | 88.9% | ▼ -1.8% | 66.5% | ▼ -7.6% | 3.7 | ▼ -0.04 |
| **Central Delivery Suite** | **101.2%** | **▲ 8.9%** | **52.2%** | **▼ -5.5%** | **27.5** | **▲ 1.09** |
| Registered Nurses and Midwives | 102.2% | ▲ 9.0% | 46.2% | ▼ -7.7% | 22.4 | ▲ 0.88 |
| Care Staff | 97.0% | ▲ 8.6% | 76.8% | ▲ 3.8% | 5.2 | ▲ 0.21 |
| **Jasmine & Honeysuckle** | **90.9%** | **▲ 2.5%** | **74.8%** | **▲ 5.4%** | **13.0** | **▼ -1.87** |
| Registered Nurses and Midwives | 87.5% | ▲ 4.1% | 69.1% | ▲ 4.3% | 8.4 | ▼ -1.02 |
| Care Staff | 97.9% | ▼ -0.8% | 86.6% | ▲ 7.6% | 4.6 | ▼ -0.85 |
| **Ward 26 SGH** | **84.8%** | **▼ -0.4%** | **58.1%** | **▼ -10.1%** | **6.0** | **▲ 0.49** |
| Registered Nurses and Midwives | 82.8% | ▲ 0.8% | 58.5% | ▼ -9.4% | 4.3 | ▲ 0.40 |
| Care Staff | 90.1% | ▼ -3.7% | 57.2% | ▼ -11.8% | 1.7 | ▲ 0.08 |
| **Total** | **95.6%** | **▲ 3.6%** | **67.3%** | **▼ -2.4%** | **11.7** | **▲ 0.33** |

Maternity Wards RNMW Ratio

| Ward name | RNMW Ratio % | Change |
|---|---|---|
| Blueberry/Holly DPoW | 69.9% | ▲ 0.9% |
| Central Delivery Suite | 81.3% | ▼ 0.0% |
| Jasmine & Honeysuckle | 64.8% | ▲ 1.3% |
| Ward 26 SGH | 71.4% | ▲ 1.0% |
| **Total** | **71.6%** | **▲ 1.0%** |

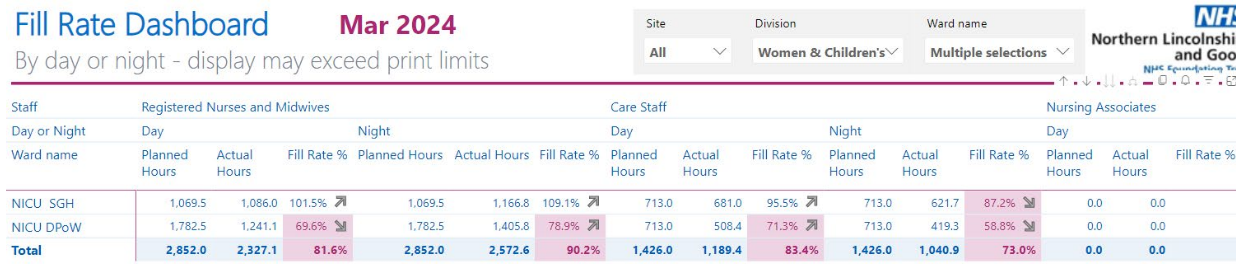
**SGH – Scunthorpe General Hospital**
**DPOW – Diana, Princess of Wales Hospital, Grimsby**

There are now 11 internationally educated midwives, all have passed their OSCE. The final 4 are in clinical areas in a supernumerary capacity.

The latest **Trust wide Maternity Dashboard** is shown in **Appendix I.**

## Neonates

Fill rate and CHPPD data for the two neonatal units is outlined below.



Fill Rate Dashboard **Mar 2024**

By day or night - display may exceed print limits

Site: All | Division: Women & Children's | Ward name: Multiple selections

| Staff | Registered Nurses and Midwives | | | | | | Care Staff | | | | | | Nursing Associates | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Day or Night | Day | | | Night | | | Day | | | Night | | | Day | | |
| Ward name | Planned Hours | Actual Hours | Fill Rate % | Planned Hours | Actual Hours | Fill Rate % | Planned Hours | Actual Hours | Fill Rate % | Planned Hours | Actual Hours | Fill Rate % | Planned Hours | Actual Hours | Fill Rate % |
| NICU SGH | 1,069.5 | 1,086.0 | 101.5% | 1,069.5 | 1,166.8 | 109.1% | 713.0 | 681.0 | 95.5% | 713.0 | 621.7 | 87.2% | 0.0 | 0.0 | |
| NICU DPoW | 1,782.5 | 1,241.1 | 69.6% | 1,782.5 | 1,405.8 | 78.9% | 713.0 | 508.4 | 71.3% | 713.0 | 419.3 | 58.8% | 0.0 | 0.0 | |
| **Total** | **2,852.0** | **2,327.1** | **81.6%** | **2,852.0** | **2,572.6** | **90.2%** | **1,426.0** | **1,189.4** | **83.4%** | **1,426.0** | **1,040.9** | **73.0%** | **0.0** | **0.0** | |

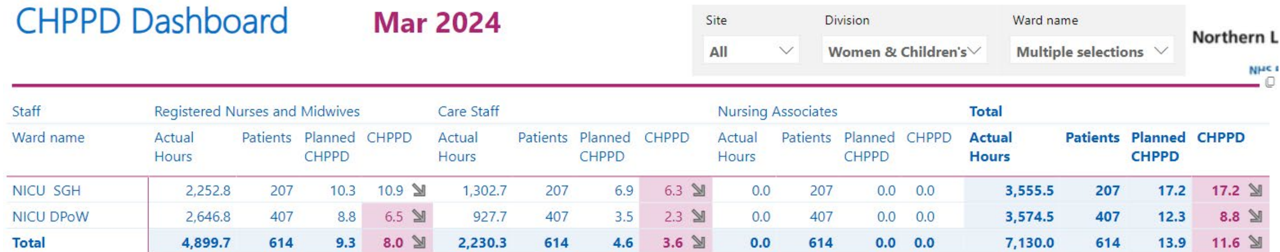
The fill rate for Registered Nurses (RN) at the Scunthorpe site has remained under the target of 95% for the night shift with a deterioration in position since the last report (Dec 2023 data) and is now showing an improved trajectory and is above target for the day shift.

At the Grimsby site, there is an improving picture in the fill rates for Registered Nurses across the day shift, although night shift RN fill rates remain below target. The HCA remain below the target of 95% across both shift profiles.

The RN position is due to on-going challenges in recruiting to the increase in the establishment, although the vacancy has now been re-aligned which will show a reduced establishment at the DPoW Site and an increased establishment at the SGH site. The deterioration in the HCA position in month is associated with an increase in sickness absence. Cot occupancy and acuity is reviewed daily, and shifts are only covered when necessary if cot occupancy or acuity dictates.

The fill rate for HCAs (Health Care Assistants) on the SGH NICU (Newborn Intensive Care Unit) has sustained an improved position due to the sustained sickness position and completed recruitment.

Any deficit in position is mitigated due to the embedded process of on-going review and movement of staff between Paediatrics and NICU to keep areas safe and the use of bank and agency where mitigation cannot be established form within baseline resource.



CHPPD Dashboard **Mar 2024**

Site: All | Division: Women & Children's | Ward name: Multiple selections

| Staff | Registered Nurses and Midwives | | | | Care Staff | | | | Nursing Associates | | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward name | Actual Hours | Patients | Planned CHPPD | CHPPD | Actual Hours | Patients | Planned CHPPD | CHPPD | Actual Hours | Patients | Planned CHPPD | CHPPD | **Actual Hours** | **Patients** | **Planned CHPPD** | **CHPPD** |
| NICU SGH | 2,252.8 | 207 | 10.3 | 10.9 | 1,302.7 | 207 | 6.9 | 6.3 | 0.0 | 207 | 0.0 | 0.0 | **3,555.5** | **207** | **17.2** | **17.2** |
| NICU DPoW | 2,646.8 | 407 | 8.8 | 6.5 | 927.7 | 407 | 3.5 | 2.3 | 0.0 | 407 | 0.0 | 0.0 | **3,574.5** | **407** | **12.3** | **8.8** |
| **Total** | **4,899.7** | **614** | **9.3** | **8.0** | **2,230.3** | **614** | **4.6** | **3.6** | **0.0** | **614** | **0.0** | **0.0** | **7,130.0** | **614** | **13.9** | **11.6** |

The CHHPD continue to fluctuate due to the number of occupied cots and the reviewed staffing levels to ensure patient safety. The care staff CHHPD is lower to a planned higher ratio of RN to HCA. There is a general trajectory of improvement across the metrics.

### Update on Birthrateplus staffing establishments

A full establishment review using Birthrate Plus methodology was undertaken in July 2022 and a review of workforce, activity and patient safety data was undertaken by the Deputy Chief Nurse and Associate Chief Nurse – Midwifery, Gynaecology & Breast Services in December 2023 for the maternity wards, delivery suites, outpatient and community services.

As part of Group working, and the ICB enthusiasm for working collaboratively across the system in some specialist roles, it has been agreed to undertake an updated Birthrate Plus assessment aligned to the timing of Hull University Teaching Hospitals NHS Trust. Their need has been recommended by their Maternity Improvement Advisor.

For reference, the previous total recommended by Birthrate Plus was 185.39 whole time equivalent (wte) against the current funded 187.94wte – positive variance of 2.55wte if providing care in a mainly 'traditional' model with limited caseload teams.

| | Current Funded wte (Bands 5 to 8) | Birthrate Plus Clinical wte | Variance wte |
|---|---|---|---|
| DPOW | 99.14 | 93.72 | 5.42 |
| SGH | 73.00 | 73.30 | -0.30 |
| Additional Specialist and Management wte (across both services) | 15.80 | 18.37 | -2.57 |
| **TOTAL CLINICAL, SPECIALIST & MANAGEMENT WTE** | **187.94** | **185.39** | **2.55** |

The service has undertaken a recent review which has identified that recruitment was continuing to fill the vacancies and ward and department managers felt that staffing levels would be appropriate when vacancies were filled. A number of recommendations have been made to be taken forward for resolution which included 1 medium adjustment for Labour Co-Ordinators DPOW to update a 19-hour Band 7 vacancy – recommend increased to 1 WTE, an increase of 18.5 hours per week.

In addition there were 6 low priority adjustments on Central Delivery Suite SGH, Ward 26 SGH, Community Midwifery Team SGH, Blueberry and Holly (DPOW), Jasmine and Honeysuckle (DPOW), Antenatal Clinic (DPOW), Community Midwifery Team (DPOW).

## 2 Patient Experience/Service User Feedback

The following section details the feedback received via Formal Complaints, Patient Advice and Liaison Service (PALS) concerns, Compliments and the Friends and Family Test (FFT). This information is taken from March 2024 information and includes performance data and themes.

### Formal Complaints and PALS Data

**KPI** -Key Performance Indicator

Table A

| Obstetrics | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|
| Number complaints open/ongoing | 6 | 2 | 1 | 2 | 2 | 4 |
| Number of open complaints out of timescale | 1 | 0 | 1 | 0 | 0 | 0 |
| Number complaints closed this month | 0 | 4 | 0 | 1 | 1 | 0 |
| Number of new complaints | 0 | 1 | 0 | 2 | 2 | 2 |
| | **Oct-23** | **Nov-23** | **Dec-23** | **Jan-24** | **Feb-24** | **Mar-24** |
| Number of PALS open | 2 | 2 | 0 | 1 | 0 | 3 |
| Number of PALS out of timescale | 2 | 0 | 0 | 1 | 0 | 2 |
| Number of PALS closed this month | 4 | 4 | 5 | 5 | 3 | 5 |
| Number of new PALS | 4 | 4 | 3 | 6 | 2 | 8 |
| | **Oct-23** | **Nov-23** | **Dec-23** | **Jan-24** | **Feb-24** | **Mar-24** |

| % of complaints closed within timescale (KPI 85%) | 0 | 75% | 0 | 0% | 100% | 0% |
|---|---|---|---|---|---|---|
| Average length of time to respond to complaints closed (working days) | 0 | 50 | 0 | 62 | 8 | 0 |
| % of PALS closed within timescale (KPI 60%) | 25% | 25% | 40% | 0% | 66% | 60% |
| Average length of time to respond to PALS closed (working days) | 12 | 10 | 7 | 16 | 10 | 6 |

| **Children & Young People including Neonates** | **Oct-23** | **Nov-23** | **Dec-23** | **Jan-24** | **Feb-24** | **Mar-24** |
|---|---|---|---|---|---|---|
| Number complaints open/ongoing | 1 | 3 | 3 | 0 | 0 | 1 |
| Number of open complaints out of timescale | 0 | 0 | 0 | 0 | 0 | 0 |
| Number complaints closed this month | 2 | 0 | 1 | 3 | 1 | 0 |
| Number of new complaints | 0 | 3 | 0 | 1 | 0 | 1 |
| | **Oct-23** | **Nov-23** | **Dec-23** | **Jan-24** | **Feb-24** | **Mar-24** |
| Number of PALS open | 2 | 1 | 2 | 5 | 4 | 1 |
| Number of PALS out of timescale | 2 | 1 | 2 | 4 | 1 | 1 |
| Number of PALS closed this month | 11 | 10 | 8 | 6 | 13 | 10 |
| Number of new PALS | 8 | 9 | 9 | 10 | 11 | 6 |
| | **Oct-23** | **Nov-23** | **Dec-23** | **Jan-24** | **Feb-24** | **Mar-24** |
| **% of complaints closed within timescale (KPI 85%)** | **0%** | **0** | **100%** | **100%** | **100%** | **0** |
| **Average length of time to respond to complaints closed (working days)** | 74 | 0 | 0 | 37 | 1 | 0 |
| **% of PALS closed within timescale (KPI 60%)** | **18%** | **60%** | **75%** | **66%** | **46%** | **60%** |
| **Average length of time to respond to PALS closed (working days)** | 13 | 6 | 5 | 6 | 12 | 10 |

March saw no formal complaints closed in Obstetrics, with 4 currently open, none of which are out of timescale. 2 new complaints were logged both with the theme of Clinical Care/Treatment. The central team continue their work with the Group Tri and Matron team for Family Services to address complaints in a timely and appropriate manner.

There were 8 new PALS concerns, 4 Clinical Treatment, 2 Staff Behaviour & Values, 1 Nursing Care and 1 Communication. 60% of closed PALS concerns achieved the 5-day timescale for closure, this is the second consecutive month of 60% against the KPI of 60% and represents a significant improvement from previous months. 3 concerns remain open, 2 of which are out of timescale.

**2023 Picker Maternity Survey**
Action plan co-produced between maternity service and Maternity and Neonatal Voices Partnership (MNVP).

Children and Young People received 1 new formal complaint, the theme being Clinical Care/Treatment. No other complaints were open, so a percentage is not applicable for March reporting.

Six new PALS concerns were logged, main theme related to delays/cancelations 3, clinical treatment 2 and communication 1. These are all related to paediatric areas and not neonatal areas. 60% of the 10 PALS closed were in timescale (against a KPI of 60%), with an average of 10 days to close a concern being noted.

Family Service complaints and concerns feedback continue to be complex and emotive in nature and this can make timescale delivery challenging, especially for PALS. Both Complaints and PALS Managers continue to keep Group Leads informed of current progress and performance will be monitored over coming months as the new structure becomes embedded. This will allow discussion on causes and explore where further support can be offered.

Two compliments were formally logged on Ulysses in November: 1 Paediatric/Neonate (SGH) and 1 Obstetrics (DPOW). They relate to patience, attentive, knowledge and skilled in the care provided.

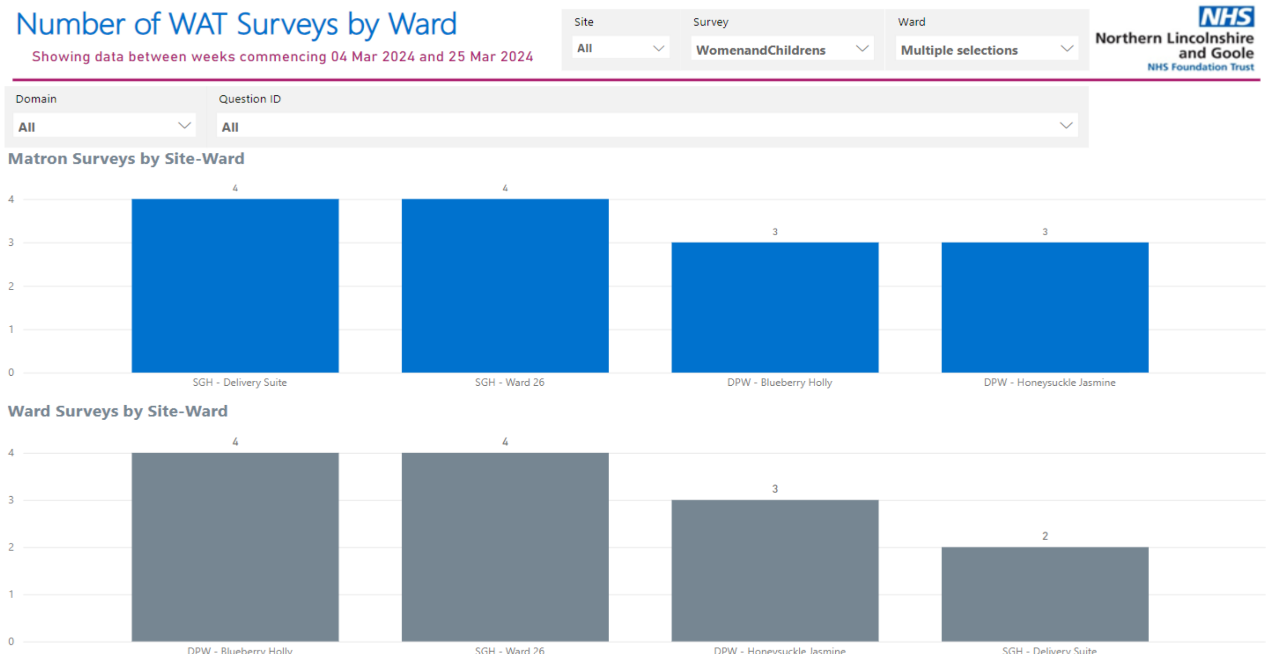
Maternity collected 95 pieces of Friends and Family Test feedback (FFT), with 61 at Diana, Princess of Wales (DPOW) and 30 at Scunthorpe General Hospital (SGH), 84 were rated positive and 11 rated negative. Children and Young people collected 12 FFT feedback; 5 at SGH and 7 at DPOW with all rating positive. Our FFT system is awaiting Phase 2 and requires support from our Information Systems Team – this is presently on hold due to other pressures on their team. Once the FFT system is fully integrated the Patient Experience Manager will focus on increasing volume of feedback through work with Wards, Departments and Services.

## 3 Assurance

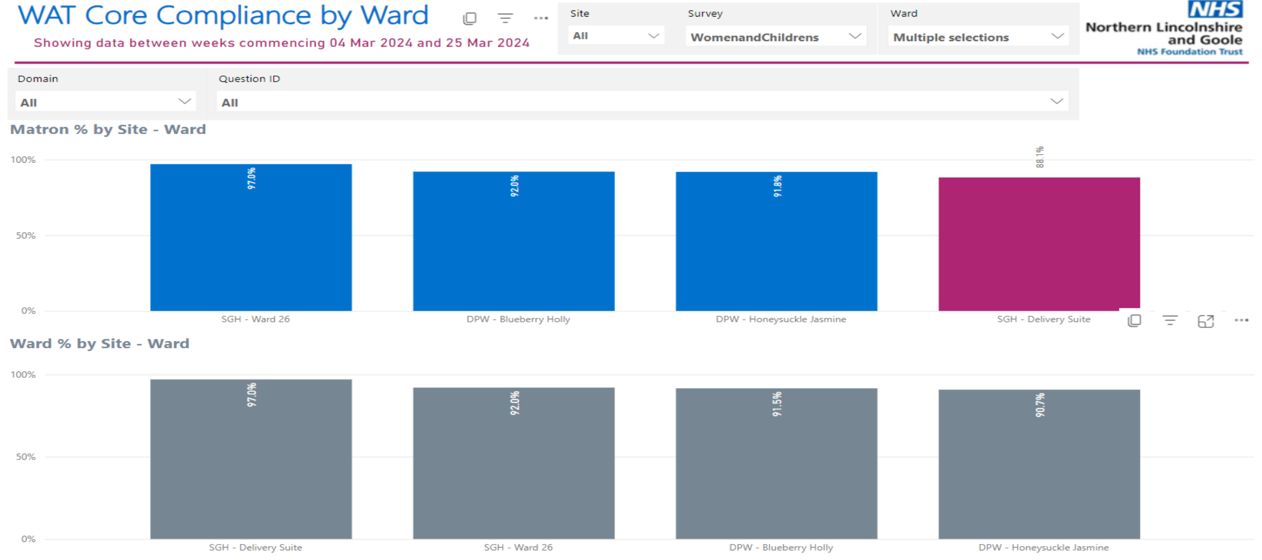
There were no visits planned to Maternity Wards or Neonatal Units throughout March, supportive visits continued to take place, reviewing individual 15 Steps improvement plans and gaining further assurance with ongoing actions previously identified.

**Ward Assurance Tool (WAT) data, Maternity and Services, March 2024**

The table below shows number of assurance surveys completed out of an expected 4 by Manager and 4 by Matron per area, at Diana Princess of Wales (DPOW) and Scunthorpe General Hospital (SGH). Matron Completion at SGH has significantly improved with the interim Matron post. Poor completion by Ward Manager on Central Delivery Suite.



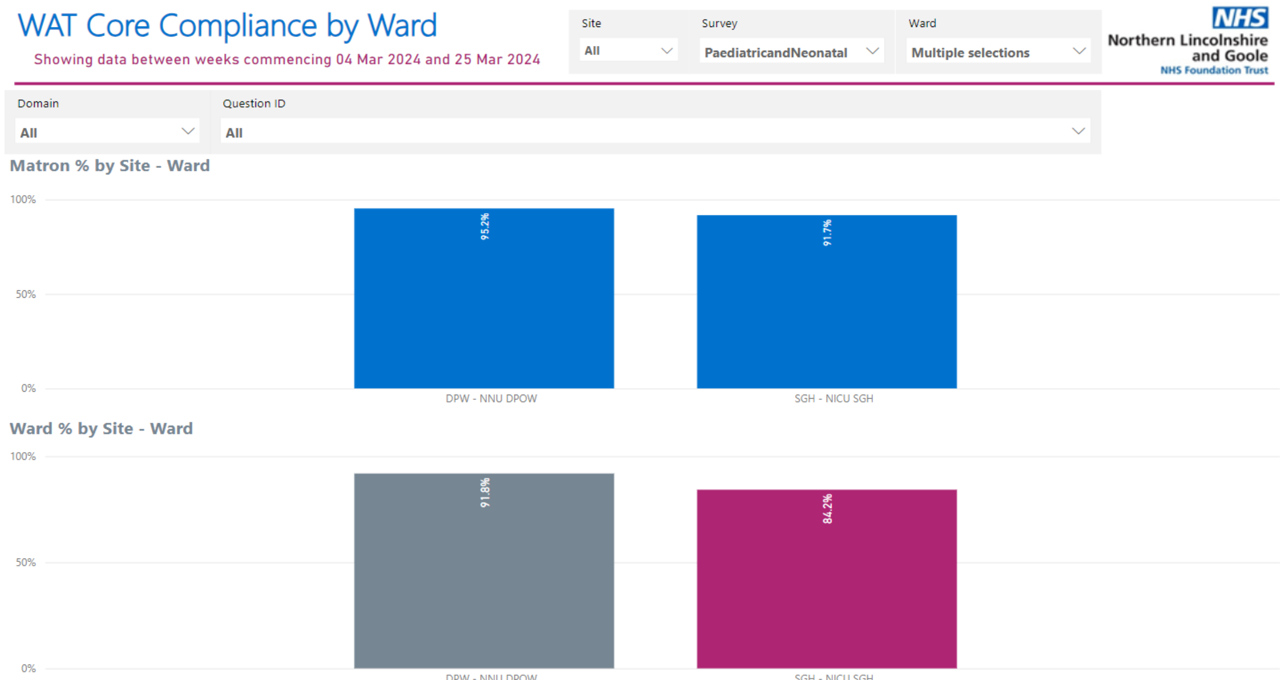

The table below shows the compliance percentage for quality standards for both Matron and Manager surveys, Central Delivery Suite dropped below the expected 90% on Matron surveys, with medications management the main theme.




**Ward Assurance Tool (WAT) data, Neonatal and Services, March 2024**

The table below demonstrates number of assurance surveys completed across Neonatal Intensive Care units (NICU) out of an expected 4 by Manager, at DPOW and SGH. Inaccurate data for Matron completion on NICU at SGH, the wrong date was selected, 3 surveys were completed.

The table below shows the compliance percentage for quality standards across Neonatal services, for Manager surveys. NICU, SGH fell below the expected 90% compliance again this month.




Themes for improvement across both sites for NICU included medications management; NICU SGH unable to secure treatment room as dual purpose – escalated on risk register, and gaps in planned establishment also contributed to the lower percentage score.
The weekly assurance tool (WAT) will be moving over to AMaT from 1st May 2024, this will increase the timeliness and reliability of the data, this has also allowed for a review of the expected standards for each area to ensure they are aligning with best practice.

**Perinatal Mortality Review Tool (PMRT – Q4 Data)**
The Maternity Service continues to use the Perinatal Mortality Review Tool (PMRT) to review deaths which meet the criteria for review, and to identify and share learning from these reviews to improve practice, safety, and patient care. The service will continue to use the reporting tool and meet the timescales identified in the technical guidance for the Maternity Incentive Scheme During Q4 (January – March 2024) the multidisciplinary team completed the perinatal mortality review tool on 4 eligible deaths. However, it should be acknowledged that reporting relates to deaths that occurred during MIS year 5 reporting period (July – November 2023) due to the lag in the review and reporting process.

| **Quarter 4 PMRT data** | **January 2024 – March 2024** | |
|---|---|---|
| **Total number of deaths** | **4** | |
| **Type of Mortality** | Antepartum Stillbirths | 1 |
| | Intrapartum Stillbirths | 0 |
| | Unspecified stillbirths | 2 |
| | Neonatal Deaths | 1 |
| **Gestational age** | <24 weeks | 0 |
| | 24 – 27 weeks | 1 |
| | 28 – 31 weeks | 1 |
| | 32 – 36 weeks | 0 |
| | 37 – 41 weeks | 1 |
| | >42 weeks | 0 |
| | Unspecified | 1 |

| Details / Themes and Trends |
| --- |
| a) There were 4 eligible baby deaths in the Trust, 100% were notified to MBRRACE-UK within seven working days and surveillance completed within one calendar month.<br>b) The parents' perspective was sought in all 4 cases in Q4, demonstrating 100% compliance against the standard.<br>c) 3 cases (75%) met the standard. Non-compliance was declared in 1 case as the MDT reviewed was delayed due to representative issues from the outside trust, impacting the timeliness of the MDT review meeting taking place. This case was declared as part of the MIS year 5 submission with a request for mitigating circumstances to be considered (and approved).<br><br>0 cases met the threshold for referral to Maternity and Newborn Safety Investigations (MNSI).<br><br>No themes were identified during quarter 4. |

## 4 Feedback

**Maternity & Neonatal Safety Champions**

The role of the Trust Board Safety Champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal) service users, LMNS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes. There are embedded monthly walk rounds across the maternity and neonatal services by the Safety Champions alternating the venue each time. It provides an opportunity for the Safety Champions to speak with staff to understand concerns and safety issues they may have and to provide the 'floor to board' communication.

A walkaround for March took place at SGH. Issues escalated were in relation to the availability of theatre 'scrubs' on the delivery suite and maternity triage staffing.

**Safety Mailbox and Shout Out Actions**

Staff can raise safety concerns through a Safety Mailbox and via Shout Out Wednesday, which occurs monthly cross site. This is a short gathering on the clinical areas where all grades of staff are encouraged to attend to express any safety concerns that they may have. All are progressing and there are no areas for escalation.

The latest **Safety Champions Improvement Plan** has been considered in detail at underpinning Maternity Board and has had oversight at the Quality and Safety Committees in Common.

## 5 Quality Improvement

**Transforming Maternity Triage Services**
The Ockenden report outlines a number of recommendations in relation to how maternity services should conduct triage for pregnant women with medical related concerns who are 16 weeks plus. These recommendations outline the need to follow a recognised model of triage to priorities timely assessment, i.e. the Birmingham Symptom Specific Obstetric Triage System (BSOTS).

This Quality Improvement Project aim is to Implement a fully operational Maternity Triage Service across the whole of the Maternity Service in NLAG, that utilises a Nationally recognised Triage Model (BSOTS). In order to enhance the patient experience and care. Phase 1 – Telephone triage and Phase 2 - face to face triage has now been successful implemented at both SGH and DPOW. Phase 2 went live on October the 16th and have received 1962 calls through the telephone triaged service with 482 women requiring to be seen triaged face to face at DPOW and 327 women been triaged face to face at SGH. Phase 1 Telephone triage has been live for over a year and has received 10436 calls during that time.

Challenges remain at both site in relation to staffing levels to consistently man Maternity Triage however this has been actively managed by the service with a contingency process in place where staffing levels are low to maintain patient care, however this falls outside the BSOTs model.

Badger net implementation will enable enhanced pathway reporting and evidence of compliance with BSOTS triage criteria metrics.
This QI project has now been closed and moved back to business as usual.

**Reducing Thermoregulation**
New-born babies following birth are at risk of thermoregulation (loss of body temperature) which can lead to other health related issues requiring admission to NICU.
This Quality Improvement projects aim is to have no more than 10% of NICU admissions as a result of babies with a temperature outside of the optimal limits (<36.4) for babies >37 week gestation by 31st March 2023 (based on a baseline mean of >1 Jan 2021 – Jan 2023 equating to 97 babies).

Whilst the baseline (mean) position is >1 the SPC chart below shows the larger variation and impact from 0 to >4 babies over 37 weeks gestation been admitted to NICU with thermoregulation.

On review of these babies there were issues with the heating system on the ward due to scheduled maintenance, this was escalated and ultimately resolved, but did result in the ward been difficult to heat for a period. In addition, new Junior Doctors rotate into the department whom may not have been aware of the ongoing work to prevent Thermoregulation. This has now been communicated via the ward huddles to ensure everyone is aware of the importance of the measures in place to keep the babies warm post birth and their importance.

This QI project has now been closed and moved to business as usual. Ongoing monitoring continues the reducing admission to neonatal units (ATTAIN) meetings.

**Antenatal Clinic (ANC) Quality Improvement (QI) Project**
The divisional Senior Management Team have agreed for the commencement of a new QI project focusing on improving the Antenatal Clinics processes at both DPOW and SGH. This work has been prioritised after initial scoping showed opportunity to improve

the service across a number of quality and performance metrics including patient and staff experience, reducing clinic over runs, aligning ANC and scanning capacity and reviewing both midwifery and medical roles within the ANC.

A capacity and demand review of the service has revealed a short fall in capacity of circa 200 per year. This is been worked through with the operational team.

## 6 Serious Incident (SI) Reporting

**Open Maternity and Neonatology Serious Incident /PSII Investigations as at 07 May 2024**

There are currently 5 Maternity Serious Incidents open in the Trust. One of these incidents is being investigated by the Maternity and Neonatal Safety Investigations programme (MNSI), formerly HSSIB. There has been no new Patient Safety Incident Investigation reported in April 2024.

Please note that the cases described in this report are also represented in the PSIRF / Serious Incident (including Duty of Candour and learning) report to the Quality & Safety Committees-in-Common in a summary form, tracking the investigation process. The table below provides immediate actions taken during the initial investigation stage to demonstrate response to risks identified; along with deadline dates or updates to the deadline dates where extensions have been agreed.

| STEIS Ref | Site | Description | Stage | Immediate Action(s) (as from 72-hour report) | Deadline date |
|---|---|---|---|---|---|
| 2023 20199 | DPOW | Delayed delivery following abnormal CTG reading | Investigation | •Registrar to have 1:1 with the fetal monitoring lead.<br>•Line manager and College Tutor to be informed and discuss with the registrar involved.<br>•Coordinator to have 1:1 with fetal monitoring lead.<br>•Labour Ward Coordinator manager to have discussion with coordinator.<br>•Discuss at Obstetrics and Gynaecology Governance - Fetal growth was fluctuating and questions around appropriate management of fetal surveillance – plan. | 09.05.2024 |
| 2023 8658 | DPOW | Maternal Cardiac Arrest | Investigation | Reviewing the issues relating to referral and acceptance for Interventional Radiology (HUTH) Investigating the decision making and potential disagreements | 23.05.2024 |

| STEIS Ref | Site | Description | Stage | Immediate Action(s) (as from 72-hour report) | Deadline date |
|---|---|---|---|---|---|
| | | | | between staff during the cardiac arrest. | |
| 2023 12695 | SGH | Lower Segment Caesarean Section (LSCS) admitted to ITU | Investigation | There were no immediate actions or learning identified.<br><br>Investigation complete, report being written. | 10.05.2024 (new date - extension agreed) |
| 2023 13122 | DPOW | Maternal death | Investigation | This case was reported to MBRRACE as a maternal death and from the review of the case, there was no immediate learning identified. | 17.05.2024 |
| 2023 13399 | DPOW | MNSI - Maternal death | Investigation | Review of the postnatal care due to the large gap between reviews.<br><br>Email sent to all midwives for student midwives not to be given care without supervision.<br><br>Email sent to Consultants and Coordinators to ensure patients with safeguarding concerns to only be considered for transfer out when an absolute must eg <27 weeks gestation. | Not applicable due to MNSI investigating. |

**Maternity Serious Incident Completed Reports (*n=1*)**

| STEIS Ref | Site | Description | Learning identified/activities |
|---|---|---|---|
| 2023 18396 | SGH | NVF shared cremation error | • To include on the safety bulletin immediate learning that all neonatal deaths should be individually cremated or buried.<br>• To include on the Maternity Safety Huddles that all neonatal deaths should be individually cremated or buried.<br>• To produce a baby loss process for a neonatal death to inform staff of the Bereavement Midwives involvement.<br>• Inclusion within the yearly mandatory update of the need for individual cremation or burial of all neonatal deaths.<br>• To develop a process document that will aide staff on the three different processes.<br>• To ensure the Bereavement Midwives are aware of their responsibilities of scanning the correct documents.<br>• The investigation findings to be discussed at Managers Meeting to inform them of the escalation process in the absence of the Bereavement Midwives Service.<br>• Audit to be undertaken to ensure correct paperwork has been completed |

**Risks and themes**
2 new risks have been added to the risk register:

| Number | Date | Title | What is the Risk? |
|---|---|---|---|
| 3310 | 25.04.24 | The ceiling on the Neonatal Unit at Scunthorpe General Hospital is in need of repair | There is a risk of flaking paint falling from the ceiling into the clinical area resulting in infection control measures which will not be adhered to, there is also a risk to patient and staff safety. |
| 3309 | 25.04.24 | Toilet facilities for parents / visitors within the Neonatal Unit at Scunthorpe General Hospital is not health safety compliant | There is a risk that the user of the toilet cannot call for help if needed as no call bell available resulting in a delay in assistance and the responder cannot gain access due to the door opening into the toilet. |

## 7 Sustainability Plan

The Trust has confirmation that the Maternity Safety Support Programme will be exited and is in the latter stage of sign off (will be presented to NHSE Board in May 24).

The **Maternity Sustainability Plan** is monitored through the Maternity Quality Improvement meeting and Maternity Transformation & Improvement Board. The plan is now complete and was ratified at the Obstetric and Gynaecology Governance meeting in May 2024. This has had oversight at Quality and Safety Committees in Common.

**Ongoing Maternity Sustainability Key Areas of Focus**

- Leadership/Culture stability and QUAD
- Safety (embedding maternity and neonatal safety champion processes)
- Incident review process (rapid reviews/PSIRP)
- Reviewed and strengthened governance structure
- Learning – identifying and sharing
- Quality Improvement
- Audit Plan

**Next Steps**

- Safety and Quality – continue to monitor embedded processes and seek opportunities for service improvement
- Co-production with new MNVP Lead (including Maternity Strategy)
- Keep QI high on maternity agenda (identifying new projects)
- Maintain senior leadership team visibility
- Continue supporting and developing our teams/engagement with teams/succession planning
- Culture – repeat SCORE survey March 24
- Professional Midwifery Advocates (PMA)

## 8 External Visits

No external visits in March.

## 9 Conclusion

The oversight report highlights all the work being undertaken within the maternity services.

**Workforce/Staffing –** Although improving position, midwifery vacancies remain challenging.

**Patient Experience –** complaints and PALS remain low. Friends and Family test (FFT) results show excellent feedback and positive experience. Overall themes (negative and positive) relate to communication and compassionate clinical care.

**Assurance**

- Local Maternity and Neonatal System (LMNS) assurance visit October 2023
- Good CQC rating for Maternity Services (Goole)

**Maternity Safety**
The Maternity Safety Champions have an embedded walk round programme visiting different areas each time and it provides assurance of a 'floor to board' communication.

There are a number of on-going Quality Improvement projects including, neonatal thermoregulation and the Antenatal day unit/clinic review. All projects have full support from the executive and maternity team and feedback from staff and service users is excellent. A closedown report has now been produced for the neonatal thermoregulation project and will then be handed over for Business as usual once approved by the Maternity Transformation and Improvement Board.

Serious incidents (SI) and Maternity and Neonatal Safety Investigations (MNSI) formally HSIB (Healthcare Safety Investigation Branch) cases remain low with the last reported SI (MNSI) in November 2023. The Trust has moved to Patient Safety Incident Report Framework and at present there is currently 1 after action review ongoing.

In relation to complaints and PALS (Patient Advice & Liaison Service) for maternity, themes related to communication and delays in clinic. Themes are reported into the Local Maternity and Neonatal System (LMNS) Perinatal Quality Safety and Assurance Group (PQSAG) and Perinatal Quality Safety Oversight Group (PQSOG) meeting.

**Clinical Negligence Scheme for Trusts (CNST)**
Assurance and monitoring will be continued for Year 6 and will be provided by:

- Family Service quad oversite and escalation as required
- Weekly cross Group meetings to commenced 17 May
- Quality & Safety Committee and Trust Board oversite
- Internal and external (LMNS) check and challenge.

**Saving Babies Lives (SBL) V3**
81% Compliance achieved for all 6 elements of SBL for quarter 3 2023/24 submission. The detailed highlight report has been shared at relevant committees for progress.

It should be noted that the Quarter 4 submission deadline was 3 June 2024 and an away day was hosted on 3 June 2024 with the LMNS and neighbouring Trusts to discuss barriers for implementation and sharing of good practice. The LMNS are undertaking peer validation, feedback will be provided at the next quarterly assurance meeting on the 10 June 2024..

**Ockenden Report**
Action plan following the initial Ockenden Report is now complete and work is progressing on the immediate and essential actions to improve maternity care, supported by the multidisciplinary team. There are currently 67 (previous 66) green, 18 amber (previous 7) and 7 National /Regional actions. The detailed action plan has been shared at relevant committees for progress.

## Appendix I – Trust wide Maternity Dashboard

### Trustwide Maternity Dashboard

Northern

| Indicator | Apr 2023 | May 2023 | Jun 2023 | Jul 2023 | Aug 2023 | Sep 2023 | Oct 2023 | Nov 2023 | Dec 2023 | Jan 2024 | Feb 2024 | Mar 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Midwife to Birth Ratio | 22.4 ↗ | 22.3 ↘ | 23.0 ↗ | 23.1 ↗ | 23.3 ↗ | 22.8 ↘ | 22.7 ↘ | 20.8 ↘ | 21.8 ↗ | | 19.6 | |
| Red Flags | 6.0 ↗ | 15.0 ↗ | 25.0 ↗ | 2.0 ↘ | 7.0 ↗ | 14.0 ↗ | 3.0 ↘ | 14.0 ↗ | 9.0 ↘ | 7.0 ↘ | 8.0 ↗ | 18.0 ↗ |
| (a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours) | 0.0 | 2.0 ↗ | 2.0 | 0.0 ↘ | 0.0 | 3.0 ↗ | 1.0 ↘ | 3.0 ↗ | 1.0 ↘ | 1.0 | 1.0 | 3.0 ↗ |
| (b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing) | 2.0 ↘ | 3.0 ↗ | 0.0 ↘ | 0.0 | 3.0 ↗ | 3.0 | 1.0 ↘ | 2.0 ↗ | 2.0 | 1.0 ↘ | 3.0 ↗ | 2.0 ↘ |
| (c) Missed medication during an admission to hospital | 2.0 ↗ | 0.0 ↘ | 2.0 ↗ | 0.0 ↘ | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 ↗ | 0.0 ↘ | 0.0 | 2.0 ↗ |
| (d) Delay of more than 30 minutes in providing pain relief | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 ↗ | 0.0 ↘ | 1.0 ↗ | 1.0 | 0.0 ↘ | 0.0 | 1.0 ↗ |
| (e) Delay of 30 minutes or more between presentation onto the ward and being seen | 1.0 ↗ | 1.0 | 0.0 ↘ | 0.0 | 1.0 ↗ | 0.0 ↘ | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 ↗ | 1.0 |
| (f) Full clinical examination not carried out when presenting in labour | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| (g) Delay of 2 hours or more between admission for induction and beginning of process | 1.0 | 3.0 ↗ | 5.0 ↗ | 0.0 ↘ | 1.0 ↗ | 1.0 | 1.0 | 0.0 ↘ | 1.0 ↗ | 0.0 ↘ | 0.0 | 1.0 ↗ |
| (h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 ↗ | 0.0 ↘ | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 ↗ |
| (i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.0 ↗ | 0.0 ↘ |
| (j) Community staff have been called in to work on the unit. | 0.0 | 6.0 ↗ | 16.0 ↗ | 2.0 ↘ | 2.0 | 5.0 ↗ | 0.0 ↘ | 8.0 ↗ | 3.0 ↘ | 5.0 ↗ | 2.0 ↘ | 7.0 ↗ |
| Continuity of Carer % | | | | | | | | | | | | |
| In Receipt of % | | | | | | | | | | | | |
| CoC In Receipt of % | | | | | | | | | | | | |
| Continuity Team Caseload | | | | | | | | | | | | |
| Divert / Unit Closures | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Actual v Planned Staffing % | 97.8 ↗ | 98.2 ↗ | 94.8 ↘ | 94.2 ↘ | 92.8 ↘ | 94.5 ↗ | 93.9 ↘ | 98.5 ↗ | 94.3 ↘ | 96.9 ↗ | 101.0 ↗ | |
| Labour Co-ordinator Supernumerary Status % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| 1:1 Care in Labour % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 99.5 ↘ | 99.0 ↘ | 99.4 ↗ | 99.5 ↗ | 99.5 ↗ | 100.0 ↗ | 100.0 |
| Vacancies | 16.0 ↘ | 10.5 ↘ | 14.5 ↗ | 14.9 ↗ | 15.5 ↗ | 15.4 ↘ | 27.9 ↗ | 29.4 ↗ | 28.4 ↘ | 22.8 ↘ | 22.5 ↘ | |
| Vacancies - Registered | 17.6 ↘ | 13.9 ↘ | 18.0 ↗ | 17.6 ↘ | 19.1 ↗ | 15.9 ↘ | 27.5 ↗ | 23.0 ↘ | 22.4 ↘ | 16.9 ↘ | 16.9 ↗ | |
| Vacancies - Unregistered | -1.6 ↘ | -3.4 ↘ | -3.5 ↘ | -2.7 ↗ | -3.6 ↘ | -0.4 ↗ | 0.4 ↗ | 6.4 ↗ | 5.9 ↘ | 5.9 ↘ | 5.5 ↘ | |
| Serious Incidents | 1.0 ↗ | 1.0 | 1.0 | 1.0 | 0.0 ↘ | 1.0 ↗ | 1.0 | 0.0 ↘ | 0.0 | 0.0 | 0.0 | 0.0 |
| Complaints | 2.0 ↗ | 1.0 ↘ | 0.0 ↘ | 3.0 ↗ | 1.0 ↘ | 3.0 ↗ | 0.0 ↘ | 1.0 ↗ | 0.0 ↘ | 2.0 ↗ | 2.0 | 2.0 |
| PALS | 1.0 ↘ | 6.0 ↗ | 6.0 | 6.0 | 4.0 ↘ | 5.0 ↗ | 4.0 ↘ | 3.0 ↘ | 3.0 | 6.0 ↗ | 2.0 ↘ | 8.0 ↗ |
| Sickness Absence (Division) % | 6.0 ↗ | 5.7 ↘ | 5.2 ↘ | 5.5 ↗ | 5.7 ↗ | 5.4 ↘ | 5.8 ↗ | 5.4 ↘ | 5.7 ↗ | 5.7 ↘ | 4.8 ↘ | |

# Appendix II – PQSM Dashboard

| A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|
| **Maternity Services** | | | | | | | |
| **CQC Maternity Ratings** | **Overall** | **Safe** | **Effective** | **Caring** | **Well-led** | **Responsive** | **Responsive** |
| | RI | RI | Good | Good | RI | Good | Good |
| | Good | RI | Good | Good | Good | Good | Good |
| | RI | RI | Good | Good | RI | Good | Good |
| **Maternity Safety Support Programme** | Yes | Fiona McDonagh / Jasmine Leonce | | | | | |
| | **Aug-23** | **Sep-23** | **Oct-23** | **Nov-23** | **Dec-23** | **Jan-24** | **Feb-24** |
| **Findings of review of all perinatal deaths using the real time data monitoring tool** | During Q2 the multidisciplinary team has reviewed care and completed the PMRT tool for 1 neonatal death, 1 antepartum late fetal loss and 3 antepartum stillbirths. Actions have been taken to address concerns/issues identified and 1 serious incident investigation is underway | | During Q3 the multidisciplinary team has reviewed care and completed the PMRT tool for for 1 late fetal loss, 1 neonatal death and 7 antepartum stillbirths in thefor 1 late fetal loss, 1 neonatal death and 7 antepartum stillbirths in the review period. Actions have been taken to address concerns/issues identified and 1 serious incident investigation is underway. | | | Report not yet available for Q4 | Report not yet available for Q4 |
| **Findings of review of all cases eligible for refe** | 1 referral to HSIB | 0 referrals to HSIB | 0 referrals to MNSI | 0 referrals to MNSI | 1 referral to MNSI (rejected) | 0 referrals to MNSI | 0 referrals to MNSI |
| **Report on:** | | | | | | | |
| | **Reported (N=3)** | **Reported (N=4)** | **Reported (N=0)** | **Reported (N=2)** | **Reported (N=1)** | **Reported (N=0)** | **Reported (N=0)** |
| **The number of incidents logged graded as moderate or above and what actions are being taken** | **Actions Taken:**<br>1) Direct feedback to operating consultant involved Instrument removed from theatre.<br>2) Safeguarding review completed Concise RCA investigation currently ongoing.<br>3) Duty of candour given, doctors contacted and lessons learnt, matron to feedback to midwifery team to cross check plan before discharge. | 1) Readmission to maternity services via A&E- Undiagnosed hypoplastic aortic arch and VSD on USS. Action Taken: Transferred to LGI awaits operation, process reviewed for management of high BMI.<br>2) Cat 1 EMCS abruption, PPH 2746ml, EUA, hysterectomy. Action Taken : Currently being investigated.<br>3) Cat 1 EMCS for abruption PPH 2746ml returned back to theatre EUA Action Taken : Action Taken: Currently being investigated.<br>4) Notified that the baby was cremated within a shared cremation however this baby was registered as a neonatal death. Action Taken: NVF service has been discontinued until processes have been fully reviewed and the governance is such to ensure this would not | N/A | 1) Baby born with Anophthalmia (left eye absent), missed screening in pregnancy. Action Taken: Screening safety incident (reportable to NHSEI) - currently under investigation<br>2) Baby admitted to NICU following resuscitation at birth on labour ward. Multiple airway manouvers made and suction removed a mucous plug under direct vision. Blood gas poor and decision made to commence passive cooling. CFAM attached, baby for transfer to a tertiary centre. Action Taken: Currently being investigated, MNSI rejected case, local rapid review completed. | Baby delivered via ventouse and episiotomy, shoulder dystocia, baby had fractured humerus<br>**Action Taken**: Duty of candour provided to parents. No further action required as recognised complication for shoulder dystocia. | N/A | N/A |
| **Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training:** | | | | | | | |
| Core competency - S&G Maternity (all staff groups) | 82.9% | 82.0% | 84.20% | 81.64% | 82.38% | 82.50% | Unable to obtain from Power BI |
| Core competency - DPOW Maternity (all staff groups) | 92.1% | 92.7% | 92.10% | 90.96% | 90.98% | 90.92% | Unable to obtain from Power BI |
| Role Specific Training - S&G Maternity (all staff groups) | 76.8% | 77.0% | 79.93% | 78.31% | 76.84% | 78.70% | Unable to obtain from Power BI |
| Role Specific Training - DPOW Maternity (all staff | 86.6% | 86.6% | 86.83% | 87.17% | 83.68% | 85.26% | Unable to obtain from Power BI |
| Other competencies - S&G Maternity (all staff groups) | 64.9% | 58.9% | 76.24% | 77.10% | 69.61% | 65.66% | Unable to obtain from Power BI |
| Other competencies - DPOW Maternity (all staff | 74.3% | 69.1% | 78.51% | 81.36% | 69.59% | 70.17% | Unable to obtain from Power BI |
| Fetal Monitoring (Trustwide Maternity Services) | N/A | N/A | 97.10% | 94.68% | 88.46% | 92.79% | 90.00% |
| PROMPT (Trustwide Maternity Services) | N/A | N/A | 93.41% | 94.68% | 94.55% | 88.02% | 90.00% |
| **Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual** | | | | | | | |
| **Midwifery staffing (source: safer staffing dashboard)** | | | | | | | |
| Blueberry/Holly - DPOW | Planned hrs: 2,939.1<br>Actual hrs: 2,657.0<br>Fill Rate: 90.4% | Planned hrs: 3,204.3<br>Actual hrs: 2,323.6<br>Fill Rate: 72.5% | Planned hrs: 2,939.1<br>Actual hrs: 2,602.3<br>Fill Rate: 88.5% | Planned hrs: 2,884.3<br>Actual hrs: 2,517.4<br>Fill Rate: 88.5% | Planned hrs: 3,105.9<br>Actual hrs: 3,055.3<br>Fill Rate: 98.4% | Planned hrs: 3,105.9<br>Actual hrs: 3,487.8<br>Fill Rate: 112.3% | Planned hrs: 3, 034.9<br>Actual hrs: 3,166.1<br>Fill Rate: 104.3% |
| Central Delivery Suite - SGH | Planned hrs:2,933.8<br>Actual hrs: 2,608.8<br>Fill Rate: 88.9% | Planned hrs:2,839.2<br>Actual hrs: 2,670.9<br>Fill Rate: 94.1% | Planned hrs:2,933.8<br>Actual hrs: 2,848.6<br>Fill Rate: 97.1% | Planned hrs:2,839.2<br>Actual hrs: 2,388.0<br>Fill Rate: 84.1% | Planned hrs:2,933.8<br>Actual hrs: 3,075.1<br>Fill Rate: 104.8% | Planned hrs:2,933.8<br>Actual hrs: 2,602.2<br>Fill Rate: 88.7% | Planned hrs:2,744.6<br>Actual hrs: 2,557.6<br>Fill Rate: 93.2% |
| Jasmine and Honeysuckle - DPOW | Planned hrs: 2,933.8<br>Actual hrs: 2,441.9<br>Fill Rate: 83.2% | Planned hrs: 2,839.2<br>Actual hrs: 2,275.9<br>Fill Rate: 80.2% | Planned hrs: 2,839.3<br>Actual hrs: 2,419.2<br>Fill Rate: 82.5% | Planned hrs: 2,839.2<br>Actual hrs: 2,471.8<br>Fill Rate: 87.1% | Planned hrs: 2,933.8<br>Actual hrs: 2,624.1<br>Fill Rate: 89.4% | Planned hrs: 2,933.8<br>Actual hrs: 2,671.4<br>Fill Rate: 91.1% | Planned hrs: 2,744.6<br>Actual hrs: 2,289.6<br>Fill Rate: 83.4% |
| Ward 26 - SGH | Planned hrs: 2,567.1<br>Actual hrs: 1,876.9<br>Fill Rate: 73.1% | Planned hrs: 2,484.3<br>Actual hrs: 1,933.3<br>Fill Rate: 77.8% | Planned hrs: 2,567.1<br>Actual hrs: 2,003.6<br>Fill Rate: 78.0% | Planned hrs: 2,484.3<br>Actual hrs: 1,861.0<br>Fill Rate: 74.9% | Planned hrs: 2,567.1<br>Actual hrs: 1,955.3<br>Fill Rate: 76.2% | Planned hrs: 2,567.1<br>Actual hrs: 2,104.2<br>Fill Rate: 82.0% | Planned hrs: 2,401.5<br>Actual hrs: 1,970.2<br>Fill Rate: 82.0% |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Obstetrician staffing - cover on the delivery suite, gaps in rotas** | | | | | | | |
| Delivery Suite - SGH | 100.0%<br>0 gaps identified | 100.0%<br>0 gaps identified | 100.0%<br>0 gaps identified | 100.0%<br>0 gaps identified | 100.0%<br>0 gaps identified | 100%<br>0 gaps identified | 100%<br>0 gaps identified |
| Delivery Suite - DPOW | 100.0%<br>0 gaps identified | 100.0%<br>0 gaps identified | 100.0%<br>0 gaps identified | 100.0%<br>0 gaps identified | 100.0%<br>0 gaps identified | 100%<br>0 gaps identified | 100%<br>0 gaps identified |
| **Service User Voice Feedback / 15 Steps Feedback** | MNVP Lead - vacancy<br>15 Steps - Antenatal clinic at SGH received 'Good'<br>Friends of Family Q2 Results:<br>DPOW 40 responses submitted - 100% positive feedback received, SGH 0 responses submitted | MNVP Lead now in post<br>15 Steps - Antenatal clinic at SGH received 'Good'<br>Friends & Family Q2 Results:<br>DPOW 40 responses submitted - 100% positive feedback received, SGH 0 responses submitted | 15 Steps - Central Delivery Suite at SGH were visited and achieved a rating of 'good'.<br><br>Friends & Family October Results:<br>DPOW received 50 responses - 48 (96%) were positive. Negative responses related to poor communication. SGH received 22 responses - 100% were positive. | 15 Steps - Ward 26 at SGH were visited and achieved a rating of 'requires improvement'.<br><br>Friends & Family October Results:<br>Not yet available for Nov 23 on Power BI. | No visits to report | Antenatal Outpatients Clinic (DPOW) achieved a rating of requires improvement, with further assurance required within standard 1, and the safe, secure storage of medications within the clinic. | No visits to report |
| **VAT Tool Ward Area Compliance** | 96.70% | 96.7% (July - Sept 23) | 96.4% (Aug - Oct 23) | 96.2% (Sept - Nov 23) | 93.9% (Oct - Dec 23) | 97.0% (Nov - Jan 24) | 94.5% (Feb 24) |
| **Staff feedback frontline champions and walk abouts** | 5 open actions - action plan in place and monitored (Reported to Board / Q&SC) | 7 open actions - action plan in place and monitored (Reported to Board / Q&SC) | 7 open actions, 4 relate to action required from Estates & Facilities Team. Action plan in place and monitored (Reported to Board / Q&SC). | 10 open actions, 4 relate to action required from Estates & Facilities Team with expected completion dates of end of January 24. Action plan in place and monitored (Reported to Board / Q&SC). | 10 open actions, 4 relate to action required from Estates & Facilities Team, completion dates extended as action relating to the holes in Theatre floor prioritised. Agreed for final completion date of the end of the financial year. Action plan in place and monitored (Reported to Board / Q&SC). | 11 open actions - Themes identified:<br><br>Estates<br>Capacity & demand / Pathway<br>Equipment / IT<br><br>Action plan in place and monitored accordingly. | 11 open actions - Themes identified:<br><br>Estates (expected closure by Apr 24)<br>Capacity & demand / Pathway<br>Equipment / IT<br><br>Action plan in place and monitored accordingly. |
| **Learning from Feedback (Patient Experience)** | **Q1 Maternity Themes identified:**<br>Distress caused by birth experience<br>Communication<br>Staff attitude<br>Waiting times for appointments<br>Support provided to mother following birth<br>Delay with patients attending afterthoughts clinic<br>**Action Taken:**<br>Discussion with staff members about inappropriate comments made to patients through Just and Learning<br>Safety Huddles Afterthoughts clinic process reviewed and expression of interest to increase midwife capacity | **Maternity Themes identified:**<br>Communication<br>Continuity<br>Attitude & Behaviours<br>Discharge<br><br>**Action Taken:**<br>Staff informed of positive feedback and feedback following complaints. Individuals concerned spoken to and reflection undertaken.<br>Complaints have been around medical staff communication rather than midwives. | **DPOW F&FT Feedback Q3 (Oct - Dec)**<br>Acorn: 20 responses - 85% positive<br>Blueberry: 66 responses - 100% positive<br>Holly: 45 responses - 98% positive<br>Honeysuckle: 22 responses - 100% positive<br>Community DPOW: 4 responses - 100% positive<br>Community Louth: 3 responses - 100% positive<br><br>**SGH F&FT Feedback Q3 (Oct - Dec)**<br>Midwifery Unit: 3 responses - 67% positive<br>Antenatal dept: 18 responses - 77.8% positive<br>CDS: 14 responses - 93% positive<br>Ward 26: 53 responses - 100% positive<br>Community: 4 responses - 88% positive<br><br>**Maternity Themes identified:**<br>Distress caused by birth experience, Communication, Staff attitude, Delays in ANC<br><br>**Action Taken:** | **DPOW F&FT Feedback Q3 (Oct - Dec)**<br>Acorn: 20 responses - 85% positive<br>Blueberry: 66 responses - 100% positive<br>Holly: 45 responses - 98% positive<br>Honeysuckle: 22 responses - 100% positive<br>Community DPOW: 4 responses - 100% positive<br>Community Louth: 3 responses - 100% positive<br><br>**SGH F&FT Feedback Q3 (Oct - Dec)**<br>Midwifery Unit: 3 responses - 67% positive<br>Antenatal dept: 18 responses - 77.8% positive<br>CDS: 14 responses - 93% positive<br>Ward 26: 53 responses - 100% positive<br>Community: 4 responses - 88% positive<br><br>**Maternity Themes identified:**<br>Distress caused by birth experience, Communication, Staff attitude, Delays in ANC<br><br>**Action Taken:** | **DPOW F&FT Feedback Q3 (Oct - Dec)**<br>Acorn: 20 responses - 85% positive<br>Blueberry: 66 responses - 100% positive<br>Holly: 45 responses - 98% positive<br>Honeysuckle: 22 responses - 100% positive<br>Community DPOW: 4 responses - 100% positive<br>Community Louth: 3 responses - 100% positive<br><br>**SGH F&FT Feedback Q3 (Oct - Dec)**<br>Midwifery Unit: 3 responses - 67% positive<br>Antenatal dept: 18 responses - 77.8% positive<br>CDS: 14 responses - 93% positive<br>Ward 26: 53 responses - 100% positive<br>Community: 4 responses - 88% positive<br><br>**Maternity Themes identified:**<br>Distress caused by birth experience, Communication, Staff attitude, Delays in ANC<br><br>**Action Taken:** | **The Friends and Family Test**<br><br>**89 responses Trustwide (Jan 24)**<br>Positive: 89.8%<br>Negative: 6.7%<br><br>**DPOW:**<br>Positive: 89.6%<br>Negative: 6.9%<br>Neutral:<br><br>**SGH & Goole:**<br>Positive: 90.0%<br>Negative: 6.6%<br><br>**Trustwide Themes:**<br>Lengthy waiting times.<br><br>**Action taken:**<br>Capacity and demand review underway. | **No update available** |
| **MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Coroner Reg 28 made directly to the Trust** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Progress in acheivement of CNST SA 10** | On track | On track | On track | On track | Compliance declared for 10 standards | Compliance declared for 10 standards | Compliance declared for 10 standards |
| **Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)** | | | | | | 22 responses (please see sheet 2) | 22 responses (please see sheet 2) |
| **Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually)** | | | | | | 1 response (please see sheet 2) | 1 response (please see sheet 2) |

Family Services Operational Dashboard - Power BI
Safer Staffing - Power BI
WAT Women and Childrens - Power BI
H:\Service Development & Modernisation\Medical Staffing\1. Master Rota File\SGH O&G\1.Rota's

**Trust Boards-in-Common Front Sheet**

**Agenda Item No: BIC(24)101**

| **Name of the Meeting** | **Trust Boards-in-Common** |
|---|---|
| **Date of the Meeting** | **13 June 2024** |
| **Director Lead** | **Mike Robson and Gill Ponder, Non-Executive Directors (Chairs)** |
| **Contact Officer/Author** | **Mike Robson and Gill Ponder, Non-Executive Directors (Chairs)** |
| **Title of the Report** | **Performance, Estates and Finance Committees-in-Common Highlight / Escalation Report** |
| **Executive Summary** | This report provides an overview of the key matters presented to and considered by the Performance, Estates and Finance Committees-in-Common from the April and May 2024 meetings. It also includes matters for escalation to the Boards, matters where additional assurance is required, confirm and challenge of the Board Assurance Framework (BAF), any action(s) required of the Boards.<br><br>The Trust Boards are asked to:<br><br>• Note the key points highlighted in the escalation report from the PEF CiC meetings held on 24 April 2024 and 29 May 2024;<br>• Note that the CaMP CiC had referred a risk about the Digital Plan Delivery to the May 2024 PEF CiC meeting for review. |
| **Background Information and/or Supporting Document(s) (if applicable)** | Performance, Estates and Finance Committees-in-Common Terms of Reference for Hull University Teaching Hospitals (HUTH) NHS Trust and Northern Lincolnshire and Goole (NLaG) NHS Foundation Trust |
| **Prior Approval Process** | The attached report has been approved by the Committee Chairs. |
| **Financial implication(s) (if applicable)** | **N/a** |
| **Implications for equality, diversity and inclusion, including health inequalities** | **N/a** |
| **Recommended action(s) required** | ☐ Approval ☐ Information<br>☐ Discussion ☐ Review<br>✓ Assurance ☐ Other – please detail below: |

**Committees-in-Common Highlight / Escalation Report to the Trust Boards**

| | |
|---|---|
| | 13 June 2024 |
| | **Performance, Estates and Finance Committees-in-Common** |
| | 24 April 2024 and 29 May 2024 |
| | The following dates of Performance, Estates and Finance Committees-in-Common meetings were quorate:<br>were quorate:<br>• 24 April 2024<br>• 29 May 2024 |

## 1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Performance, Estates and Finance (PEF) Committees-in-Common (CiC) at their meetings held on 24 April 2024 and 29 May 2024, including those matters which the committees specifically wish to escalate to either or both Trust Boards.

## 2.0 Matters considered by the committees

2.1 The Committees considered the following items of business:

**29 May 2024**

- Board Assurance Frameworks (BAF)
- Financial Report – Month 1 (2024/25)
- Deep Dive into Diagnostics
- Digital Plan Delivery Report – Data Accuracy and Access to Reporting
- Contract for supply of Radiopharmaceuticals and Associated Consumables approved
- CQC Action Report
- Group Integrated Performance Reports (IPR)
- Estates and Facilities update
- Health and Safety Policy Statement approved

**24 April 2024**

- Board Assurance Frameworks (BAF)
- Annual Plan update (Operational and Financial) including Cost Improvement Programme (CIP)
- Deep Dive on Urgent Care
- CQC Action Report
- Financial Report – Month 12 (2023/24)
- Group IPR

- Care Group Transitional Arrangements
- Estates and Facilities update & Lifts Deep Dive

## 3.0 Matters for reporting / escalation to the Trust Boards

3.1 The Committees agreed the following matters for reporting / escalation to the Trust Boards:

**a. Financial position** – Whilst the Group had delivered a small surplus in 2023/24 a large proportion of the savings delivered had been non-recurrent which had contributed to the revised underlying deficit of £105.3 million at year-end. For 2024/25, the Committees were concerned about the following:

- the high-risk Cost Improvement Plan (CIP) savings planned, with £10.5 million of unidentified savings and a requirement to deliver all CIP savings planned to maintain the cash position and meet the financial plan for the year
- the financial performance being £2 million adrift of the month one plan, with the plan becoming more challenging as the year progresses
- the Group's cash balance was £53.6 million for month one with an anticipated requirement for Central Cash Support in Quarter two (highly dependent on the actual delivery of CIP savings planned in year). As there is a 3-4 month lead time to secure support, a more detailed Cash Report will be presented to the Committees in June.

**b. Annual Plan and CIP** – The Committees received an update on the latest annual operational and financial plan submission at the April meeting, which included a CIP of £84.6 million, which was 6% of turnover and the highest requirement ever for both Trusts. The plan had been amended a number of times during the submission process, but did not yet include aligned activity, finances and workforce plans. The Committees were unable to endorse the plan for Board approval without that alignment. (Post Meeting Note: The Annual Plan was subsequently reviewed at the Board Development meeting in May, where it became clear that the available financial envelope and ERF expectations could not be aligned due to the requirement to submit a plan with no headcount increases, despite pre-existing commitments such as the staffing of the CDCs. All alignment gaps in the Group's submission reflect national guidance and are due to be formally approved by the Board in June.)

**c. Urgent Care Deep Dive** – The positive actions being undertaken were noted against the initial improvements evidenced, particularly the progress with rota changes to align demand and capacity. However, neither Trust was meeting the 76% standard, despite decreased attendances. Whilst the benefits of the Same Day Emergency Care (SDEC) and Integrated Acute Assessment Unit (IAAU) models were being seen, frailty remained a concern as too many elderly patients were being admitted after long waits in the Emergency Department (ED).

**c.1 Multi-Agency Discharge Events (MADE)** – Assurance was noted by the Committees on the effectiveness of the North and South Bank MADE events and the lessons learned and shared from them, although concerns were expressed about the ability to embed and sustain the improvements seen during these events.

d. **Cancer Performance** – NLaG was now receiving Tiering support from NHS England for Cancer performance in addition to the actions being taken to focus on the diagnostic journey, consistent achievement of the Faster Diagnosis Standard and visibility of and development of an alternative pathway for patients on the 62-day Cancer pathway where diagnostics had ruled out cancer.

e. **Referral to Treatment (RTT) Performance -** Approximately 6,000 outpatient clinic patients required their outcome to be input on the electronic Lorenzo system, due to initially recording it on a paper record during the transition to the new system. The Committees were assured that there was a recovery plan in place to clear the backlog within 3 weeks.

f. **Fire alarm replacement** – The Committees had previously been advised that the installation of the fire alarm systems at Scunthorpe General Hospital (SGH) was complete and that the risk score would reduce accordingly. That was included in the last highlight report to the Board. However, the Committees have now been advised that the risk score cannot be reduced until testing of the newly installed system has been carried out, which is now planned for completion by August 2024. This timescale includes the installation and zoned testing timescales.

g. **Cancelled operations and late starts** – HUTH reported 35% of operations cancelled on the day were due to non-clinical reasons (against a performance tolerance of 0.5%), this equated to 129 such cancellations for April. This compared to 14% cancellations at NLaG. Late starts were also a concern. Work to improve effective theatre utilisation to improve productivity was noted by the Committees.

h. **Contract for Supply of Radiopharmaceuticals and Associated Consumables (HUTH) –** The Committee approved the contract, but again expressed concern at receiving a renewal request months after the expiry of the previous contract.

i. **Health and Safety Policy –** The Committees approved the high-level Health and Safety Policy for the Group, which would be underpinned by more detailed policies covering each specific area.

## 4.0 Matters on which the committees received assurance:

4.1 The Committees received assurance on the following items of business:

a. **Progress on CQC Actions –** The Committees were assured that appropriate work was in progress to ensure a consistent Group approach in addressing the required CQC actions for both Trusts.

b. **Finance** - The Committees were assured that the Group had delivered its financial plan for 2023/24. In month 1, the material reduction in temporary staffing expenditure at NLaG was noted (particularly in Nursing), which contributed to a strong CIP delivery in month. That was offset at Group level by slippage on the CIP programme at HUTH.

c. **Performance** – Whilst many of the constitutional standards were not yet being met, the updated IPR provided the Committees with assurance that effective improvement

plans were in place to address cancer and referrals to treatment (RTT) performance. The Committee were struck by the number of measures which were very close to target and asked what final push could be made to get those measures to achieve the relevant targets. The Committees also noted the improvement in 62 Day Cancer Performance across both Trusts.

d. **Care Group Transitional Arrangements** – The Committees were assured on transitional arrangements to the new Care Group structure.

e. **LED Lighting** – The Committees recognised the achievement in securing funding for the installation of LED lighting.

f. **Group-wide Contracts** – Ongoing plans to align North and South Bank contract end dates to enable future tendering of Group-wide contracts provided assurance to the Committees, although it was noted that this was a two to three year plan.

g. **Diagnostics Deep Dive** – The Committees were assured by the work highlighted as part of the deep dive to improve performance in specific modalities, including reducing unwarranted variation across the Group, equalising waiting times and improving activity levels by making greater use of available equipment.

h. **Digital Plan Delivery update – Data Accuracy and Access to Reporting** - The PEF CiC received the Digital Plan Delivery report at the May 2024 meeting as requested by the CaMP CiC. The report confirmed that timely and appropriate access to reports remained available and the concerns raised about the accuracy and availability of data since the migration to Lorenzo were due to a lack of awareness of how to access the reports. This had been mitigated with increased staff communications and IT service desk support.

## 5.0 Matters on which the committees have requested additional assurance:

5.1 The Committees requested additional assurance on the following items of business:

a. **Risk Register** – it was noted that the Capital and Major Projects (CaMP) CiC have referred a risk relating to the lack of Committee oversight of the Risk Register to the Audit, Risk and Governance (ARG) CiC for review on behalf of all CiCs of whether there is a gap in controls and, if so, if that gap had been sufficiently mitigated. It was noted that the revised Risk Register should be available from July 2024 meetings.

b. **Water Tank replacement at SGH** – The Committee asked for confirmation that sufficient work had been undertaken on the replacement of the water tanks at SGH to enable the improvement notice to be lifted at the April meeting. It was subsequently confirmed that the notice for Water Tanks had been lifted, but there was an ongoing notice relating to Water pipework. To avoid future confusion, the Committee requested that future Estates and Facilities reports to the Committee should include a table showing the status of all open improvement notices from external bodies.

c. **Management of Estates, Facilities and Development Risks** – concerns remained around significant risks which were currently unfunded and it was noted that this would not change in the short term. However, the Committees were assured on the management of the risks and the mitigations in place.

d. **Loss of income from catering and retail outlets** – the Committees suggested a strategic review of retail and catering arrangements due to the loss of income reported via the Estates and Facilities report.

e. **Items for information –** The Committees discussed and agreed the need for the following minutes/reports to be received by the PEF CiC for future meetings:
   - Consolidated North Bank Site Report;
   - Consolidated South Bank Site Report;
   - Planned Care Board Meeting Minutes;
   - Unplanned Care Board Meeting Minutes.

## 6.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

6.1 The Committees received the areas of the BAF for which they have oversight which included a progress update regarding the harmonisation and rationalisation of the BAFs for HUTH and NLAG. The Committees will further consider the Committee specific areas of the BAF upon receipt of the planned revised version once available and will continue to receive the current version until this time.

## 7.0 Trust Board Action Required

7.1 The Trust Boards are asked to:

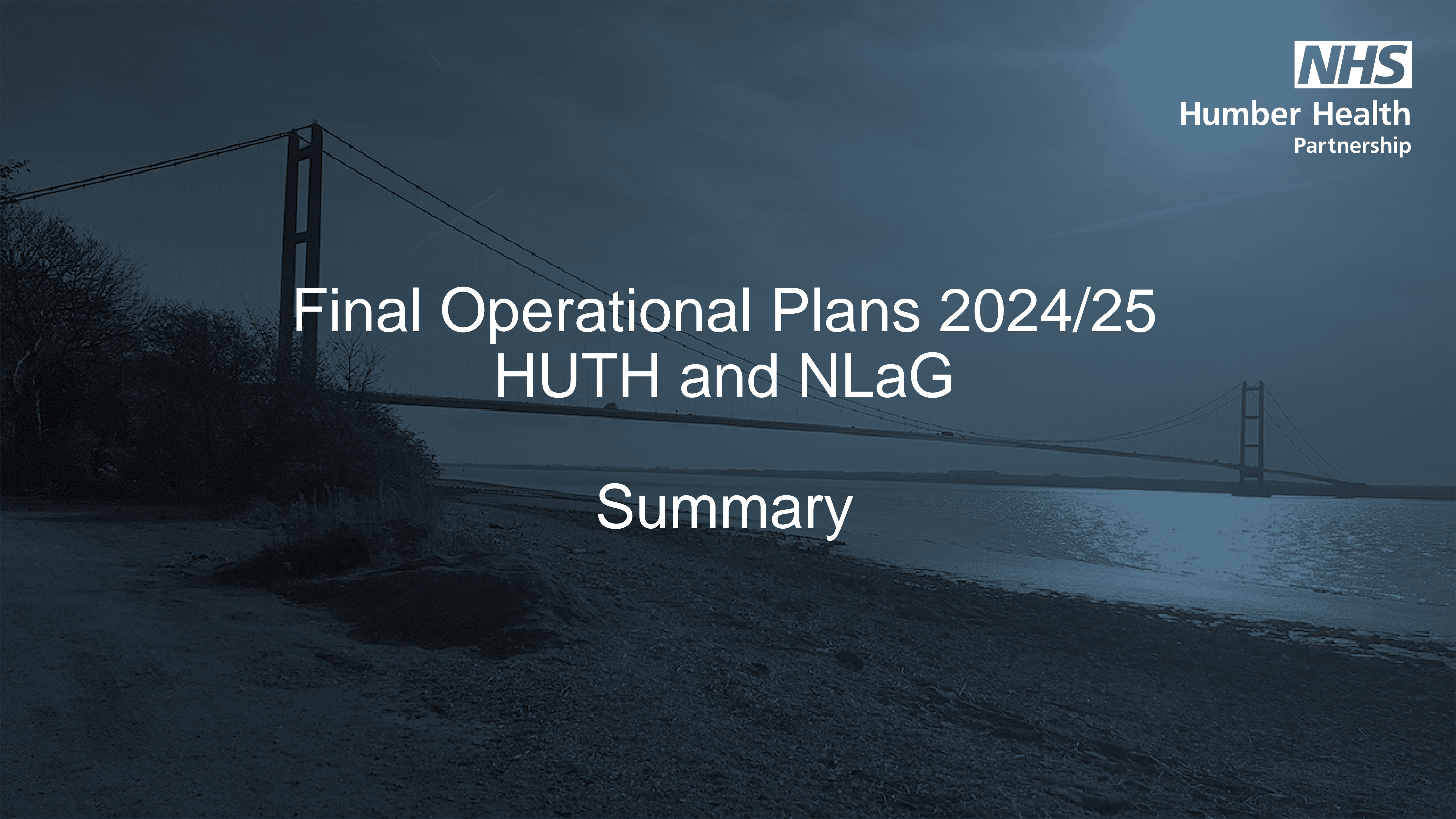
- note the key points highlighted in the escalation report from the PEF CiC meetings held on 24 April 2024 and 29 May 2024
- note the high risks associated with delivery of the CIP plan for the year and the implications of under delivery on the Group's cash position.

**Gill Ponder, PEF CiC Chair**
For meetings held on 24 April 2024 and 29 May 2024

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)102**

| **Name of Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Ivan McConnell, Group Chief Strategy & Partnerships Officer |
| **Contact Officer / Author** | Adam Creeggan, Group Director of Performance<br>Jackie Railton, Deputy Director, Planning & Performance |
| **Title of Report** | Annual Plan: Operational Plan & Financial Plan 2024/25 – HUTH and NLaG |
| **Executive Summary** | The report provides a summary of the NHS Operational Planning requirements for 2024/25 and the activity plans for both Trusts. |
| **Background Information and/or Supporting Document(s)** (if applicable) | The Operational Plan is based upon National Planning Guidance issued by NHSE.<br><br>The key priorities within the guidance are:<br><br>• Recovery of core services to pre Covid 19 levels<br>• Supporting the workforce<br>• Improving productivity<br>• Finance<br><br>The Plan has been subject to multiple reviews by the Humber and North Yorkshire ICB, NHSE both nationally and regionally during its preparation<br><br>Additionally, the plan has been discussed at Committees and a Trust Board Development session.<br><br>**The Trust Boards-in-Common are asked to approve the Operational Plan** |
| **Prior Approval Process** | Performance, Estates and Finance CiC (initial drafts)<br>Board Development session (May 2024)<br>Executive review and sign off |
| **Financial Implication(s)** (if applicable) | |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |


NHS
Humber Health
Partnership
Final Operational Plans 2024/25
HUTH and NLaG
Summary

# NHS 2024/25 Priorities and Operational Planning Guidance (published 27 March 2024)

Overall priority for the NHS in England: "Recovery of core services and productivity following the Covid-19 pandemic".

**Priorities 2024/25**

To improve patient outcomes and experience we must continue to:

- maintain our collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach
- improve ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge, and maintaining the increased acute bed and ambulance service capacity that systems and individual providers committed to put in place for the final quarter of 2023/24
- reduce elective long waits and improve performance against the core cancer and diagnostic standards
- make it easier for people to access community and primary care services, particularly general practice and dentistry
- improve access to mental health services so that more people of all ages receive the treatment they need
- improve staff experience, retention and attendance.

## Recovery of core services

- A focus on:
  - shifting activity to settings outside of hospital
  - increasing diagnostic capacity
  - Shifting the balance of outpatient activity towards 1st appointments or for a procedure
  - Improving the productivity of priority cancer pathways
  - Investing in technology
  - Improving support to GP practices
  - Increasing the use of community pharmacies.
- NHS Impact (Improving Patient Care Together) to support delivery of clinical and operational excellence. Focus will be on interventions that improve patient flow.

## Supporting the workforce

- Emphasis on improving staff experience, retention and attendance.
- Focus on pregnancy loss, menopause
- Embedding the NHS Equality, Diversity and Inclusion Improvement Plan
- Implementing actions in the NHS Sexual Safety Charter to improve safety at work

## Improving productivity

- Deliver more with the resources we have
- Reduce temporary staff spend and off framework agency use
- Reduce delayed discharges
- Improve adoption of and compliance with best value frameworks and contracts
- Productivity and supporting metrics to be introduced and reported on from Q3 2024/25.

## Finance

- Deliver a balanced net system financial position for 2024/25
- Cost uplift factor 2024/25 = 1.7%
- Allocations include a nominal 2% for pay and allows a 0.1% increase for pay drift (final pay arrangements for 2024/25 not yet agreed)
- Efficiency factor is 1.1% nationally
- Reduce agency spend to maximum of 3.2% of total pay bill across 2024/25
- Elective Recovery Fund – in scope:
  - Elective spells (day case and ordinary)
  - 1st outpatient attendances
  - Outpatient procedures that group to a non-WF HRG with a published price
  - Advice and guidance that results in a diverted pathway.

# Other key actions:

- ICBs and providers to complete the NHS Impact self assessment and use to create a shared, measureable plan for embedding improvement
- Embed a quality and equality impact assessment (QEIA) process as part of financial and operational decision-making (including cost improvement plans)
- Reduce proportion of waits over 12 hours in ED
- Maintain G&A beds at levels funded and agreed in 2023/24 operational plans
- Improve access to virtual wards (80%+ utilisation) with a focus on frailty, acute respiratory infection, heart failure, children and young people
- reductions in:
  - admitted and non-admitted time in emergency departments, and in particular arranging appropriate services for mental health patients requiring urgent care
  - the number of patients who are still in hospital beyond their discharge ready date, as well as the length of delay
- all Type 1 providers to have an SDEC service in place at least 12 hours a day, 7 days a week and an acute frailty service in place at least 10 hours a day, 7 days a week
- make significant improvement towards the 85% day case and 85% theatre utilisation

## Other key actions:

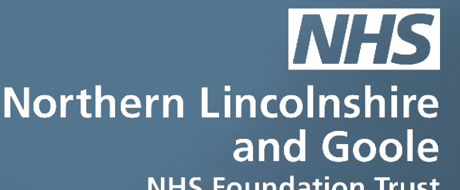
- New metric measuring the proportion of all outpatient attendances that are for first or follow-up appointments attracting a procedure tariff (the proportion of activity that is pathway completing). To meet the national ambition of 46% systems to deliver a 4.5 percentage point improvement against their 2022/23 baseline up to a maximum local ambition of 49%.  (HUTH plan = 44.17%, NLaG plan = 49.59%)
- improve patient and list management, including consistent application of the referral to treatment (RTT) rules suite, utilisation of the national access policy and a strong focus on validation, so that at any time at least 90% of patients waiting over 12 weeks are validated
- Cancer:
  - improve productivity in priority pathways; lower GI (at least 80% of referrals accompanied by a FIT result), skin (accelerate the adoption of teledermatology) and urological cancers (continued implementation of nurse-led biopsy and implementation of risk-stratification tools in prostate cancer)
  - establish, where not already in place, breast pain pathways and unexpected bleeding pathways for women receiving HRT
  - support the delivery of NHS-wide early diagnosis programmes, including the expansion of targeted lung health checks (TLHC), by ensuring sufficient CT-guided biopsy, endobronchial ultrasound (EBUS) and treatment capacity to diagnose and treat people identified with cancer, and commissioning the required phlebotomy capacity to support implementation of the Multi-Cancer Blood Test Programme in participating areas.

# NHS Objectives 2024/25 and current Group compliance

| Area | Objective | HUTH Compliance | NLaG Compliance |
|---|---|---|---|
| Quality and patient safety | • Implement the Patient Safety Incident Response Framework (PSIRF) | Yes | Yes |
| Urgent and emergency care | • Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 | 61.2% (Mar 24) | 66.39% (Mar 24) |
| | • Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25 | No | No |
| Primary and community services | • Improve community services waiting times, with a focus on reducing long waits | | |
| | • Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need | | |
| | • Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels | | |
| Elective care | • Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties) | 69 (Mar 24) | 28 (Mar 24) |
| | • Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107% | | |
| | • Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25 | 44.17% | 49.59% |
| | • Improve patients' experience of choice at point of referral | | |
| Cancer | • Improve performance against the headline 62-day standard to 70% by March 2025 | 54.4% (Feb 24) | 71.1% (Mar 24) |
| | • Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026 | 81.7% (Feb 24) | 72.5% (Mar 24) |
| | • Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 | | |
| Diagnostics | • Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% | Achieving in MRI and Audiology | |
| Maternity, neonatal and women's health | • Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment | | |
| | • Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities | | |

# NHS Objectives 2024/25 and current compliance

| Area | Objective | HUTH Compliance | NLaG Compliance |
|---|---|---|---|
| **Mental health** | • Improve patient flow and work towards eliminating inappropriate out of area placements | | |
| | • Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019) | | |
| | • Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery | | |
| | • Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025 | | |
| | • Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025 | | |
| **People with a learning disability and autistic people** | • Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025 | | |
| | • Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population | | |
| **Prevention and health inequalities** | • Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025 | | |
| | • Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025 | | |
| | • Increase vaccination uptake for children and young people year on year towards WHO recommended levels | | |
| | • Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people | **Ongoing** | **Ongoing** |
| **Workforce** | • Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions | | |
| | • Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors | | |
| | • Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan | | |
| **Use of resources** | • Deliver a balanced net system financial position for 2024/25 | **Group – Break even position** | |
| | • Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25 | | |

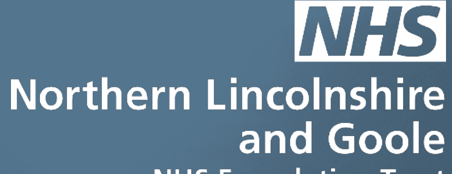



## Summary of Changes in HUTH/NLAG Second Cut Submissions

Changes to previous draft submissions have taken into account the NHS 2024/25 Priorities and Planning Guidance issued 27 March 2024. These included:

- Revised A&E trajectory to achieve 78% 4 hour compliance (all types combined) – now based on geographic footprint, not individual provider.
- SDEC – June go live for Type 5 attendances at HUTH delayed to July. Adjustments made to zero LOS and SDEC totals for month of June 2024. (HUTH SDEC total: 9.042, NLaG SDEC total: 16,509)
- New outpatient metric – conversion of follow ups without procedure into new op/follow up with procedures: HUTH 48.2% and NLaG 49.0% NHSE set targets. Impacts at HUTH with adjustments to outpatient activity forecasts.
- Revised RTT trajectories– forecast position to March 2025 now arrests waiting list growth for both Trusts and reduces >52 week backlog at NLAG:
  - NLAG: mitigates first cut >52 week growth of 29.4% (311 pathways). Revised plans generate -10.1% (-106 pathway) reduction in the >52 week backlog
  - HUTH >52 week trajectory remains unchanged with a reduction of -40.8% (961 pathways)
  - In combination with NLAG the aggregate reduction in >52 waits for 24/25 is -31.3% (-1,067 pathways)

# Summary: Outpatients

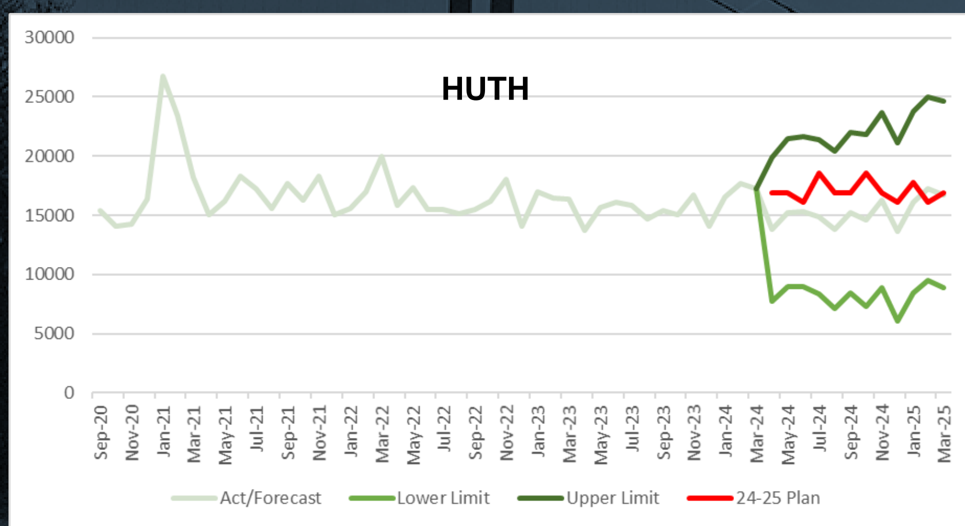



| Domain: Outpatients | HUTH 2023/24 | HUTH Plan 2024/25 | HUTH Plan as % of 2023/24 | Change from First Draft submission | NLaG 2023/24 | NLaG Plan 2024/25 | NLaG Plan as % of 2023/24 | Change from First Draft submission |
|---|---|---|---|---|---|---|---|---|
| All outpatient attendances | 858457 | 862193 | 100% | | 366872 | 373440 | 102% | |
| No. of episodes moved to or discharged to PIFU as outcome of outpatient attendance | 13909 | 21899 | 157% | | 11879 | 18671 | 157% | |
| PIFU as % of total outpatient attendances | 1.6% | 3.4% | By March 2025 | | 3.2% | 5.0% | By March 2025 | |
| 1st outpt spec acute | 202619 | 202490 | 100% | 12429 | 102460 | 110887 | 108% | |
| Outpatient procedures - ERF Scope | 119360 | 143301 | 120% | 14535 | 62855 | 64411 | 102% | |
| 1st attendance without procedures | 186420 | 204724 | 110% | 14538 | 96222 | 102094 | 106% | |
| Follow up spec acute | 473775 | 470078 | 99% | | 146440 | 143436 | 98% | |
| Outpatient follow up without procedure ERF scope | 406987 | 374011 | 92% | -29063 | 181887 | 169234 | 93% | |
| % follow up without procedures | 57.10 | 51.80 | 91% | | 53.34 | 50.41 | | |

# Phased Plans: Outpatient New (in ERF Scope)

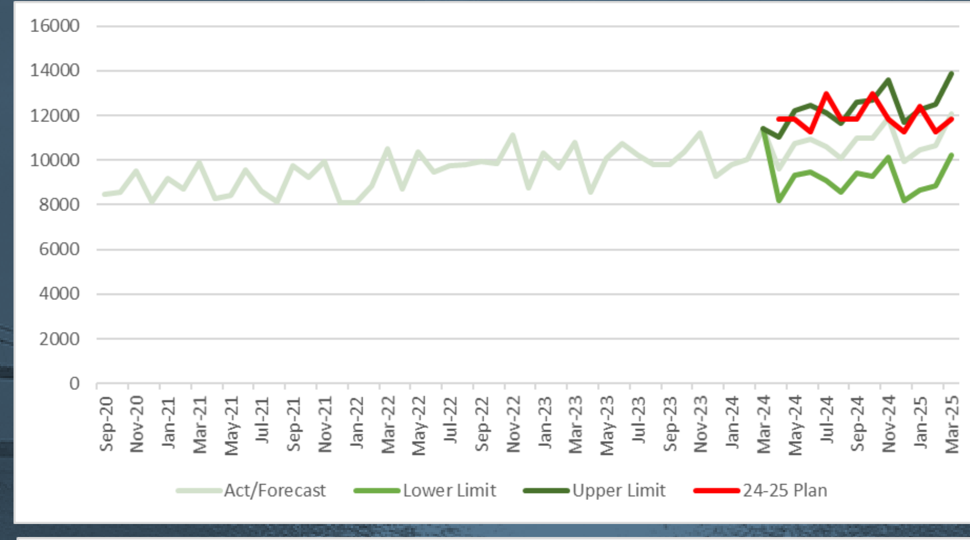
Northern Lincolnshire and Goole

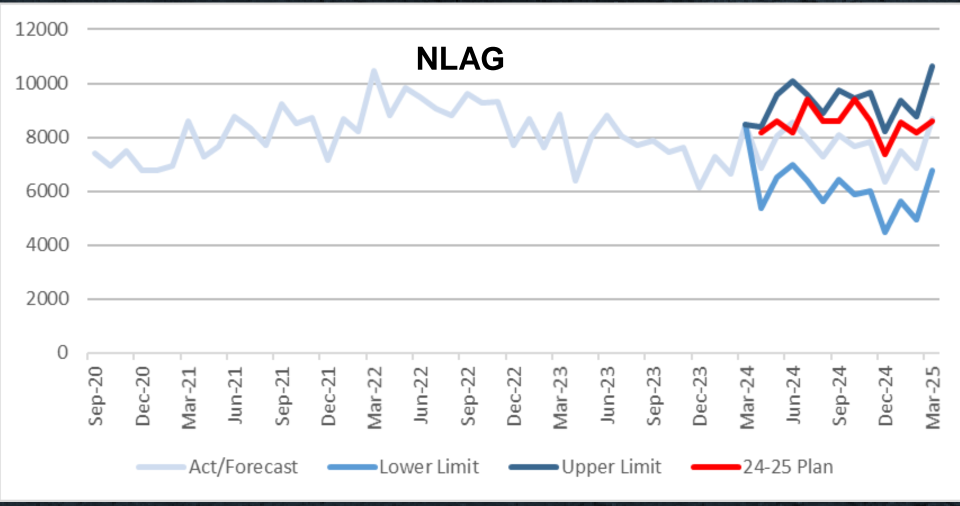
## Outpatient first attendances without a procedure



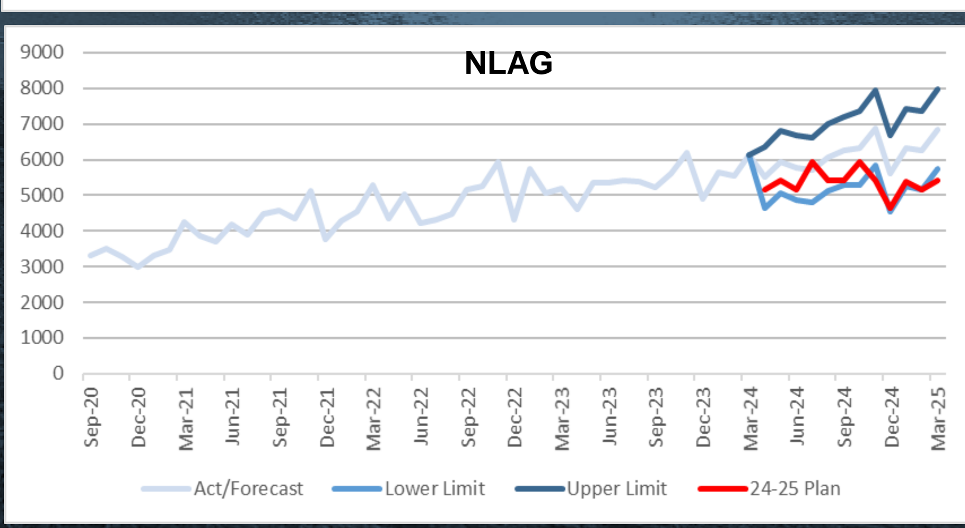

HUTH: increase in OP First of 10.9% on 23/24 actuals. Outpatients with procedure increase by 18.2% on 23/24 actuals driven by increased activity and improved data recording

## Outpatient procedures



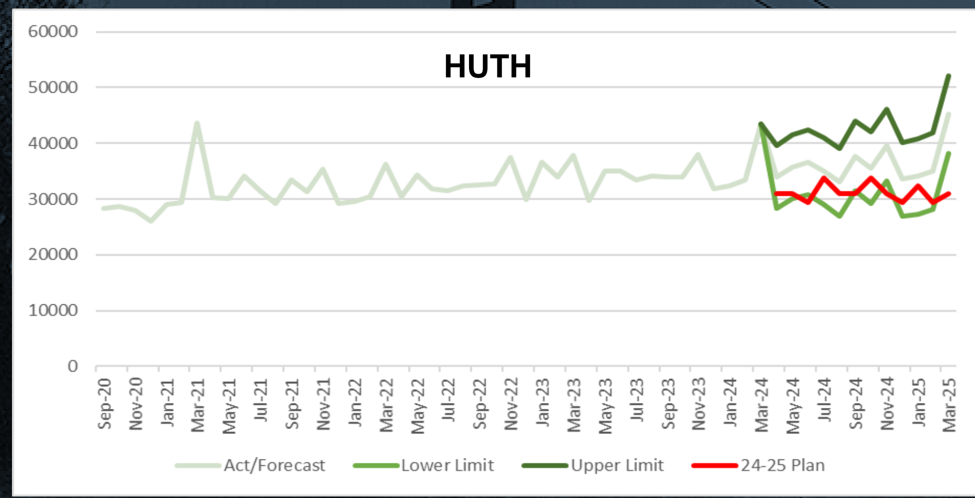

NLAG: increase in OP First of 9.9% on 23/24 actuals. 23/24 outpatient with procedure rates are maintained as NLAG currently meets the 48% target



NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

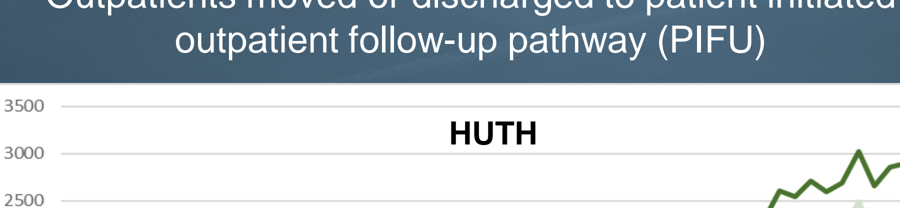
# Phased Plans: Outpatient Follow Up (in ERF Scope)

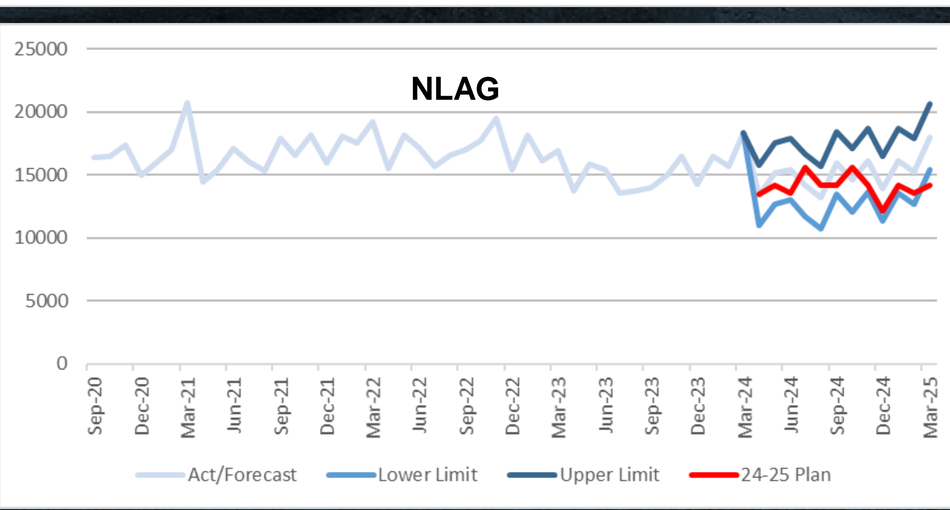
## Outpatient follow up attendances without procedure



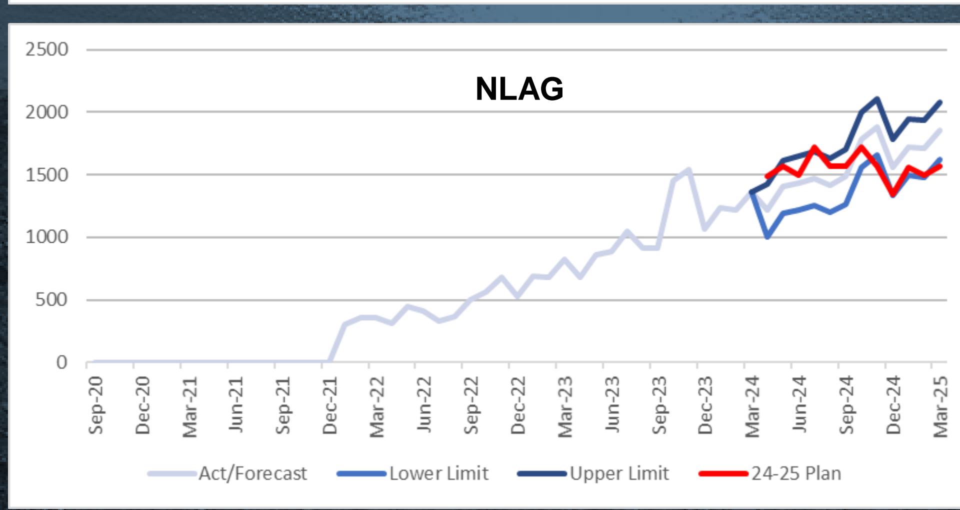

HUTH: reduction in follow ups without procedure of -8.8% on 23/24 actuals and a 34.8% increase in patients discharged to a PIFU pathway

## Outpatients moved or discharged to patient initiated outpatient follow-up pathway (PIFU)




NLAG: reduction in follow ups without procedure of -4.3% on 23/24 actuals and a 41.6% increase in the volume of patients discharged to a PIFU pathway.



# Summary: ED Attendances

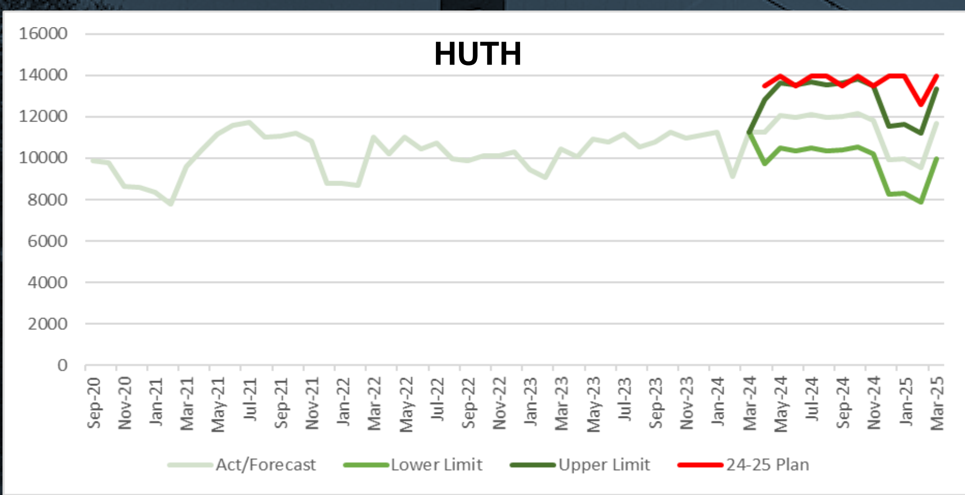
| Domain | HUTH 2023/24 | HUTH Plan 2024/25 | HUTH Plan as % of 2023/24 | Change from First Draft submission | NLaG 2023/24 | NLaG Plan 2024/25 | NLaG Plan as % of 2023/24 | Change from First Draft submission |
|---|---|---|---|---|---|---|---|---|
| A&E attendances | | | | | | | | |
| Total no attendances Types 1, 2, 3 AE excluding planned follow ups departing in less than 4 hours | 63580 | 113648 | 179% | -7243 | 108323 | 127619 | 118% | -1969 |
| Total no attendances Types 1, 2, 3 AE excluding planned follow ups | 129947 | 164250 | 126% | | 171591 | 176062 | 103% | |
| % attendances Types 1, 2,3 AE excluding planned follow ups, departing in less than 4 hours | 48.9 | 78.3 by March 2025 | | Revised threshold | 63.4 | 78.0 by March 2025 | | Revised threshold |
| No of attendances Type 1 AE where patient spent less than 4 hours from time of arrival to admission, discharge or transfer | 63580 | 51460 | 81% | -7179 | 108323 | 60034 | 55% | -7951 |
| No of attendances Type 1 AE | 129947 | 98550 | 76% | | 171591 | 108477 | 63% | |
| % of attendances at Type 1 AE excluding planned follow ups departing in less than 4 hours | 48.93 | 64.5 by March 2025 | | | 63.13 | 64.9 by March 2025 | | |
| No of attends at other type AE where patient spent less than 4 hours from time of arrival to admission, discharge or transfer | | 62188 | | | | 67585 | | |
| No of other type AE attendances | | 65700 | | | | 67585 | | |
| % of attendances at Types 2 and 3 AE excluding planned follow ups departing in less than 4 hours | | 99.0 by March 2025 | | | | 100.00 | | |
| Same Day Emergency Care | | 9042 | | -990 | | 16509 | | |

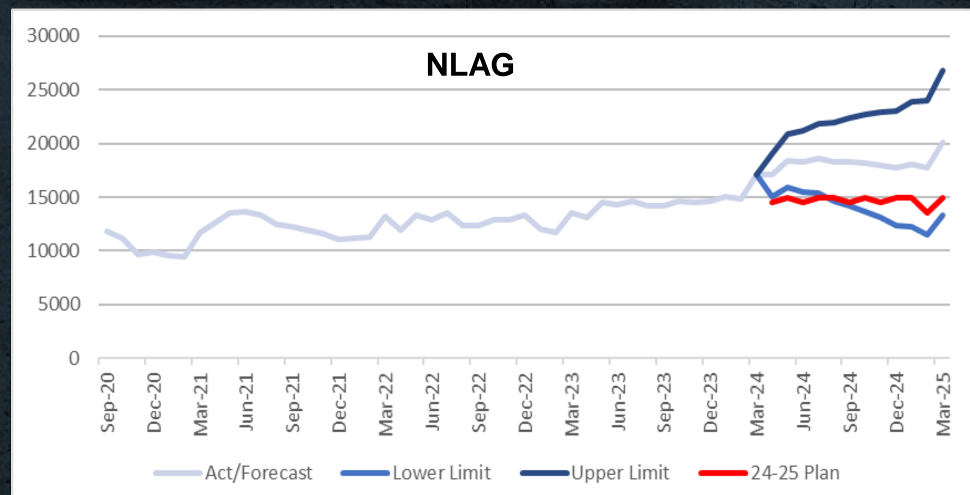
Hull University Teaching Hospitals NHS Trust

# Phased Plans: ED Attendances

Northern Lincolnshire and Goole NHS Foundation Trust

## TOTAL attendances in A&E departments

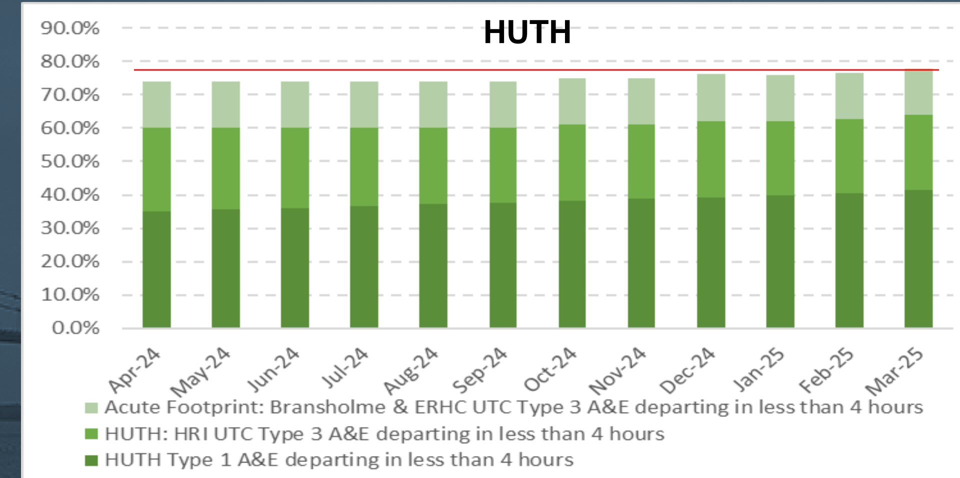


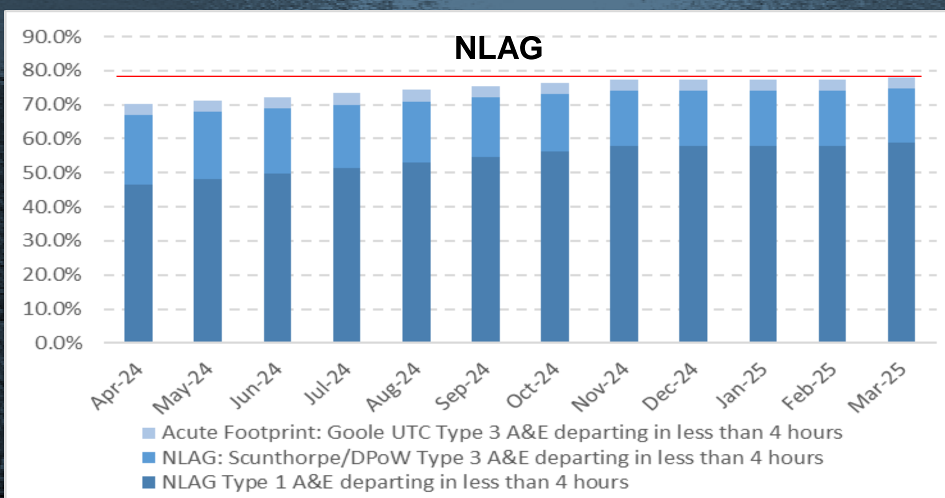




HUTH: Increased activity reflects the FYE of HRI UTC

A&E 4 Hour Target: NE&Y Region/HNY ICB have instructed trajectories based on Acute footprint rather than Acute Provider. This incorporates 14.0% and 3.3% into HUTH and NLAG due to footprint UTCs, MIUs etc. This creates 24/25 HHP targets of 64.0% for HUTH and 74.7% for NLAG.

## A&E 4 Hour Target

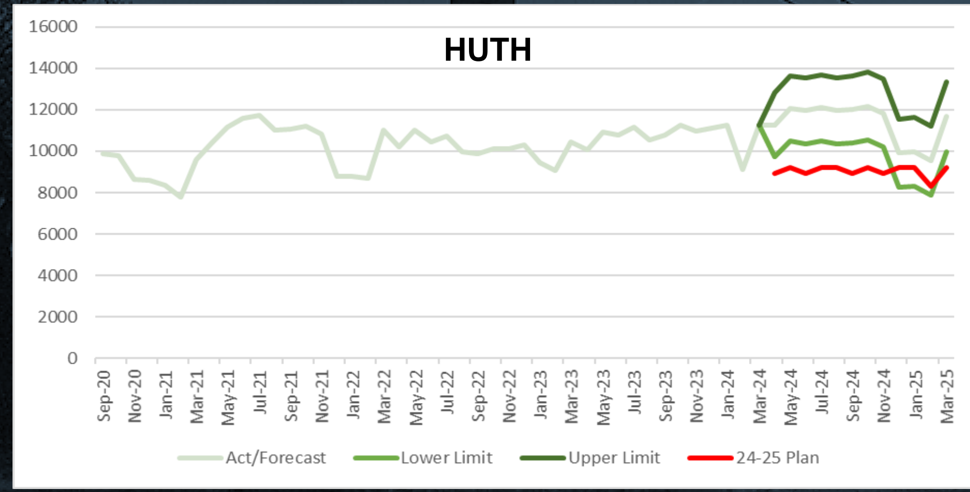


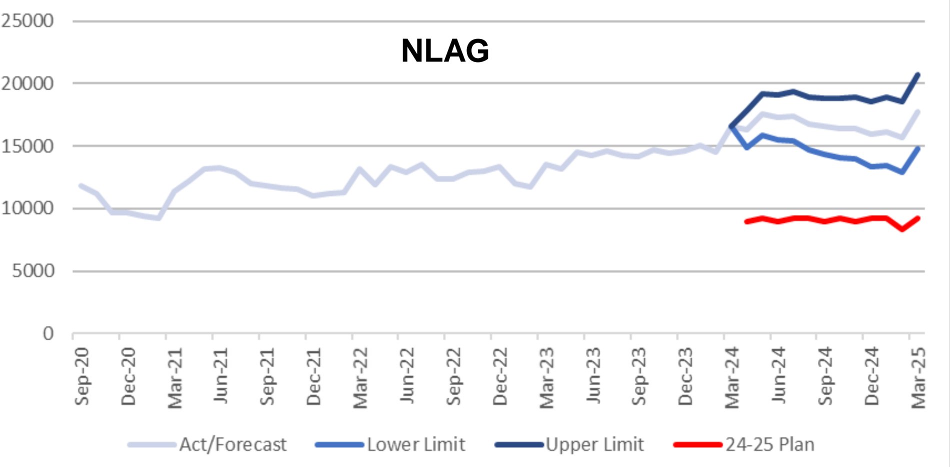



# Phased Plans: A&E Attendances by Type

Northern Lincolnshire and Goole NHS Foundation Trust

Number of Type 1 attendances in A&E departments

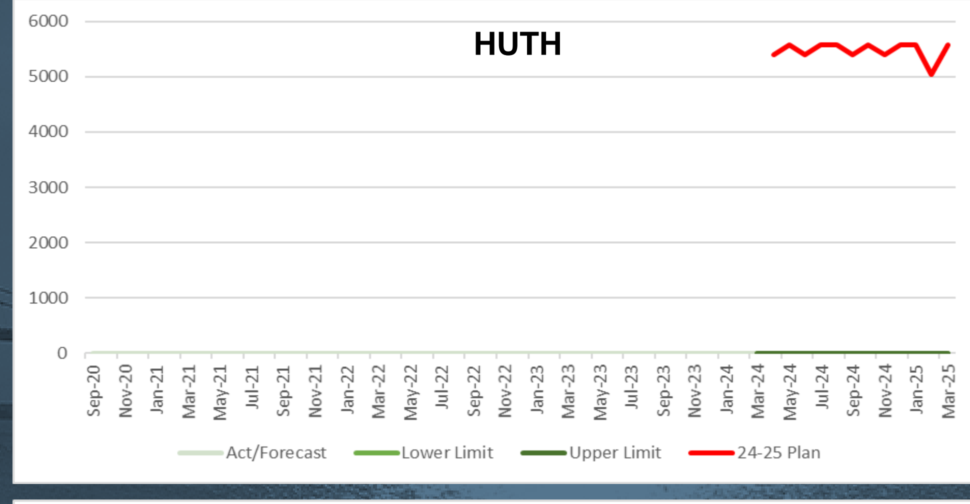


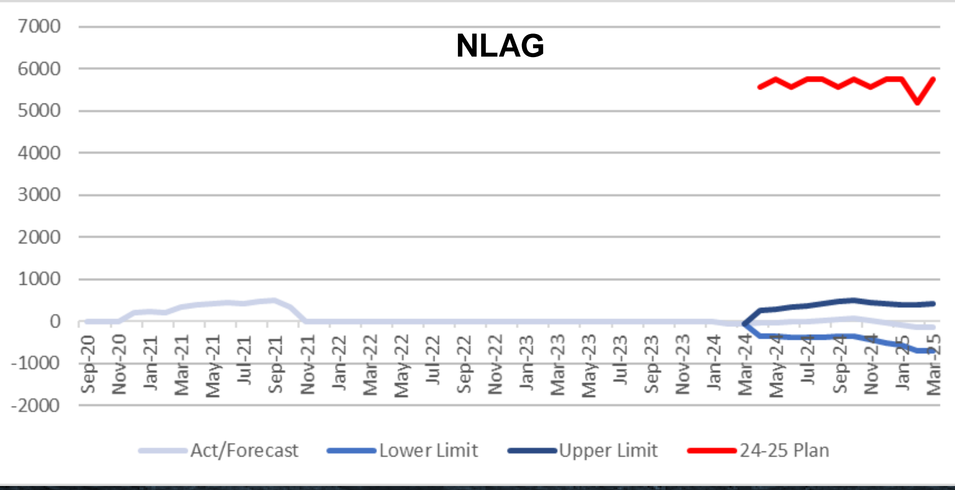



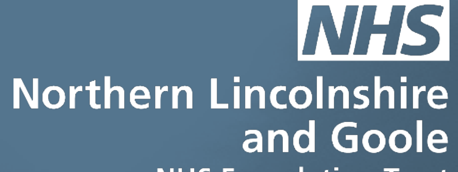

HUTH: Reflects the full year effect of streaming of historic Type 1 activity to HRI UTC

NLAG: Reflects the full year effect of correction of historic reporting of Scunthorpe UTC from Type 1 to Type 3

Number of Type 3 attendances in A&E departments





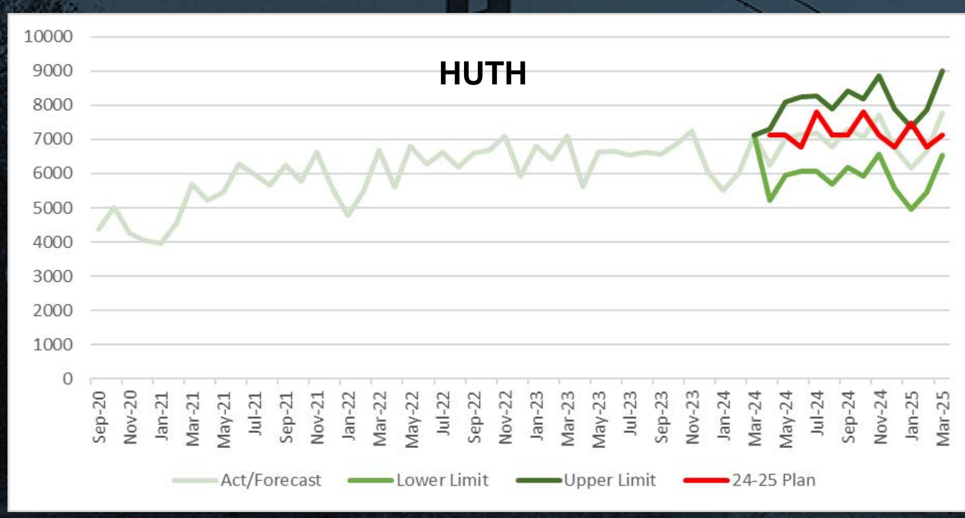

# Summary: Elective and Non Elective Spells

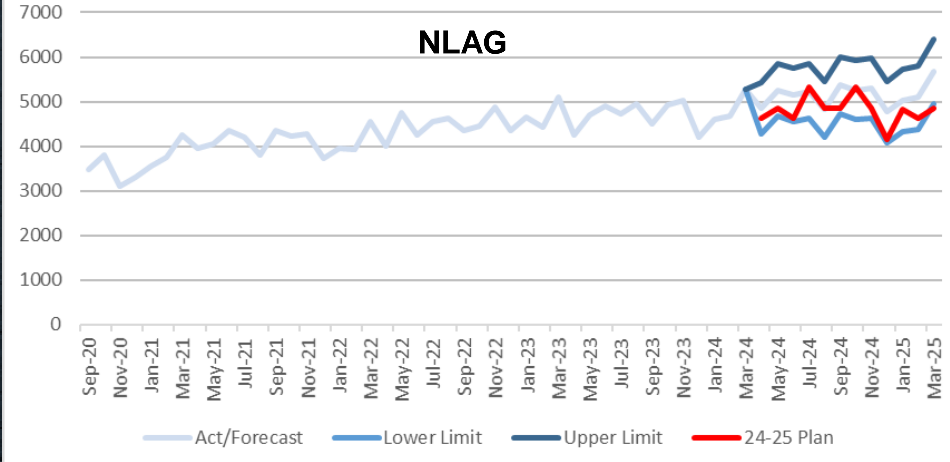
| Domain | HUTH 2023/24 | HUTH Plan 2024/25 | HUTH Plan as % of 2023/24 | Change from First Draft submission | NLaG 2023/24 | NLaG Plan 2024/25 | NLaG Plan as % of 2023/24 | Change from First Draft submission |
|---|---|---|---|---|---|---|---|---|
| Elective Spells | 92075 | 101259 | 110% | | 61486 | 62997 | 102% | |
| day case | 78696 | 86225 | 110% | | 56357 | 57812 | 103% | |
| ordinary spells | 13378 | 15034 | 112% | | 5129 | 5185 | 101% | |
| day cases (under 18 years) | | 2689 | | | | 866 | | |
| ordinary spells (under 18 years) | | 631 | | | | 250 | | |
| Non-Elective Spells | 61345 | 53479 | 87% | 750 | 61299 | 46623 | 76% | |
| LOS of zero days | 22498 | 14836 | 66% | 750 | 29028 | 13455 | 46% | |
| LOS of 1 day or more | 38847 | 38645 | 99% | | 32272 | 33168 | 103% | |

# Phased Plans: Elective Spells

Northern Lincolnshire and Goole NHS Foundation Trust

## Day Case Elective Spells

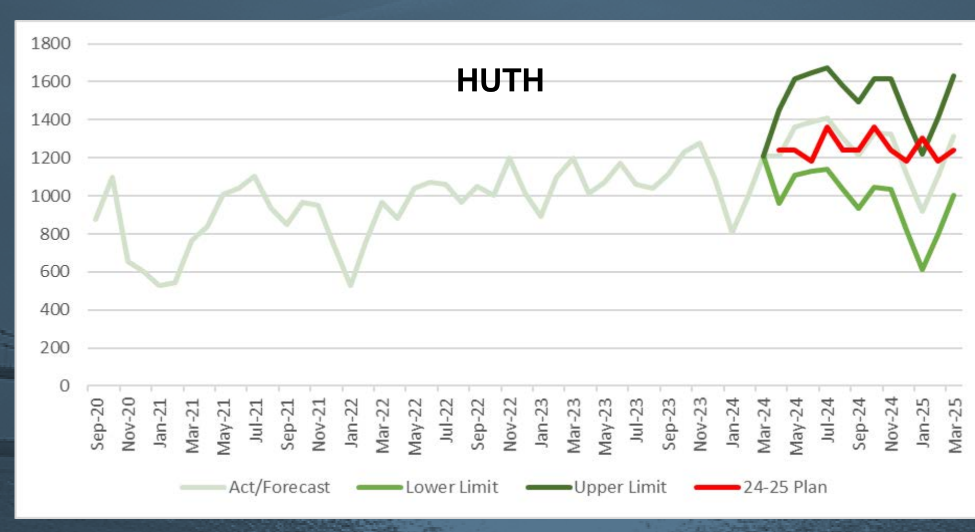


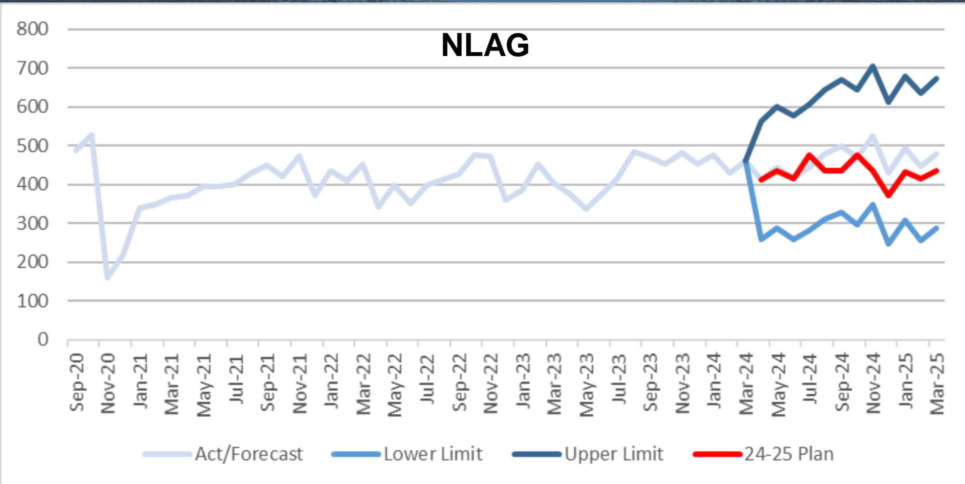




HUTH: Increased DC volumes reflects the part year effect of Castle Hill expansion

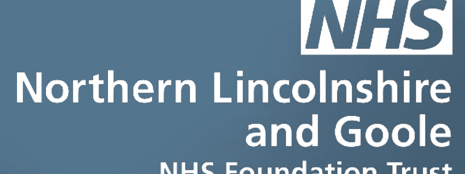
NLAG: No material changes in spell volumes

## Inpatient Elective Spells

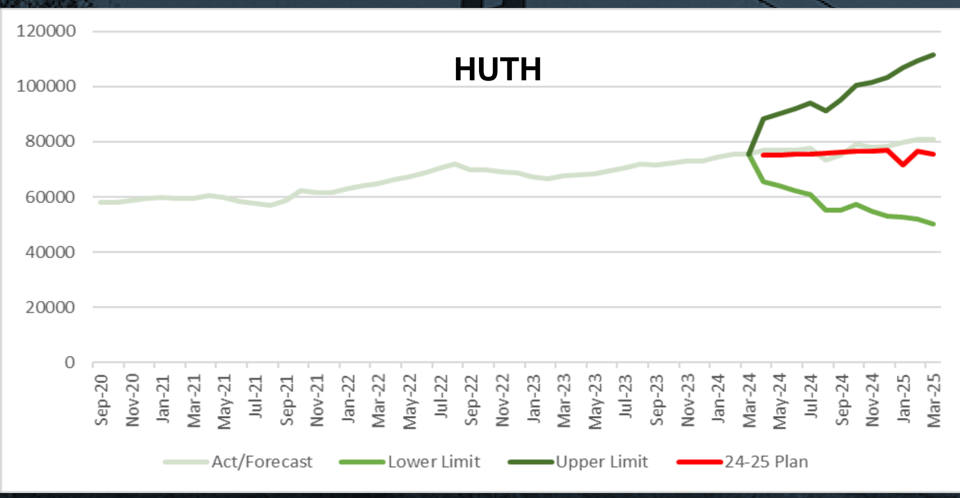


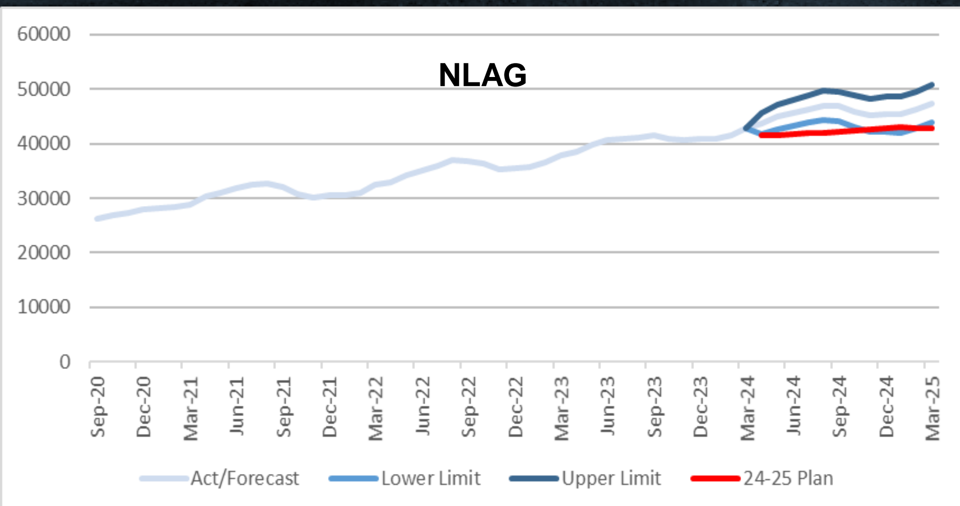



# Phased Plans: Referral to Treatment (RTT) Delivery



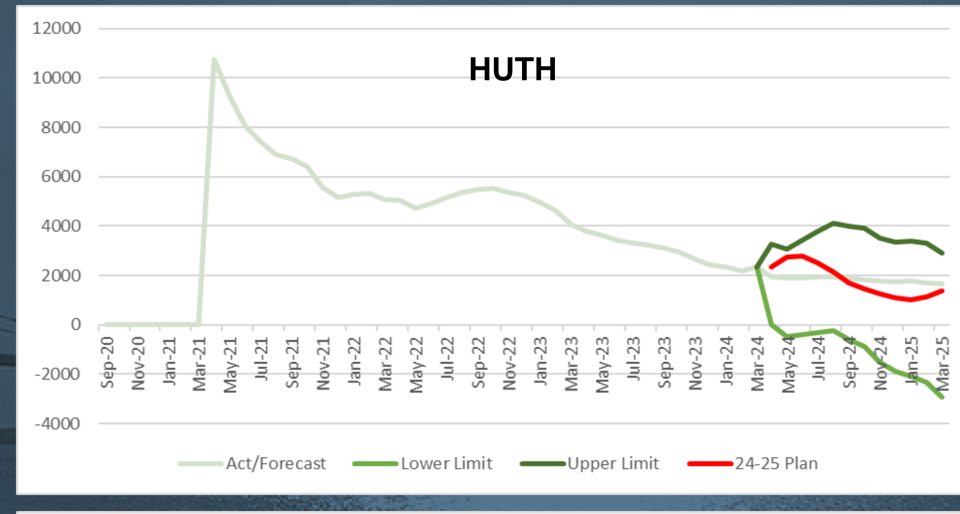

Total Patient Tracking List Size (Waiting List)

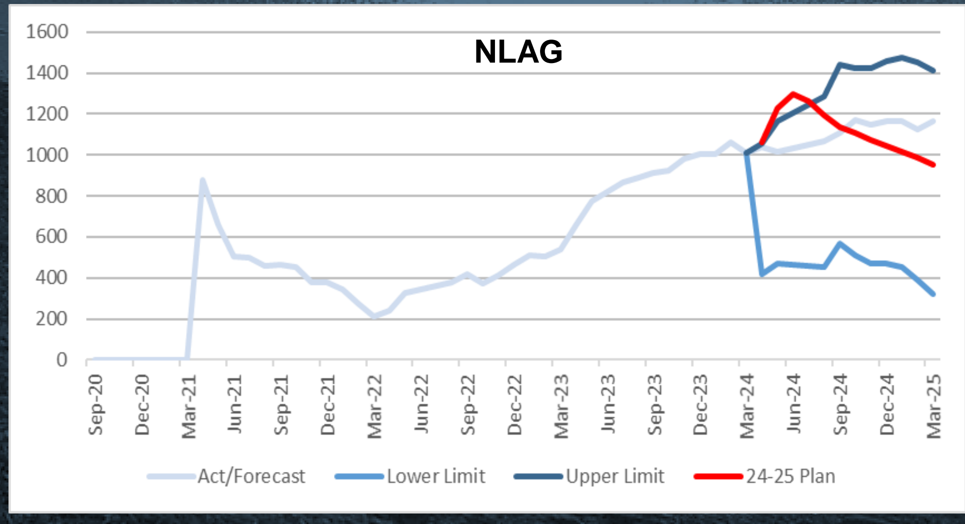



Revised plans for both Trust arrest the PTL/>52 week growth shown in the 1st cut submission. In year delivery is linked to a number of factors:

1) Increased first outpatient & diagnostic activity
2) System referral reduction via ICB led Single Point of Access model
3) Increased use of fallow capacity via insourcing



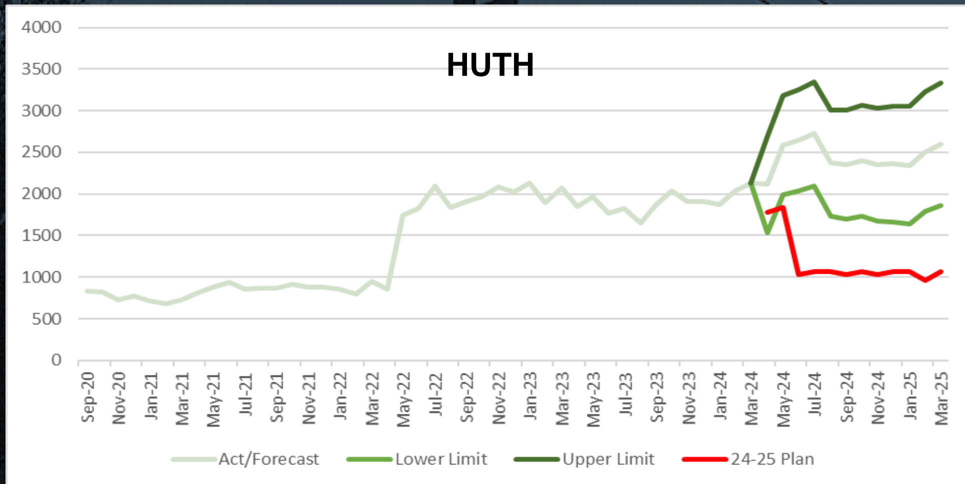



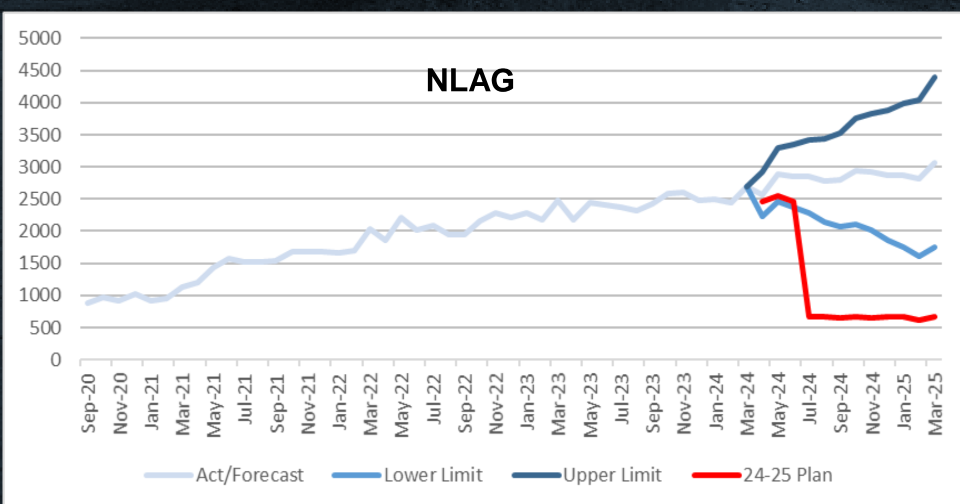
Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

# Phased Plans: Non Elective Spells

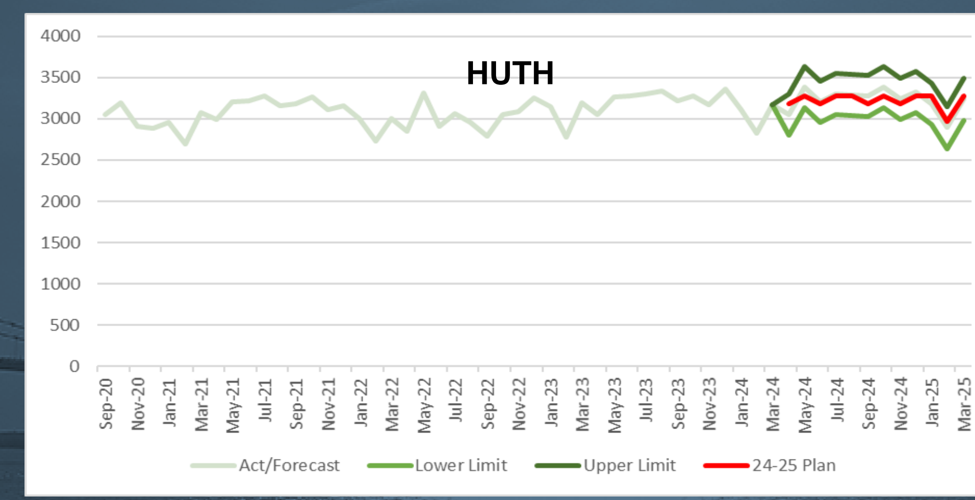
## Non Elective Spells with a Length of Stay 0

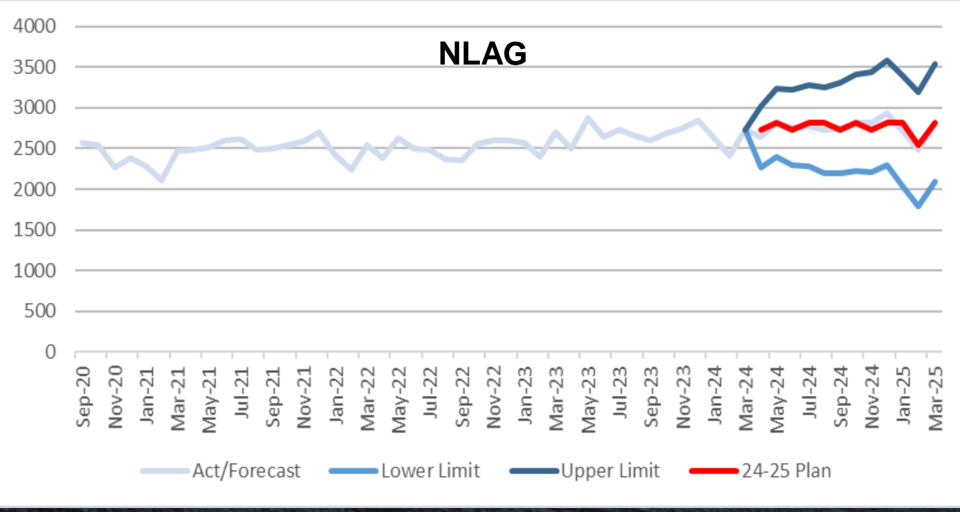



Reduction in LOS=0 in both Trusts reflects national recording change to SDEC activity which becomes A&E Type 5 (OP attendance) rather than an admission (spell)

## Non Elective Spells with a Length of Stay >0



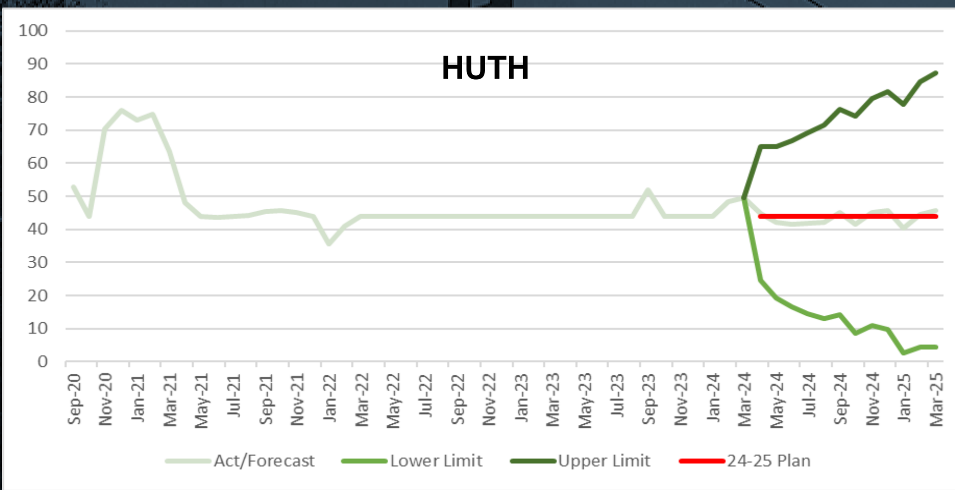



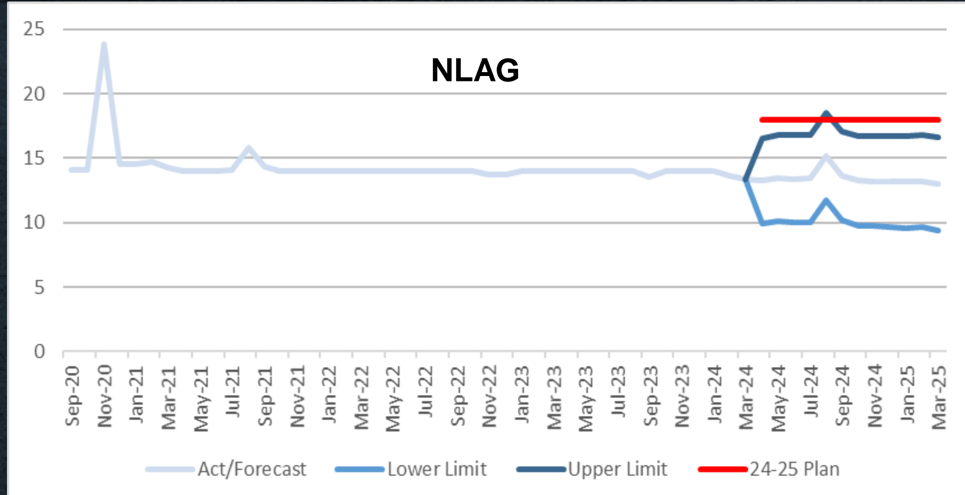
NHS
Hull University Teaching Hospitals
NHS Trust

# Phased Plans: Beds

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

## Adult Critical Care Beds



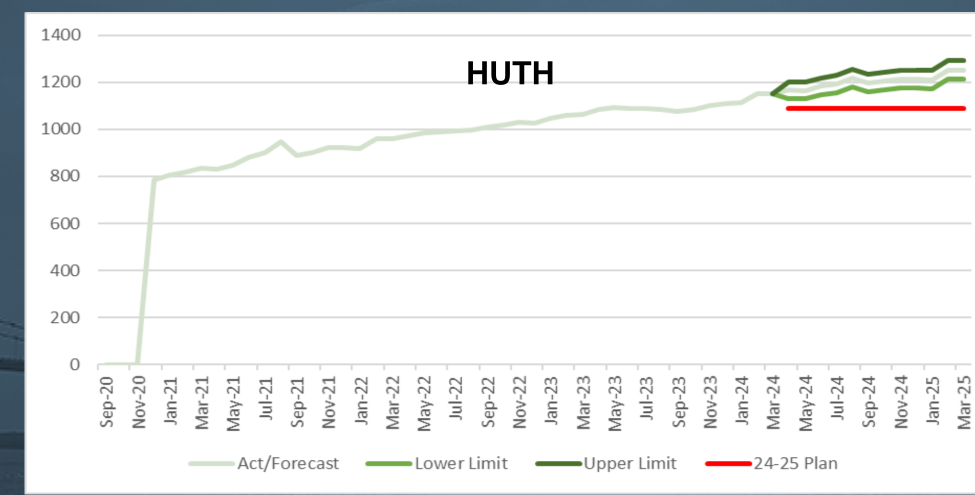



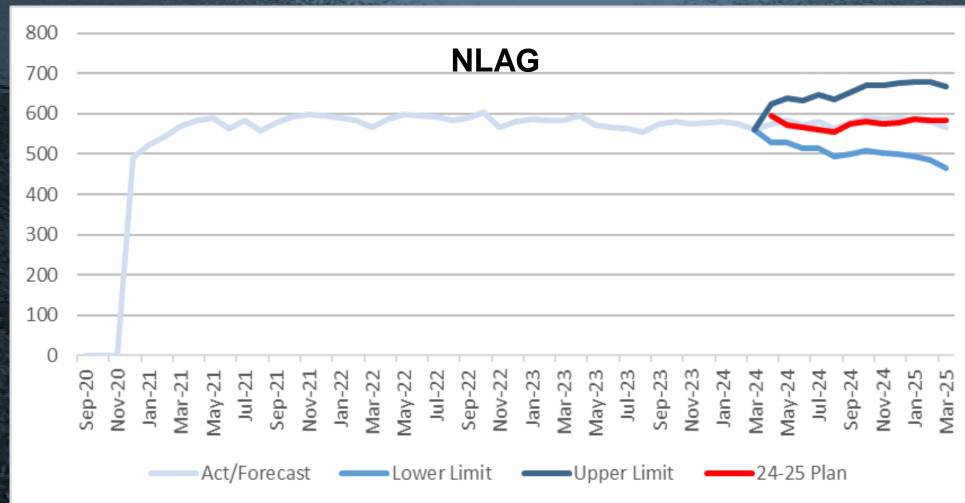

No material change in bed use at either Trust.

Where variance to underlying trend is shown this reflects variation in currencies – the 24/25 plan is based on average beds open rather than the range of bed use. This does highlight particular risk at HUTH in which forecast demand may continue to exceed available funded beds

NB. The 24/25 plan excludes routine use of escalation beds which are subject to winter funding arrangements

## Adult General & Acute Beds



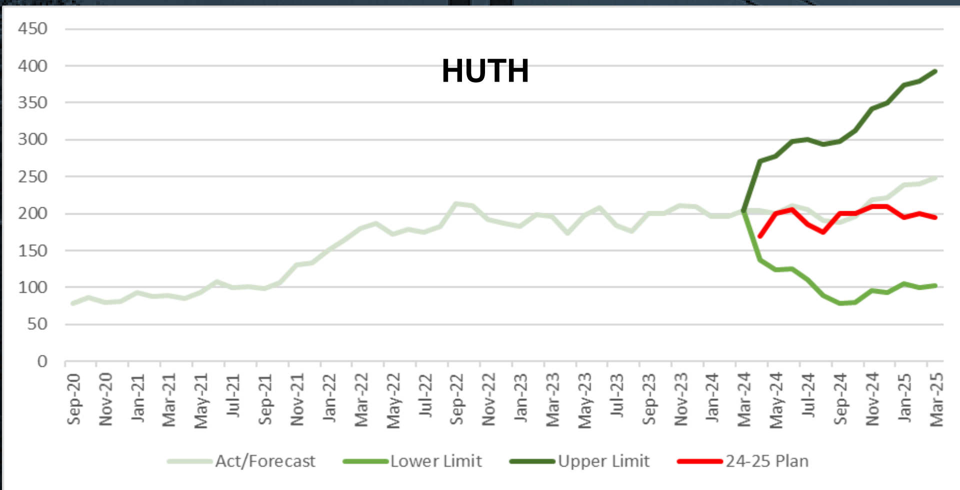



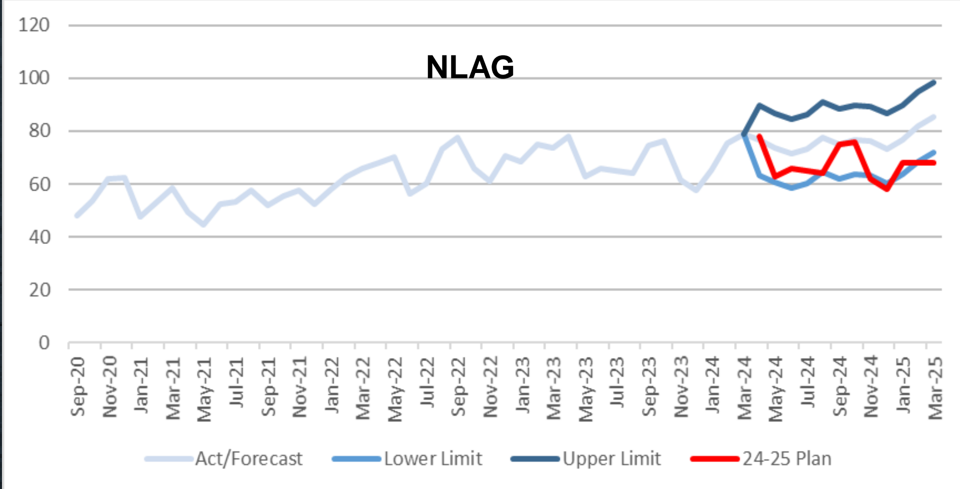
Hull University Teaching Hospitals NHS Trust

# Phased Plans: Beds

Northern Lincolnshire and Goole NHS Foundation Trust

## Reducing length of stay for patients in hospital for >21 days



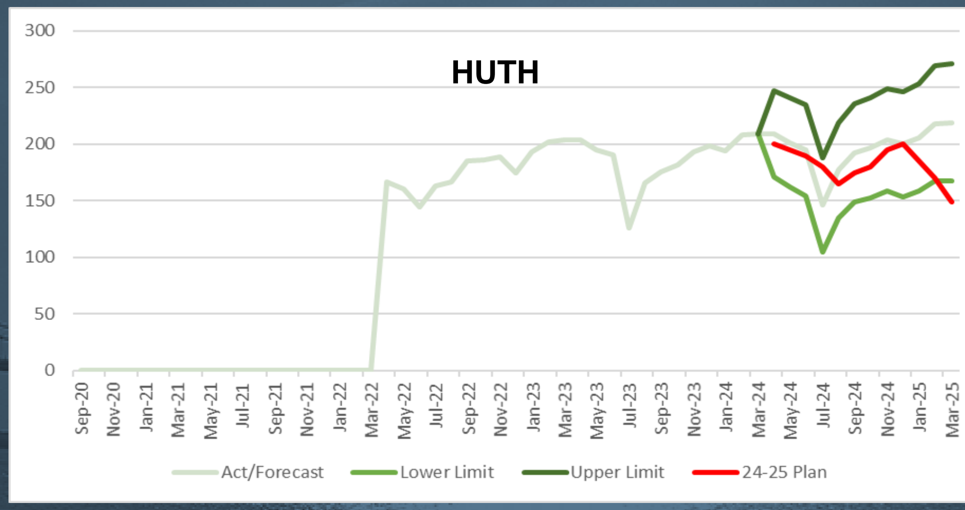



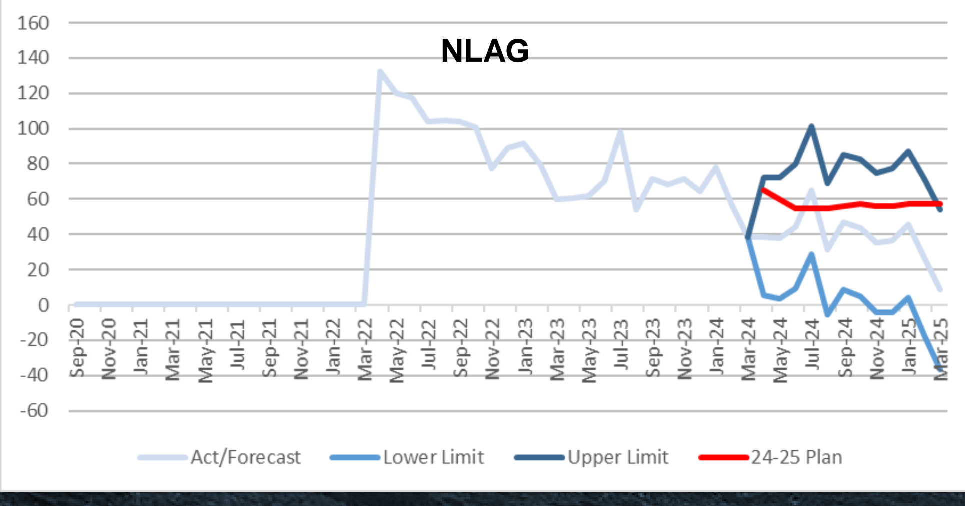

As part of mitigation of the risk to non-elective bed demand in the previous slide both Trusts are forecasting reduction in NCTR occupancy:

- HUTH – to reduce to no more than 15% of G&A beds occupied by NCTR patients by March 2025 (149 patients/beds)
- NLaG – to reduce to no more than 10% of G&A beds occupied by NCTR patients by March 2025 (57 patients/beds)

Both changes in NCTR levels generate and associated impact in arresting the underlying upward trend in admissions >21 days

## Number of beds occupied by patients no longer meeting the criteria to reside (NCTR)



# Summary: Diagnostics

| Domain | HUTH 2023/24 | HUTH Plan 2024/25 | HUTH Plan as % of 2023/24 | Change from First Draft submission | NLaG 2023/24 | NLaG Plan 2024/25 | NLaG Plan as % of 2023/24 | Change from First Draft submission |
|---|---|---|---|---|---|---|---|---|
| Diagnostics | | | | | | | | |
| MRI | 32432 | 31214 | 96% | | 60406 | 58619 | 97% | |
| CT | 70263 | 71182 | 101% | | 122014 | 127390 | 104% | 15202 |
| Non obstetric ultrasound | 54029 | 54605 | 101% | | 47109 | 66513 | 141% | |
| Colonoscopy | 3305 | 4182 | 127% | | 6762 | 8349 | 123% | |
| Flexi sigmoidoscopy | 1392 | 2195 | 158% | | 2415 | 2541 | 105% | |
| Gastroscopy | 5550 | 6203 | 112% | | 6496 | 7986 | 123% | |
| Echocardiography | 8150 | 6738 | 83% | | 12405 | 10088 | 81% | |
| Dexa | 5219 | 4752 | 91% | | 2675 | 2904 | 109% | |
| Audiology | 6429 | 7092 | 110% | | 5086 | 4240 | 83% | 400 |

# Summary of System Plans

## Operational Planning Priorities – Activity performance

| Area | Objective | Target 24/25 | HNY ICB | YSTHFT | HDFT | NLAG | HUTH |
|---|---|---|---|---|---|---|---|
| Urgent and Emergency Care emergency | Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 | 78.00% | 78.00% | 78.00% | 78.00% | 78.00% | 78.00% |
| | Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25 | <30 mins | YAS 30:23 | | | | |
| Primary and community services | Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need | N/A | 85.00% | | | | |
| Elective care | Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties) | 0 | 0 | 0 | 0 | 0 | 0 |
| | Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107% | 108.90% | 114.8% | 106.6% | 107.00% | 110.5% | 108.7% |
| Cancer | Improve performance against the headline 62-day standard to 70% by March 2025 | 70.00% | 70.03% | 70.00% | 70.59% | 70.87% | 70.05% |
| | Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026 | 77.00% | 77.01% | 77.02% | 77.11% | 77.04% | 77.03% |
| Diagnostics | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% | 95.00% | 82.85% | | | | |

## Opportunities to increase activity/ERF income above 24/25 plan

- Discussion held at RTT and Diagnostic Delivery Groups regarding the need to ensure that specialties restore services to (and exceed) baseline (2019/20). Investment opportunities identified to date include:

| RTT Recovery | Additional activity per month |
|---|---|
| Cardiology | 260 |
| Gastroenterology (NLaG) | 462 |
| Neurosurgery | 64 |
| Neurology | 60 increasing to 120 |
| ENT | 390 |
| Plastic Surgery | 300 |
| Ophthalmology – Cataracts | 100 |
| Ophthalmology – Glaucoma | 190 |
| Ophthalmology – Retinal Surgery | 240 |
| Ophthalmology – Medical Retina | 160 |
| Ophthalmology – Neuro | 210 |
| Orthoptics | 130 |

| Diagnostic Modality | Additional activity per month |
|---|---|
| Dexa Scans | 140 |
| Cystoscopy | 80 |
| Endoscopy (NLaG) | 100-200 |
| Chemical Pathology | 16 |
| Imaging – Cardiac CT | 100 |
| Imaging – CT | 280 |
| Imaging – mobile MRI | 690 |
| Relocation of Colposcopy service to CHH | 18 sessions per week |
| Hysteroscopy (following CHH relocation) | TBC |

**Trust Boards-in-Common Front Sheet**

**Agenda Item No: BIC(24)103**

| | |
|---|---|
| **Name of the Meeting** | Trust Boards-in-Common |
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Kate Truscott and Tony Curry, Non-Executive Directors and Chairs of the Workforce, Education and Culture Committees-in-Common |
| **Contact Officer/Author** | Kate Truscott and Tony Curry, Non-Executive Directors and Chairs of the Workforce, Education and Culture Committees in Common |
| **Title of the Report** | Workforce, Education and Culture Committees in Common highlight and escalation reports from:<br>• 30 April 2024<br>• 23 May 2024 |
| **Executive Summary** | The attached report highlights the work of the Workforce, Education and Culture Committees-in-Common at both its 30 April 2024 and 23 May 2024 meetings.<br><br>The report highlights matters considered by the Committees, matters for escalation to the Boards, any additional assurance required, confirm and challenge of the BAF and any action required of the Boards.<br><br>Recommendation:<br>The Boards-in-Common is asked to note the attached report and endorse the Staff Charter as recommended by the Committees in Common. |
| **Background Information and/or Supporting Document(s)** (if applicable) | The attached reports provide Committees-in-Common highlights and escalations to the Boards-in-Common. |
| **Prior Approval Process** | The attached report has been approved by the Committees-in-Common Chairs. |
| **Financial implication(s)** (if applicable) | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/A |
| **Recommended action(s) required** | ☐ Approval<br>☐ Discussion<br>✓ Assurance<br>☐ Information<br>✓ Review<br>✓ Other – please detail below: Endorse the Staff Charter |

V.10

**Committees-in-Common Highlight / Escalation Report to the Trust Boards**

| | |
|---|---|
| | 13 June 2024 |
| | Workforce, Education and Culture Committees in Common |
| | 30 April 2024<br>23 May 2024 |
| | Yes on both occasions |

## 1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meeting(s) held on 30 April 2024 and 23 May 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

## 2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

**30 April 2024**

- Board Assurance Framework
- CQC WECC Actions HUTH/NLAG
- Group IPR
- Group reduction in agency spend
- Group Recruitment Time to Hire
- Freedom to Speak Up – HUTH/NLAG
- Care Group development and Support HUTH/NLAG
- Impact of Lorenzo NLAG
- Band 2/3 HCSW duties and job descriptions
- National Minimum Wage impact upon lower paid staff
- HUTH OCS GMB Briefing
- Group Job Planning Development
- Group medical engagement update
- HUTH/NLAG EDS 22 Approval

**23 May 2024**

- Board Assurance Framework
- CDC Recruitment issues
- Medical Workforce Update

- HUTH Nursing and Midwifery staffing Report
- NLAG Nursing and Midwifery staffing report
- CQC HUTH/NLAG Action updates
- Group IPR
- Group Memorandum of Understanding
- Guardian of Safe Working HUTH
- Guardian of Safe Working NLAG
- Group Staff Charter
- Un-registered nurse vacancy rate
- Nursing band 2/3 options
- Pharmacy Recruitment update

## 3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting / escalation to the Trust Boards:

**30 April 2024**

a) NHS England has removed funding for resilience HUBs for all NHS Trusts, which will have an impact upon our staff not being able to access mental health services. HUTH no longer has a full-time Health and Wellbeing manager. Those staff accessing current mental health services will access trust counselling and OH services, but it is not the advanced support that is required. Staff with long term mental health issues will have to attend their GPs in the first instance. It is likely that the HUTH Psychology team will get more referrals following these changes. Similarly, NLaG will not have a dedicated Health and Wellbeing Manager. However, 2 People Promise Managers are to be funded by NHS E to support delivery across all aspects of the NHS People promises.

b) HUTH - OCS GMB Union matter – work is ongoing between OCS and GMB to ensure terms and conditions of service are met. Reasonable assurance was gained by the Committees in Common due to the progress being made and future approach.

c) NLAG - Impact of transition to Lorenzo – there was an initial impact on the teams, in particular ward clerks and receptionists. Support from the HUTH teams and dedicated staff at NLAG has meant that the project has been successful with staff now preferring the patient information system.

**23 May 2024**

a) Hull University had received a ‘good’ CQC rating which had been influenced by the HUTH apprenticeship programme amongst other improvements.
b) HUTH International Nurse retention had reduced from 98% to 91% due to the increased Visa costs.
c) The WEC CIC agreed the Group Staff Charter recommending approval by the Boards in Common.
d) HUTH/NLAG CDC risks – The CIC was assured that there was a plan in place but there were many variables such as finance, governance, remote reporting and recruitment that could impact on it.
e) Band 2/3 uplift financial implications. A report detailing the required funding to be shared with the CIC and was being reviewed by the Cabinet.

## 4.0 Matters on which the committees have requested additional assurance:

a. The committees requested additional assurance on the following items of business:

**30 April 2024**

a) CQC Action plans WECC NLAG/HUTH were given reasonable assurance relating to the process. However, further work needed to be undertaken in relation to compliance rates for mandatory training. Resuscitation training and safeguarding training was highlighted. Compliance levels for medical staff were still cause for concern, hence limited assurance for completion levels.

b) Agency spend NLAG – a reduction from c4000hrs per week to c1400hrs per week has been achieved in the first few weeks. The CIC gave reasonable assurance and thanked the teams for their hard work.

c) Group vacancy control – The CIC discussed the impact around potential delays due to the more stringent vacancy control procedure. This included a critical analysis of all workforce requirements set against a context of the Group's cost improvement programme. Reasonable assurance was received regarding the process.

d) HUTH/NLAG Freedom to Speak Up reports – the number of concerns raised had increased in both organisations, as promotion of the service had increased.

e) The main themes of concerns raised at HUTH were: general support/improvement ideas/patient safety and changes to working practices. NLAG main themes were inappropriate behaviour and patient safety. Reasonable assurance was given on these reports.

f) Care Group Development and Support – The OD Team worked with the Group Chief Operating Officer to develop a comprehensive support and development plan which was to be rolled out over the coming months Reasonable assurance was received.

g) Band 2/3 HCSW duties and job descriptions at HUTH/NLAG – the national profiles had changed and there was work ongoing with staff side to review and determine which posts needed to be graded at which level, dependent upon the requirements of the service. In addition the National Minimum Wage (NMW) had been increased and resulted in a tiny financial advantage for NHS Band 2 staff salary scale of 1p. Legal advice was taken and the Group has had to cease some deductions from gross salary to ensure that staff were not paid below the National Minimum Wage.

Reasonable Assurance was received.

h) Group Medical engagement – work is ongoing regarding the engagement, recruitment and management of medical staff and these will be aligned with the Trust Strategy once published. Reasonable assurance was received regarding the approach.

i) Group Equality Delivery System 22 report was presented to the CIC for approval. The report covered 3 domains for both organisations, Workforce Health and Wellbeing, Inclusive Leadership and Commissioned or Provided Services. The CIC approved the report which would be published on Trust websites outlining what each organisation was doing to deliver its Public Sector Equality Duty.

j) Group Job Planning
The Group Chief Medical Officer informed the Committee that initial work undertaken had highlighted the similarities and differences in approaches to Job Planning across the Group. The number of Programme Activities undertaken and the split between Direct Clinical Care and Supporting Professional Activities had been identified. Work would be ongoing to achieve a harmonised approach across the Group.

**23 May 2024**

a) HUTH CQC Actions – There are still issues with the overnight triage in maternity services but this is being monitored closely by the Teams.
b) NLAG unregistered nursing staff position was discussed and the CIC were assured that a good, robust plan was in place. The over-establishment for registered nurses for NLAG had not yet been approved which would impact on the non registered workforce position and the gaps remained. The CIC gave limited assurance until the establishment was
c) Medical Consultant vacancies were presented to the CIC. There were Certificate of Completion of Training issues which could impact on the 23 new consultants that had been recruited. A report to the next WEC CIC detailing the issues and solutions would be received in July 2024. Limited assurance was given for this item.
d) Pharmacy recruitment had been referred by the the Quality and Safety CIC. This was discussed and a plan was in place and the CIC was assured that there was safe service provision. However the mix of grades within the team meant that the service was not functioning as well as it could and the CIC deferred the item back to the Quality and Safety CIC in case any quality issues were emerging.
e) Details of agency expenditure would be incorporated into the monthly integrated performance report
f) A report on the current leadership programmes provided across the group would be presented at a future CIC meeting , followed by proposals for future leadership programmes
g) The new Group Staff Charter was reviewed and ratified by the CIC. It was agreed that this would be recommended to the Board for approval.

## 5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

a. The committees considered the areas of the BAFs for which it has oversight and has proposed the following change(s) to the risk rating or entry:

**30 April 2024**

The committee considered the areas of the BAF for which it has oversight and noted the progress being made regarding the merged Group risks.

**23 May 2024**
The CIC ratified the Q4 BAF risk ratings relating to workforce, leadership and culture.  Boards in Common approval was recommended by the CIC.

The CIC also noted the Q1 updates to the HUTH/NLAG merged risks.

## 6.0 Trust Board Action Required

a. The Trust Boards are asked to:

- Note the escalation reports from the meetings held 30 April and 23 May 2024
- Endorse the Staff Charter as recommended by the Committees in Common

***Kate Truscott, Chair of Workforce, Education and Culture CIC***

***24 May 2024***

# Staff charter

## COMPASSION

Put the safety and care of patients and colleagues at the heart of everything you do

Listen to your colleagues and patients, understand, empathise and take action to help

Treat everyone with kindness and support those who need assistance or guidance

Do the right thing, even if this is more difficult to do

## HONESTY

Take responsibility for your actions, decisions and behaviours

Report concerns about safety, quality and negative behaviours as quickly as possible

Communicate constantly and clearly at all times; create and respond to a constant loop of honest feedback

Be open about mistakes, apologise, learn and improve

## RESPECT

Trust and appreciate your colleagues say thank you and well done

Talk to everyone in a respectful and polite manner and listen when others want to speak

Understand and appreciate the perspectives, choices and beliefs of others and never discriminate against anyone

Respect and use each others' strengths; act respectfully by giving, receiving and acting on constructive feedback

## TEAMWORK

Meet regularly as a whole team, discuss goals, actions and ideas for improvement. Commit to being good team members

Include all colleagues in key discussions about the team or service

Tackle poor behaviours as they arise

Agree high professional standards as a team; give yourselves time to reflect on how to constantly improve

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)104**

| | |
|---|---|
| **Name of the Meeting** | Trust Boards-in-Common |
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Simon Nearney, Chief People Officer |
| **Contact Officer/Author** | NLAG – Liz Houchin, Freedom to Speak Up Guardian<br>HUTH – Fran Moverley, Freedom to Speak Up Guardian |
| **Title of the Report** | **Freedom to Speak Up (FTSU) Guardian Quarterly Report (Quarter 4) and Annual Report 2023/2024** |
| **Executive Summary** | Each report provides the Q4 and annual report for 2023/2024 for NLAG and HUTH respectively. Each report gives an update including an overview of the number of concerns raised, national and regional updates and the proactive work undertaken by each Freedom to Speak Up Guardian. |
| **Background Information and/or Supporting Document(s)** (if applicable) | Not applicable |
| **Prior Approval Process** | Both NLAG and HUTH reports have been submitted to the Workforce, Education and Culture Committee in Common on 30th April 2024. |
| **Financial implication(s)** (if applicable) | Not applicable |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | Not applicable |
| **Recommended action(s) required** | ☐ Approval ☐ Information<br>☐ Discussion ☐ Review<br>✓ Assurance ☐ Other – please detail below: |

**Hull University Teaching Hospitals NHS Trust**

**Freedom to Speak Up Guardian Report**

**Quarter 4 and Annual Report 2023/2024**

## 1. Purpose of the paper

This paper provides the Group Trusts Boards-in-Common (meeting held in public) with an overview of the Hull University Teaching Hospitals NHS Trust (HUTH) Freedom to Speak Up Guardian (FTSUG) activity during quarter 4 (Q4) and the annual report of the 2023/2024 financial year.

The paper further provides an update on the Trust's speaking up arrangements, including the themes of the concerns raised and the activities undertaken by the HUTH FTSUG. The paper also includes details of the ongoing joint working with the FTSUG at Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) as the Trusts create a Group leadership structure.

## 2. Introduction/background

Following the Francis Review, all organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. This role acts impartially and provides an option to raise concerns in a confidential manner. There are a number of processes at HUTH in place that allow staff to raise concerns. These include:

- Line manager or senior manager
- FTSUG
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Freedom to Speak Up Policy for the NHS (CP451)
- Staff Conflict Resolution and Professionalism in the Workplace Policy (CP269)
- Grievance Policy (CP036)
- Counter Fraud Plus (CFP) Team

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) issue guidance which sets out the expectations on healthcare professionals to take appropriate action to raise concerns about patient care, dignity and safety.

## 3. Trust contacts – Q4 (1st January 2024 to 31st March 2024)

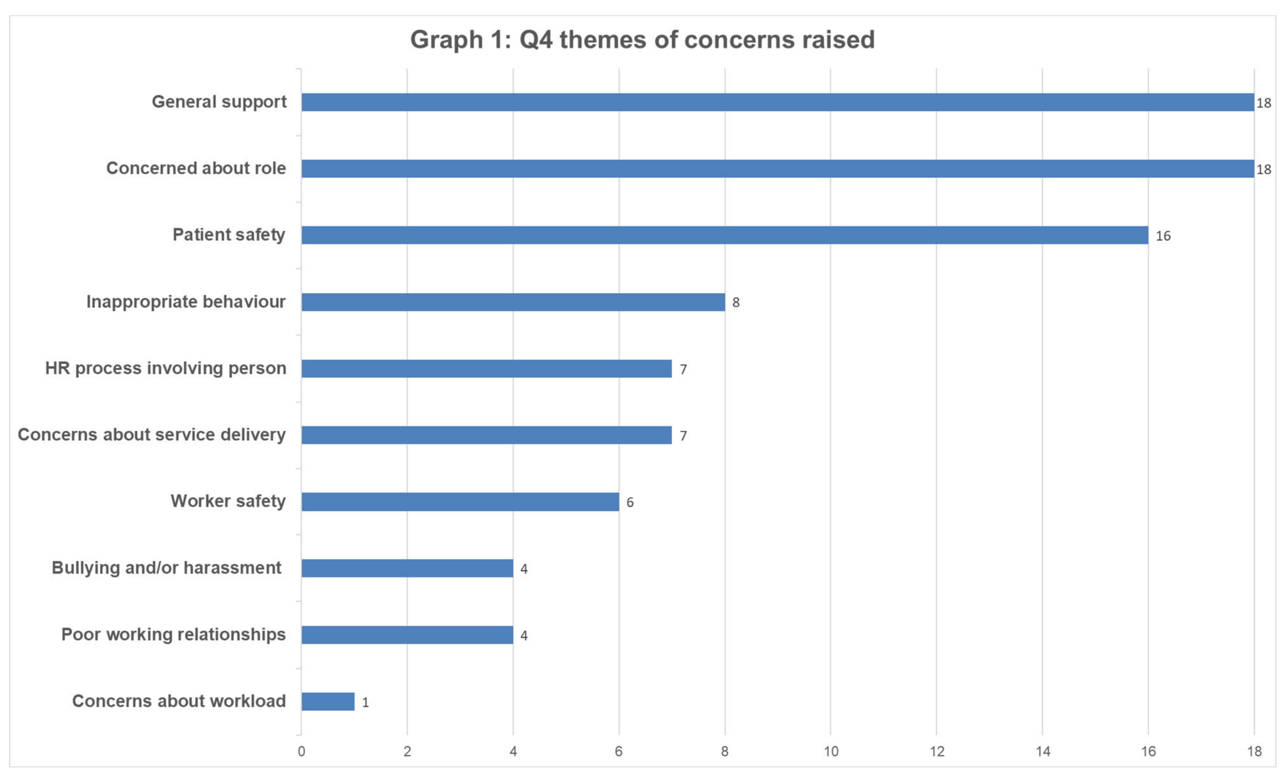
The FTSUG reports on individual contacts received from members of staff, students, trainees and volunteers, to the Trust committees including the Group Trusts Boards-in-Common, Workforce Education and Culture Committee in Common and to the Audit, Risk and Governance Committee in Common.

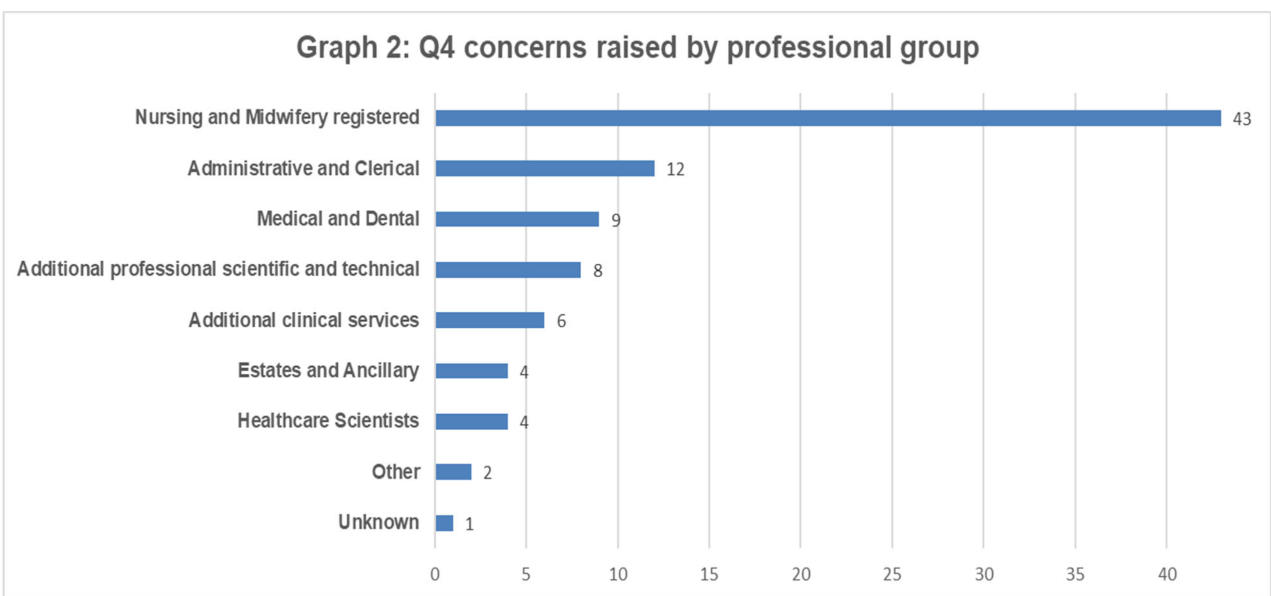
High level information, including the number of individual concerns, is also reported to the National Guardian Office (NGO) and published annually.

### 3.1 Q4 – individual contacts to the FTSUG

For the Q4 2023/2024 data:

- During Q4, 89 further individual concerns were received by the FTSUG.
- Graph 1 provides the main theme of the concerns received by the FTSUG during Q4.
- Graph 2 provides the professional group of staff making contact with the FTSUG during Q4.




### 3.2 Q4 – themes and comments

- During Q4 89 individual concerns were received by the FTSUG; the highest number reported during a quarter to the FTSUG since the role was implemented. This was a significant increase to the previous highest quarter (49 cases during Q3 2023/2024).
- Only 1 of the 89 concerns was reported anonymously to the FTSUG via a letter, which was also copied to others including the Group CEO. The Group CEO instigated an investigation into the allegations, and has kept the FTSUG updated throughout (where appropriate). The FTSUG was unable to communicate with the sender of the letter; the Group CEO included information in a Group-wide e-mail bulletin confirming the issues raised in the letter were being investigated and to encourage all staff to raise their concerns with the FTSUGs or directly with the CEO's private office.
- The highest number of reasons for staff approaching the FTSUG were jointly - general concerns (18) and concerns about an individual's role (18), followed by concerns about patient safety (16).
  - The general concerns were very varied with no specific themes and included improvement ideas and concerns about practices allegedly occurring at the Trust.

- Concerns raised about an individual's role were also varied, and in many of the cases the FTSUG gained agreement to involve the Human Resources team to assist in resolving any issues.
- Of the 16 individual's contacting the FTSUG about patient safety concerns, this represented 7 standalone concerns; the majority of which were agreed for the FTSUG to escalate to senior management for investigation. In the remaining cases, the individuals planned to raise their concerns directly.

- During Q4, the FTSUG received an increase in a number of different staff groups raising concerns including Administrative and Clerical, Additional Professional Scientific and Technical and Medical and Dental. Most notably was the significant increase in Nursing and Midwifery staff speaking up to the FTSUG; to 43 individuals (from 11 in Q3 2023/2024). The FTSUG has been working throughout the quarter with senior leaders to raise these concerns and ensure investigation and feedback is provided to the staff members.

### 3.3 Q4 - FTSUG activities

A high level summary of the activities of the FTSUG during Q4 are detailed below:

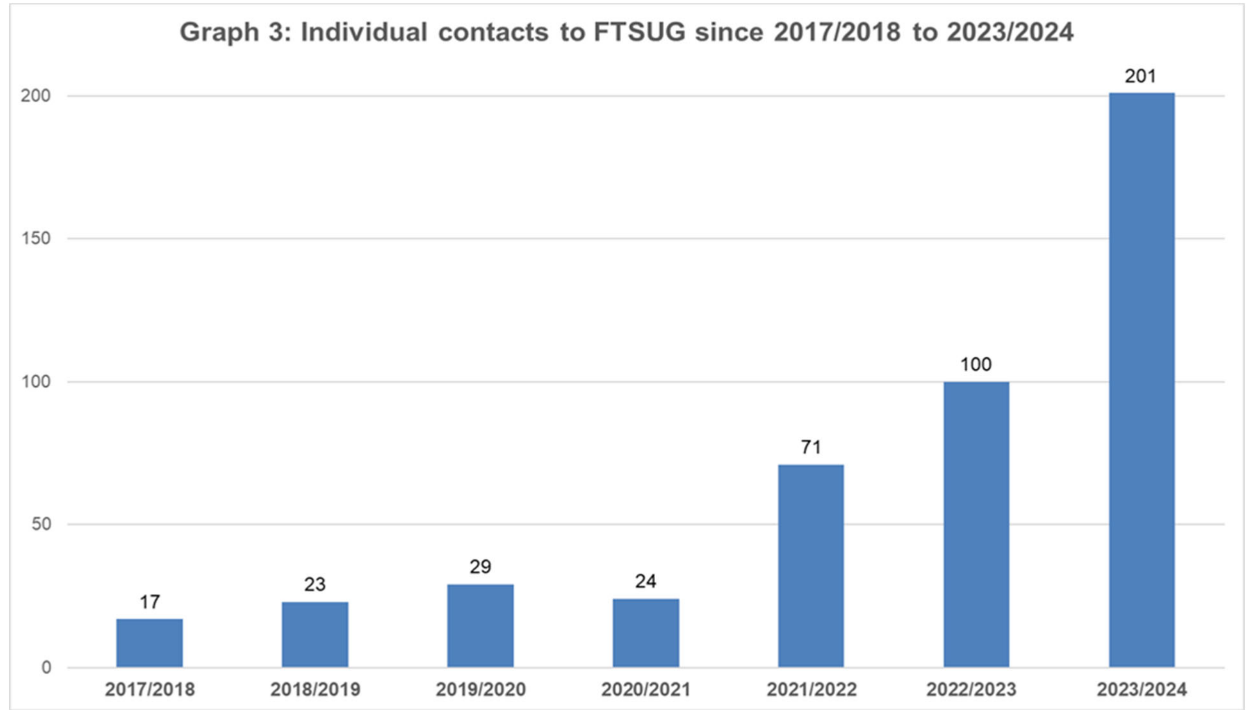
- Continued work in support of the NHS England Board Self-Reflection and planning tool action plan. A progress report against the improvement and strengths action plan is included as Appendix 1 to this report.
- The FTSUG and Group Director of Learning and Organisational Development previously identified an opportunity to provide support and supervision to the leadership teams of the HUTH Staff Networks. This is to ensure the Staff Networks are supported when dealing with individuals reaching out for support with speaking up about discrimination in relation to their protected characteristic. An initial informal discussion took place to discuss content and the first 'hot topics' session was delivered in March 2024 to discuss setting boundaries, signposting network members and to work through anonymous case studies. This offer of support has been well received and well attended by leaders in the Staff Networks.
- Presented at NHS England Quality Interventions senior leader engagement meeting an overview of trainees approaching the FSTUG and themes. The verbal feedback during the meeting recognised the positive collaborative work between the FTSUG, Guardian of Safe Working Hours and other Trust departments.
- Group partnership working – involved in the development of the NHS England sexual safety charter working with Safeguarding and HR representatives.
- Working in collaboration with the HR team to provide feedback on the development of a new exit interview for staff; in support of gathering information and learning for exiting employees.
- Involved in the launch of the new LGBTQIA+ anti-discrimination framework and becoming a member of the follow up circle group.
- Invited by the HR team to support the review of the Raising Concerns at Work (whistleblowing) policy (CP169).
- Further training of two additional Speak Up Champions in the Corporate Functions directorate.
- Presented at the HR Advisory team meeting information on the NHS England Staff Support scheme to ensure that HR colleagues are aware of the option to support staff members.
- Introductory meeting with the Guardian of Safe Working Hours to discuss cross referrals and partnership working.
- Invited by the Guardian of Safe Working Hours to present at the Junior Doctor Forum; this was positively received and the Chair has promoted the FTSUG role across all junior doctors.
- Presented jointly with the NLAG FTSUG at the Pastoral and Spiritual Care team meeting to discuss and promote partnership working.
- Conducted walk arounds with the Interim Deputy Chief Nurse on the 13$^{th}$ floor and the Neonatal Intensive Care Unit at Hull Royal Infirmary to promote speaking up and speak with staff members about any concerns.
- Attended the National Guardian Office annual conference and was able to offer the Speak Up Champions Network the opportunity to attend virtually. Positively seven Speak Up Champions registered to attend.

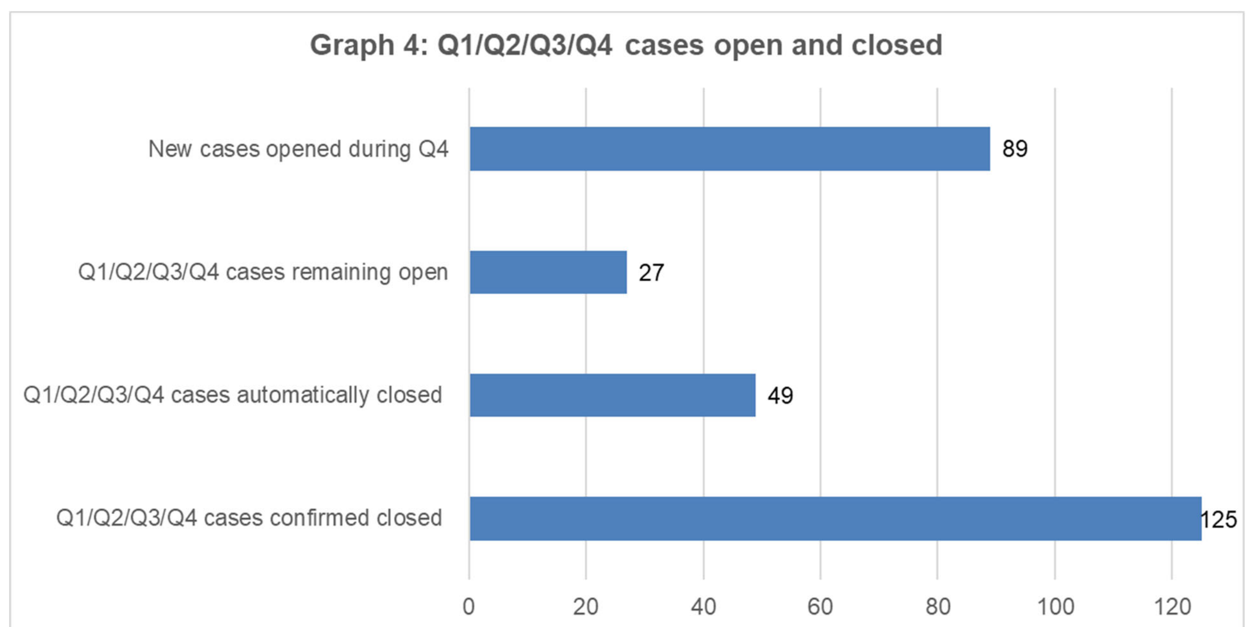
## 4. Trust contacts – annual (1st April 2023 to 31st March 2024)

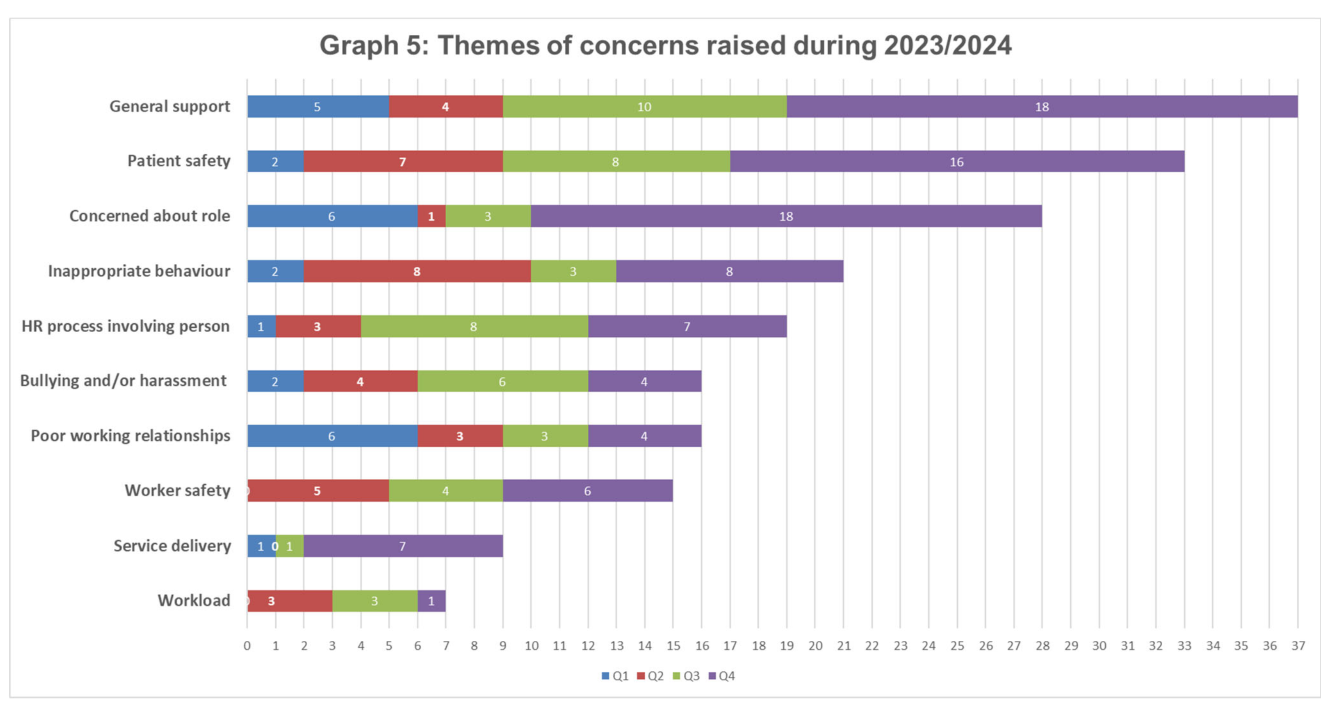
### 4.1 Annual – individual contacts to the FTSUG

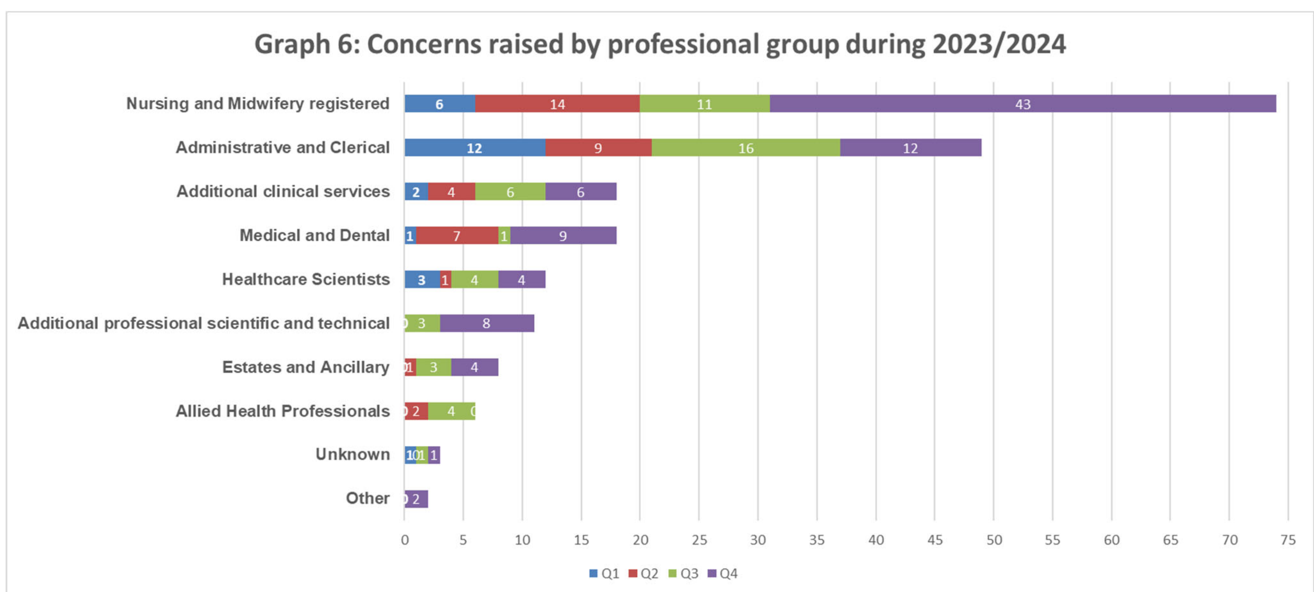
For the annual data during 2023/2024:

- Graph 3 shows the annual number of individual concerns received by the FTSUG on comparison with the annual data since 2017.
- Graph 4 summaries the total numbers of open and closed cases (data extracted at 03.06.24.).
- Graph 5 provides the annual themes of the concerns received by the FTSUG.
- Graph 6 shows the annual number of concerns per professional group of staff making contact with the FTSUG.






## 4.2 Annual – themes and comments

- The annual number of concerns raised to the FTSUG significantly increased to 201 cases, and is the highest recorded for the Trust since the introduction of the FTSUG role. This is in comparison to 100 cases in 2022/2023 and 71 in 2021/2022 (graph 3). Of the 201 cases, this reflected 179 standalone concerns. NB – the national guidance requires Trusts to report on numbers of *individuals* approaching the Guardian.
- Annually only 1.5% cases (3 in total) were reported to the FTSUG fully anonymously and the individuals did not reveal their identity to the FTSUG. It is positive that anonymous reporting remains low and can be inferred as individuals have trust in speaking with the FTSUG, even if they continue to speak up confidentially. The HUTH anonymous reporting rate is also low in comparison nationally – the 2023/2024 annual National Guardian Office report is not yet available, however in 2022/2023 nationally 9.3% of cases were completely anonymous.
- The most common reason for raising a concern was 'general support/concerns' and remains the same as 2022/2023 (graph 5) but has increased from the previous year from 21 to 37. These cases have been very varied and across different Health Groups, and often have been applicable Trust-wide. Concerns raised relating to patient safety and individual's roles have both further increased in the numbers of individuals approaching the FTSUG.

- The FTSUG has continued to work with staff members to agree how to escalate the concerns, whether the individual follows a Trust policy (e.g. grievance) or the FTSUG has escalated agreed information to senior staff for investigation.
- Staff in Nursing and Midwifery roles were the most likely to approach the FTSUG – with a significant increase from 23 (2022/2023) to 74 staff during 2023/2024. During 2023/2024 the FTSUG has worked alongside the Interim Chief Nurse and Interim Deputy Chief Nurse to promote speaking up including offering joint drop in sessions for staff and undertaking walk arounds in the clinical areas. The second most common staff group to speak up were Administrative and Clerical staff with 49 concerns; a further increase from 23 cases the previous year.
- Throughout the year in the event an individual has consented for the FTSUG to assist in escalating concerns; the FTSUG has been received positively with senior leadership, managers and the HR teams wanting to assist the individual in resolving the concerns.

**5. Additional updates**

**5.1 Regional and national information and data**

During 2023/2024 the FTSUG continues to be part of the newly formed North East and Yorkshire and the Humber regional network of FTSUGs and accesses monthly meetings to continue to share best practice and learning.

The FTSUG successfully passed the annual mandatory training from the NGO in order to continue to be registered as the Trust's FTSUG and has accessed other learning from the NGO including attending a community of practice session and the annual national conference. The FTSUG was also a participant in a focus group to improve the national guidance for speak up champions; with suggestions from the HUTH FTSUG being implemented.

**5.2 Group leadership structure**

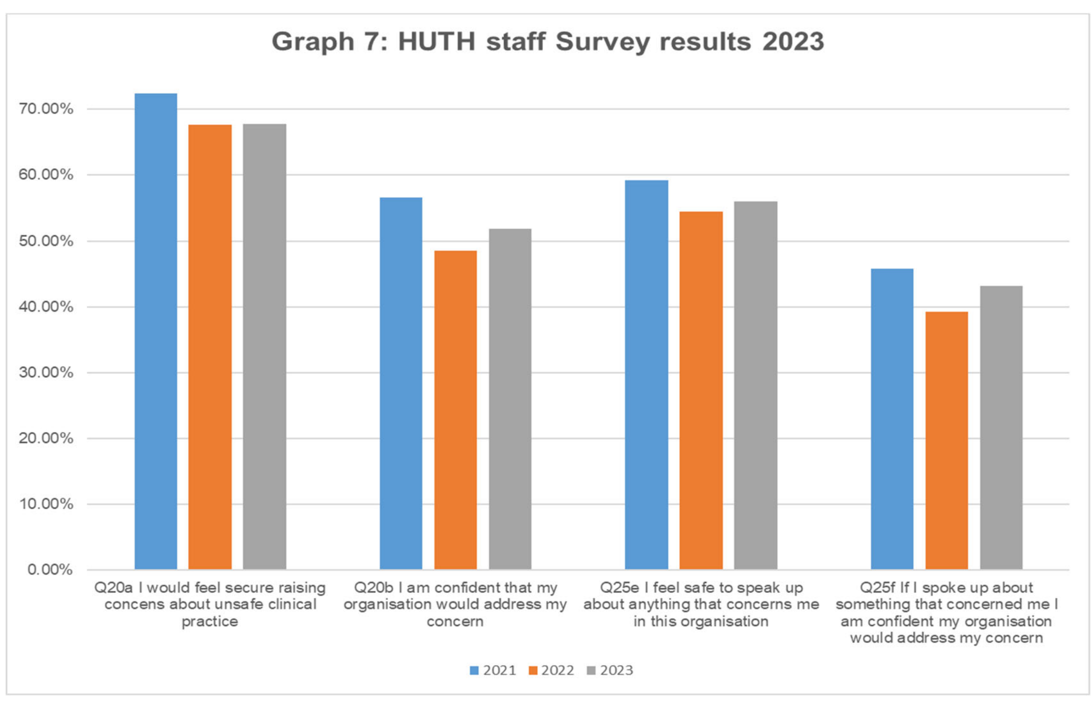
The HUTH FTSUG has an existing partnership with the NLAG FTSUG and this has continued to strengthen with the creation of the Group leadership structure. Both FTSUGs have now held two joint working sessions in January 2024 and March 2024 to discuss aligning future plans, including:

- In the areas of reporting where there is national guidance; the FTSUGs are already reporting consistently. Where there are gaps in national guidance; the FTSUGs have established there are similarities between current reporting but the FTSUGs have agreed a consistent approach to be implemented with effect from the Q1 2024/2025 reporting year and the establishment of the Care Groups. This includes minor changes to the concern codes that each FTSUG used to report the types of concerns received by staff.
- The FTSUGs have commenced working to ensure that each Trust report for Group Committees in Common is consistent and now present alongside each other.
- It was proposed to the Group Boards in Common and agreed, that a joint Group Freedom to Speak Up Strategy is created for implementation in Q2 2024/2025.
- Both FTSUGs have engaged with other FTSUGs across England who operate as a group and will be attending a roundtable focus group led by the NGO to share practices.

**5.3 Staff Survey results**

The 2023 Staff Survey included four questions that relate to staff feeling secure about speaking up and the confidence that concerns are addressed. Graph 7 below provides the 2023 results for the Trust in comparison to the 2021 and 2022 results; the results are based on the percentage of staff answering 'strongly agree' and 'agree' to each question.

The Trust scores for each question shows a slight increase from the 2022 scores, which is positive, but further improvements are required to ensure that staff feel confident to raise any concerns and that they will be listened to and issues acted upon.




## 5.4 NHS England Board Self-Reflection and planning tool update

The Board development session on 8th February 2023 discussed the self-reflection and planning tool and the resulting improvement plan and identification of strengths. A further update to this action plan is detailed in Appendix 1 of this report. The action plan has now been split into ongoing and completed actions and the Board are asked to approve the extension of eight remaining actions to enable further work to take place.

## 6. Conclusions

The Trust has continued to support the FTSUG role and it is positive that the number of individuals approaching the FTSUG continues to increase. The total number of concerns for 2023/2024 doubled to 201 which indicates an increased awareness of the FTSUG role and the willingness of staff to want to speak up about concerns and improvement ideas.

The FTSUG continues to work to build networking and relationships with key individuals and teams across the Trust and with external FTSUGs, to strengthen partnership working and sharing good practice.

The FTSUG has continued to promote speaking up arrangements at HUTH during 2023/2024, including supporting the national awareness month and offering a number of different ways that staff can contact the FTSUG.

## 7. Recommendation

The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

The Group Trusts Boards-in-Common 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.

Further to section 5.4 above, the Board are asked to approve the extension of the HUTH-specific action plan.

**Frances Moverley**
**Head of Freedom to Speak Up - HUTH**
**June 2024**

## Appendix 1: Board Self-Reflection. Summary of high-level development actions:

| ACTIONS IN PROGRESS | | | |
|---|---|---|---|
| **Development areas to address in the next 6–12 months** | **Target date** | **Action owner** | **Progress update** |
| Action 3:<br>Continually review the speak up champion network, to promote champions within different staffing groups and at different levels across the Trust. | 31/03/24<br>*Proposed extension: 31/12/24* | FTSUG | **Action in progress**<br>• Bimonthly training dates booked until end of 2023.<br>• Bimonthly training dates for 2024 are in place.<br>At 03/06/24:<br>• The Speak Up Champion Network has been expanded to 27 trained Speak Up Champions. Trust-wide email sent April 2024 promoting the training. Further 14 places booked on training in July 2024 and September 2024. Additional training date in November 2024 planned and advertised.<br>• Speak Up Champions have been mapped per Care Group and there are minor gaps with some Care Groups with no Champions. FM to discuss with senior management to recruit as widely as possible across the Trust. |
| Action 5:<br>Launch the feedback survey for staff who have spoken up to the FTSUG. To include:<br>• Consideration will be given to including a question regarding whether they experienced positives behaviours that encouraged them to speak up.<br>• 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.<br>• Monitor the feedback survey responses for information on staff subject to detriment and where possible, to understand the circumstances.<br>• A free text box if respondents are comfortable feeding back their experiences. Review the answers from the feedback survey, and include any appropriate case studies (with consent of the staff member) in future Board reports. | 31/03/23<br>*Proposed extension: 30/09/24* | FTSUG | **Action in progress**<br>• Question about whether the individual had experienced positive behaviours when speaking up considered and included in the feedback survey.<br>• Question about referral route and awareness of the FTSUG role included in the feedback survey.<br>• Free text box included in the survey to include permission to share stories of speaking up.<br>• Final amendments to the feedback survey to be made – Digital Communications team confirmed in work plan.<br>• Questions related to protected characteristics approved by Equality, Diversity and Inclusion Committee 18.01.24. Final checks in progress and feedback survey will commence.<br>At 03/06/24:<br>• Delay in survey due to further changes required (as per the National Guardian Office change in guidance), currently with the Communications Team to progress using Encapsulate to satisfy data protection requirements. Aim to launch the survey in Q2. |
| Action 6:<br>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 | 31/03/24<br>*Proposed extension: 30/11/24* | Group Director of Learning & Organisational Development | **Action in progress**<br>• Initial discussion held between Head of Organisational Development and FTSUG to discuss incorporating existing Health Education England e- |

| | | | |
|---|---|---|---|
| alongside being explicit how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbiotic way as a leader. | | | learning into line manager development.<br>• PACT embedded into all of the leadership programmes and how to speak up. Programmes will be reviewed with the move to the group leadership model but speaking up with remain with any new/revamped programmed.<br>• January 2024 - Head of Learning and Organisational Development confirmed looking at opportunities to include speaking up content in future leadership training. Requested an extension to the target date.<br>• FTSUG met with OD Facilitator to discuss including a bespoke speaking up module within the new Inclusion Academy.<br>At 03/06/24:<br>• Bitesized programmes are due to begin again in end of June 2024 and full programmed activity will begin end of October 2024 – FTUG content will be included. |
| Action 7:<br>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<br>*Proposed extension: 30/11/24* | Group Director of Learning & Organisational Development | **Action in progress**<br>• The Maternity reporting tool is now live and Cardiology is currently in progress.<br>• FTSUG a member of the new Circle Group for Maternity and is actively part of triaging and discussing any concerns raised.<br>• Cardiology incivility reporting tool launched on 10th November 2023.<br>• FTSUG continues to be involved in the monthly circle groups. |
| Action 8:<br>Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators. | 31/03/24<br>*Proposed extension: 30/11/24* | Group Director of Learning & Organisational Development | **Action in progress**<br>• Initial discussion held between Head of Organisational Development and FTSUG to discuss what indicators and data could be appropriately used for a Trust wide group.<br>• This action needs further thought as more reporting tools are made live. Zero tolerance to ableism launched October 2023 in addition to the existing zero tolerance to racism.<br>• LGBTQ+ framework and circle group are due to go live February 2024.<br>• Group Director of Learning and Organisational Development have identified a potential support/supervision need for staff network leadership teams – informal meeting to discuss further the scope of this work in February 2024.<br>At 03/06/24:<br>• Head of OD (South) now in post and has EDI and Cultural Transformation as part of their portfolio. Target date of 31st August 2024 for roll out of Zero Tolerance tools Groupwide. |
| Action 9:<br>Development of a Trust wide Professionalism and Kindness programme that supports just and speaking up culture. | 31/03/24<br>*Proposed extension: 30/11/24* | Group Director of Learning & Organisational Development | **Action in progress**<br>• PACT “Professionalism and Civility Training” launched from late August 2023 onwards, alongside a marketing campaign to allow us to reflect on how “Bad Behaviour Doesn’t Work – Time to Change”.<br>• PACT has been delivered to approximately 150 leaders and is currently on hold for a group roll out as needed. PACT is also delivered in the new |

| | | | |
|---|---|---|---|
| | | | format to all new starters and this includes a FTSUG contacts and how to report concerns.<br>• Currently on hold subject to the Group leadership structure.<br>At 03/06/24:<br>• New Values and Staff Charter now in place. Head of OD (South) has been tasked with creating the following Group Programme:<br>  ○ Civility and Respect Campaign refresh and relaunch (bad behavior doesn't work)<br>  ○ Required Learning for Leaders inc PACT<br>  ○ "What's it like to be managed by me?" and "What's it like to work with me?" style content<br>  ○ Cultural Ambassadors (NLAG have currently and scoping out group roll out)<br>  ○ Cultural Dashboard – People metrics triangulated to give an overall picture of culture in a care group or department |
| Action 13:<br>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<br>*Proposed extension: 31/12/24* | FTSUG | **Action in progress**<br>• FTSUG conducted a breakdown per Health Group of the staff survey 2022 results. Presented information within the Health Group Governance briefing reports.<br>• January 2024 – initial discussion with NLAG FTSUG to discuss best practice and different ideas for triangulation.<br>At 03/06/24:<br>• March 2024 commenced reviewing 2023 staff survey results in relation to the four speaking up questions. Trust-wide results communicated to each Health Group in the governance briefing reports.<br>• Ongoing discussions with the Workforce Intelligence team to provide data to Care Group triumvirates, in conjunction with other relevant workforce data. |
| Action 14:<br>Create a freedom to speak up strategy. To include:<br>• Inclusion of this improvement plan created by the Board self-reflection and planning tool.<br>• 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<br>*Proposed extension: 31/12/24* | FTSUG | **Action in progress**<br>• Initial work underway to develop a draft strategy; including reviewing other Trust's strategies.<br>• January 2024 – discussed with NLAG FTSUG to propose a joint Group. NLAG current strategy due for renewal August 2024.<br>At 03/06/24:<br>• In February 2024 the Board agreed to the creation of a joint Group FTSU strategy. NLAG and HUTH FTSUGs have commenced the early stages of developing a strategy. Development day planned in June 2024. |

| ACTIONS COMPLETED | | | |
|---|---|---|---|
| **Development areas to address in the next 6–12 months** | **Target date** | **Action owner** | **Progress update** |
| Action 1:<br>Scheduled assessments and review of associated improvement programmes of speaking up arrangements. | 30/06/23 | Executive Lead | **Action completed**<br>• 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. |
| Action 2:<br>Continue to grow contacts via the champions and promotion to identify themes for learning and improvement programmes. | 31/03/24 | FTSUG | **Action completed**<br>• 6 further Speak Up Champions recruited and trained during March, April, May, June and July 2023.<br>• List of local Speak Up Champions continually updated on staff intranet Pattie and bimonthly network meetings for all Champions providing peer support and development are in place.<br>• Private workspace on Pattie set up for Champions to provide a central resource for key updates and resources.<br>• Recruitment to being a Speak Up Champion continues to be promoted at local induction events e.g. internationally educated nurses, junior doctors.<br>• At 29.01.24. 24 active Speak Up Champions trained and further 4 are booked on training.<br>At 03/06/24:<br>• The Speak Up Champion Network has been expanded. Currently 27 Speak Up Champions trained, with 13 further places booked on training in July 2024 and September 2024. |
| Action 4:<br>Update the 2023 speaking up communications plan. To include:<br>• Clear messages that detriment will not be accepted or tolerated at HUTH.<br>• Communication of the new national speak up policy once ratified.<br>• Further reminders about the availability of the e-learning modules as self-managed learning.<br>• Incorporate, where possible, positive stories of speaking up. | 31/12/23 | FTSUG<br>Request communications from senior leaders. | **Action completed**<br>• New national speak up policy has been personalised and circulated to stakeholders. The Workforce Transformation Committee on 20th July 2023 was cancelled – currently seeking ratification through email approval to progress the policy.<br>• Joint drop in session with the York and Scarborough NHS Teaching Hospitals NHS Trust held for SHYPS staff took place 27th July 2023. Further dates will be scheduled to provide further opportunities to speaking up.<br>• The new Group CEO circulated communications in reflection of the recent national media coverage into the conviction of a neonatal nurse and the importance of speaking up in the NHS.<br>• Joint drop in session with the FTSUG and Chief Nurse scheduled for 31st August 2023.<br>• Attendance planned to provide a market stall to raise awareness of speaking up at the Staff Disability Network conference in October 2023. |

| | | | |
|---|---|---|---|
| | | | • Repeated communications and bulletins from the Group CEO promoting a speaking up culture at HUTH and the FTSUG role.<br>• During speak up awareness month in October 2023, a timetable of activities was promoted across the Trust including joint drop in sessions and walk arounds with the Interim Chief Nurse and FTSUG.<br>• Ad hoc communications e.g. Daily Update linked to speaking up, circulated Trust-wide.<br>• Future - 2024 Communications Plan to be developed, where possible in conjunction with the NLAG FTSUG. |
| Action 7:<br>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 | Group Director of Learning & Organisational Development | **Action in progress**<br>• The Maternity reporting tool is now live and Cardiology is currently in progress.<br>• FTSUG a member of the new Circle Group for Maternity and is actively part of triaging and discussing any concerns raised.<br>• Cardiology incivility reporting tool launched on 10th November.<br>• FTSUG continues to be involved in the monthly circle groups. |
| Action 10:<br>Implementation of the new NHS England speaking up policy. To include:<br>• Implement the new NHS England speaking-up policy before January 2024. This is also an action recorded from an audit of the speaking up service conducted during December 2022.<br>• Review the new national speak up policy template and include reference to the processes if a staff member feels subject to detriment. | 31/12/23 | FTSUG | **Action completed**<br>• National policy transferred into HUTH template and personalised.<br>• Policy could not be ratified due to Workforce Transformation Committee on 20th July 2023 being cancelled. Approval sought via email approval.<br>• Approval via email confirmed. Policy now published live on Pattie (reference CP451). |
| Action 11:<br>Involve key stakeholders (e.g. Staff Support Networks) in the consultation process of the policy. | 31/03/23 | FTSUG | **Action completed**<br>• 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. |
| Action 12:<br>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**<br>• Discussed with Head of Organisational Development the inclusion of the speak up e-learning into existing leadership development courses and future line manager training. |
| Action 13:<br>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 completed**<br>• Self-reflection and planning tool reviewed and shared with NLAG FTSUG.<br>• HUTH FTSUG has contacted other FTSUGs working in similar sized acute Trust's across the region to discuss sharing. |

| | | | |
|---|---|---|---|
| | | | • 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.<br>• HUTH results compared to NLAG. Copies of improvement plans requested from two other acute NHS trusts for comparison.<br>• Contact made with Mid Yorkshire Teaching NHS Trust and Group (Kettering General Hospital and Northampton General Hospital).<br>At 03/06/24:<br>• Reviewed the self-reflection and improvement tool from Cambridge Community Trust, previously rated as the highest in the FTSU Index. |
| Action 14:<br>Implement requesting for feedback from senior nursing staff when concerns are escalated directly by the FTSUG, as per the request of the Chief Nurse. | 31/03/23 | FTSUG | **Action completed**<br>• Ongoing feedback requested as appropriate |

## Summary of areas of strength to share and promote

| **High-level actions needed to share and promote areas of strength (focus on scores<br><br>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 completed**<br>• Self-reflection and planning tool reviewed and shared with Northern Lincolnshire and Goole NHS Foundation Trust.<br>• 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.<br>• FTSUGs at three other Trust's across the region have requested observing the training the HUTH FTSUG provides to Speak Up Champions to gather best practice ideas.<br>• HUTH FTSUG to present training videos produced at the Trust by the FTSUG at the next regional FTSUG meeting due to interest from other Trusts. |

# Freedom to Speak Up (FTSU) Guardian - Q4 Report January to March 2024

# and

# Annual Report for 2023-2024

**Liz Houchin**
**22nd April 2024**

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## 1. Executive Summary

This paper provides an update regarding NLaG activity for Q4 2023-24 (which covers the period January to March 2024) and also provides an annual update for 2023-24. Within this paper the results of the National Guardians Office publications are presented alongside NLaG information to provide national and regional comparison and context.

## 2. Strategic Objectives, Strategic Plan and Trust Priorities

This paper satisfies the Trust Strategic Objective of 'Being a good employer' and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

## 3. Introduction / Background

The paper is presented in a structured format to ensure compliance with the "Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts'' published by the National Freedom to Speak Up Guardians Office and NHS Improvement. The presentation of this information is structured in such a way that enables the FTSU Guardian to describe arrangements by which Trust staff may raise any issues, in confidence, concerning a range of different matters and to enable the Board to be assured that arrangements are in place for the proportionate and independent investigation of such matters and that appropriate follow-up action is taken.

## 4. Assessment of FTSU Concerns Raised

4.1 In Q4 2023-24 the number of concerns received were 73, thirty-two of those were closed on the same day after giving advice or signposting to other services. There were 5 concerns raised anonymously in Q4.

4.2 The total number of concerns raised in 2023-24 was 321, this will be the sixth consecutive year that the number of colleagues contacting the Guardian has risen. This could be due to several factors including an increased confidence that staff feel able to raise concerns.

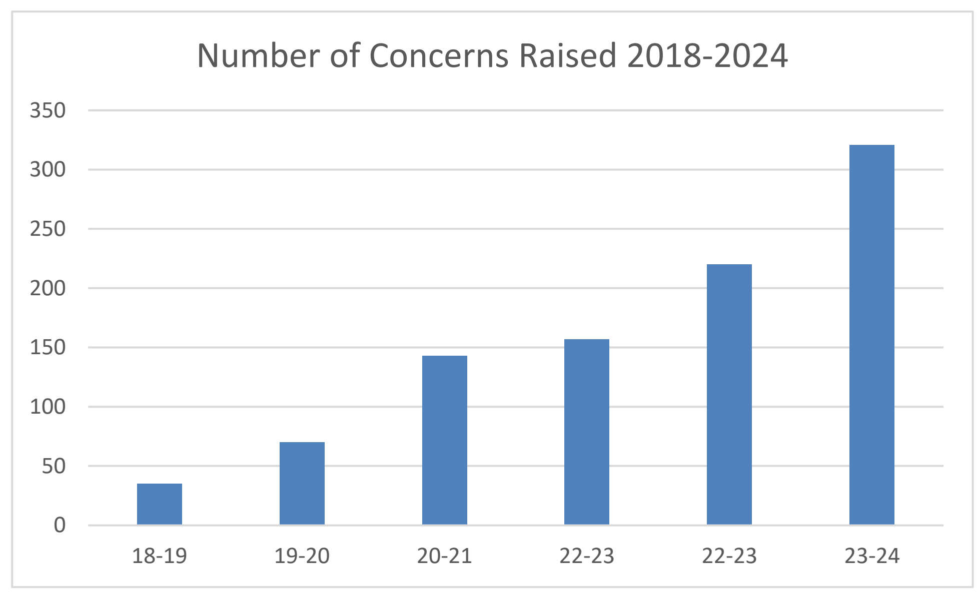
4.3 For the year 2023-24 (up to Q3), 20 concerns were raised anonymously, which is 6% compared with the national figure of 8% (Model Hospital data accessed April 2024) and is higher than previous years. This may be due to an increase in the number of concerns received via the staff app, which gives staff the opportunity to report anonymously.

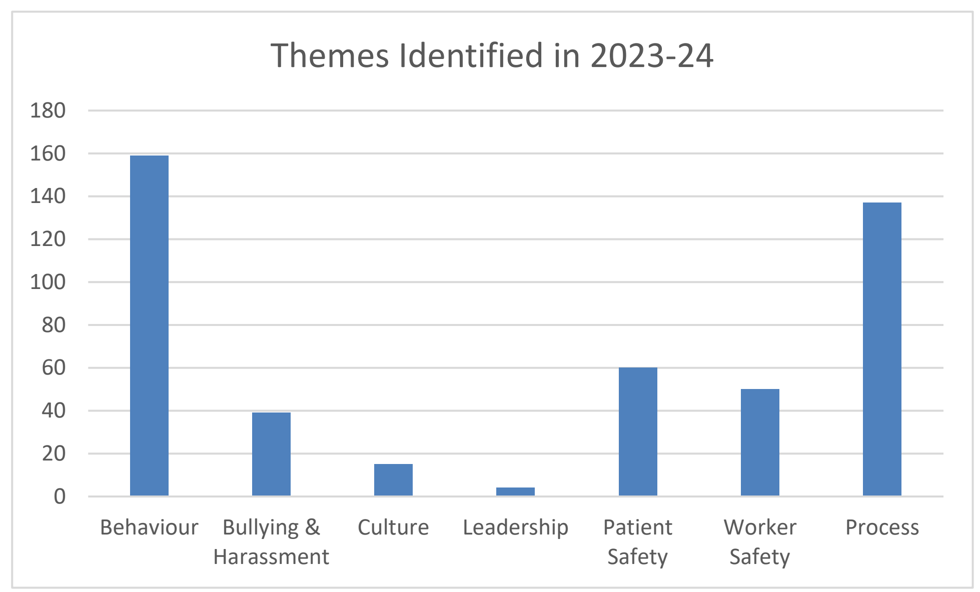
4.4 For the year 2023-24 (up to Q3), 13% of cases brought to the Guardian had an element of patient safety and is comparable with peer providers.

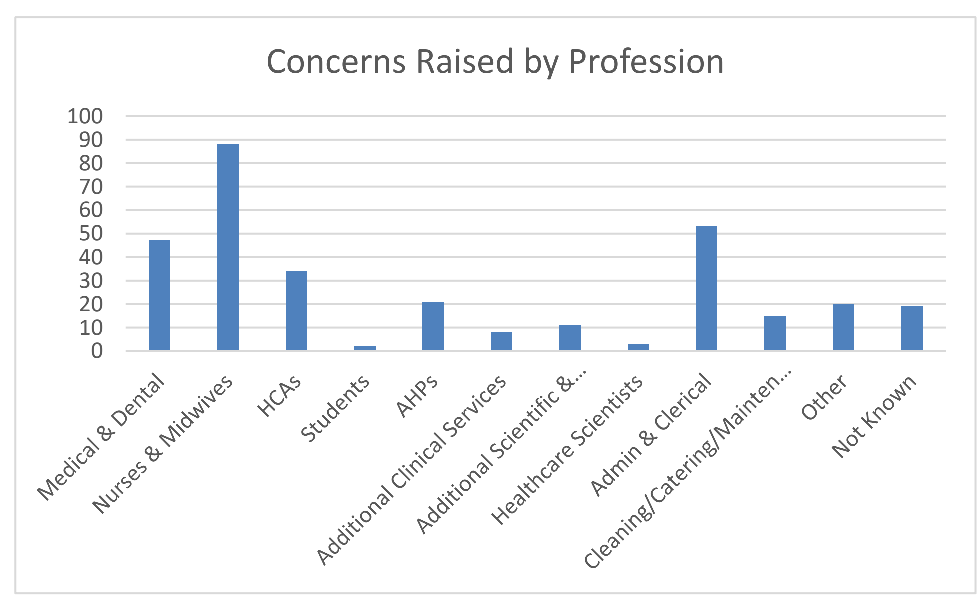
4.5 For the year 2023-24 (up to Q3), 4% of cases related to bullying and harassment, this compares to 22% against peer providers.

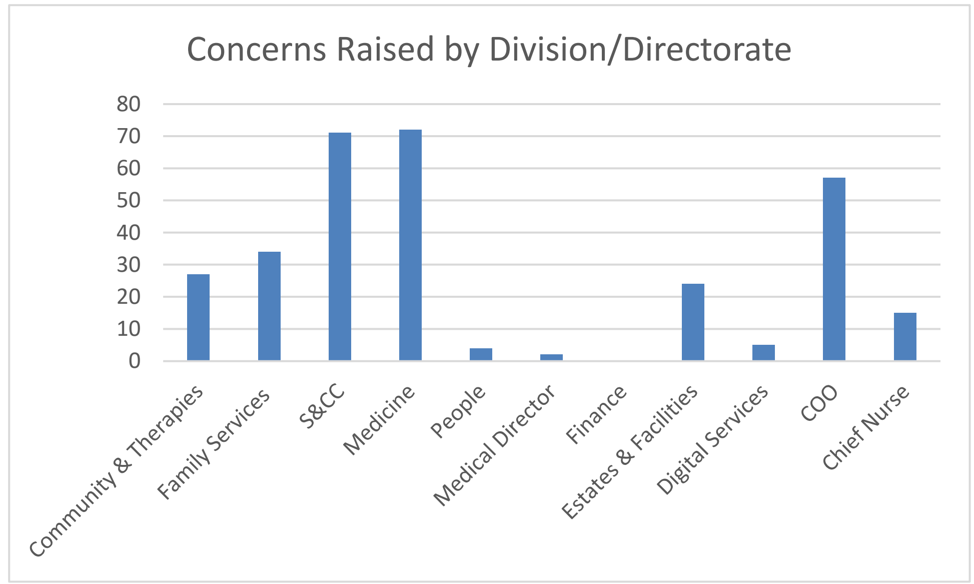
4.6 The main themes raised were around process, behaviours, worker safety and patient safety. The National Guardian Office (NGO) data indicates that 33% of cases raised nationally are linked to inappropriate behaviours, at NLaG for 2023-2024 there were 159 which is 49.5%. This is an indicator for the continuation of the culture transformation work.

4.7 The main themes raised were around process, behaviours, worker safety and patient safety. The National Guardian Office (NGO) data indicates that 33% of cases raised nationally are linked to inappropriate behaviours, at NLaG for 2023-2024 there were 159 which is 49.5%. This is an indicator for the continuation of the culture transformation work.






The diversity of different professions across all divisions contacting the FTSU Guardian, continues to demonstrate an increased awareness of the Guardian role amongst staff in the Trust.

| Area of Concern | No | Themes and Lessons Learnt |
|---|---|---|
| Behaviour | 159 | Most of these relate to behaviours that are not in line with Trust values or behaviour that is unprofessional. |
| Process | 137 | These are cases where staff were either unsure of how to proceed with a concern and needed help signposting/support to the appropriate services or around Trust policies and procedures not being followed. |

| Area of Concern | No | Themes and Lessons Learnt |
|---|---|---|
| Patient Safety | 60 | Various issues including staff levels, skill mix and impact of new systems and processes on patient safety. Each concern is looked into individually and escalated as appropriate. |

4.8 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and most concerns were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the DOP /CEO for awareness and support if required.

4.9 FTSUG Feedback /Evaluations received:

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback has been provided by staff that have spoken up and has been predominantly positive.

| 2023-24 | Feedback received | Would you speak up again? Yes |
|---|---|---|
| Total | 32 | 31 Yes 1 Maybe |

Within the feedback received, the following are extracts of qualitative feedback received:

- ***The FTSU Guardian gave me time and space to air my concerns in a very safe environment.***

- ***Liz was a fantastic person to talk to about my issues, she took the time to help me and provide encouragement when I had none about the situation. She took the concern seriously, confidentially and understood when I didn't want to put my name to the problem. I was sceptical at first due to past issues not being addressed but I can't thank Liz enough for the help she has provided. Thanks again.***

- ***I think if Liz had not personally chased up my complaint it would have been swept under the rug as they didn't respond until after Liz sent them a reminder.***

4.10 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that ‘speaking up’ can have for staff and the subsequent benefits to patient care and experience.

The FTSUG was contacted by a colleague who was leaving the organisation and wanted to complete an exit interview. FTSUG highlighted to the colleague that there was an online option (link shared) as well as asking for a face to face interview. Colleague decided to meet FTSUG as wanted to share concerns about the number of colleagues leaving the department and that face to face exit interviews were not being offered. The outcome the colleague wanted was for the management team to be aware of the numbers leaving, to look at why colleagues were leaving, and if anything could be done to retain staff. FTSUG spoke to management team to share this information.

## 5.0 Regional and National Information and Data

5.1 National update

The National Guardian's Office reported 25,382 cases were brought to Guardians in 2022-23 which is a significant increase on previous years. All FTSU Guardians must complete annual refresher training and the focus for the coming year's training (cycle starts April 2024) will be on equity, diversity, inclusion and belonging.

Q4 data for 2022-23 has been submitted to the NGO by the Guardian, with data for previous quarters checked and reconciled for accuracy.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent discussions included discussion around defining detriment, Guardian capacity and how organisations utilise FTSU Champions. The national staff survey was also discussed and how the NGO and Guardians can support organisations to increase confidence for staff to feel safe to speak up.

## 6.0 Proactive work of the FTSUG during 2023-24

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Quarterly attendance at Patient Safety Champion Meetings
- Walk round with Comms to access knowledge of Guardian role and future Comms plan
- Attendance at all network meetings

6.1 Future Plans

- Work with HUTH FTSU Guardian to develop Group FTSU Strategy.
- Continue to raise profile of the Guardian.
- Work with the Care Groups to ensure that learning from concerns is embedded into practice.

## 7.0 Indicators of Success

The NHS Staff Survey results for the following questions are an indicator of how staff feel about 'speaking up' in the Trust.

The results from the 2023 survey indicate an increase from staff in feeling able to raise concerns either about unsafe clinical practice or anything that concerns them, and an increase in confidence that the organisation would address these concerns.

| NUMBER | QUESTION | NLAG 2022 | NLAG 2023 | National average |
|---|---|---|---|---|
| | The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it? | 46% | 49% | 49% |
| | I would feel secure raising concerns about unsafe clinical practice. | 66% | 67% | 70% |
| | I am confident that my organisation would address my concern about unsafe clinical practice. | 45% | 51% | 55% |
| | I feel safe to speak up about anything that concerns me in this organisation. | 55% | 56% | 60% |
| | If I spoke up about something that concerned me, I am confident my organisation would address my concern. | 38% | 43% | 48% |
| People Promise Overview | 'We each have a voice that counts' – Raising concerns. | 6.4% | 6.5% | 6.7% |

## 8.0 Conclusion

The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

## 9.0 Recommendations

The Trust Board is asked to:

a) Note the report for assurance
b) Approve the report

Compiled By: Liz Houchin
Date: 22nd April 2024

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)105**

| **Name of Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | 13th June 2024 |
| **Director Lead** | Simon Nearney / Ivan McConnell |
| **Contact Officer / Author** | Mano Jamieson / Karl Portz / Lucy Vere / Jackie Railton |
| **Title of Report** | Equality Delivery System 2022 (EDS2022) |
| **Executive Summary** | The purpose of the report is to inform the committee of the detail of the assessment that was carried out to conduct the Hull University Teaching Hospitals NHS Trust's & Northern Lincolnshire & Goole NHS Foundation Trust's EDS 2022 for 2023/24.<br><br>The EDS 2022 in this report covers three Domains. Domain 1 (Commissioned or Provided Services) Domain 2 (Workforce Health & Wellbeing) and Domain 3 (Inclusive Leadership) all 3 were taken to April WECC though only 2 & 3 were directly for consideration by WECC. As although not directly a workforce issue, Domain 1 is also included as this contributes to the overall scoring and is still the responsibility of the Executive and Non-Executive Directors and the Chairman and Chief Executive Officer. As per national reporting guidance once approved by EMC this report will be published on both Trust websites. |
| **Background Information and/or Supporting Document(s)** (if applicable) | The EDS 2022 is the nationally mandated return that is to be published on all NHS Trusts websites and outlines what each organisation is doing to deliver its Public Sector Equality Duty |
| **Prior Approval Process** | A version of this report was considered at WECC in January 2024, however, on review of the papers it was noted that full actions plans were not visible. Equally, it was felt beneficial to re-present the report to include Domain 1 (Commissioned or Provider Services). That was done for the April WECC Committee in Common |
| **Financial Implication(s)** (if applicable) | None identified at this stage. |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | The return highlights what an NHS Trust is doing to promote EDI within the organization and how it is addressing health inequalities in the population that it serves |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

## 1. Background

The Equality Delivery System (EDS) was launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

In November 2012 there was a review of EDS and, a refreshed EDS – known as EDS2 – was made available in November 2013.

A further review has taken place, and a new EDS is to be launched soon. Officially the numbering system is being dropped but it is likely that this will, colloquially, be known as EDS2022, at least to begin with.

All NHS providers are required to implement the EDS, having been part of the NHS Standard Contract from since April 2015 (SC13.5 Equity of Access, Equality and Non-Discrimination). In addition, NHS Commissioning systems are required to demonstrate 'robust implementation' of the EDS as set out in the Oversight Framework.

## 2. The New EDS 2022

The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

The EDS comprises eleven outcomes spread across three Domains, which are:

1) Commissioned or provided services

2) Workforce health and well-being

3) Inclusive leadership.

The outcomes are evaluated, scored and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement.

The scoring system is significantly different to that used in EDS2.

## 3. Leadership

One Board, Governing Body member, senior or system leader for each organisation or partnership of organisations, should be identified as the EDS Champion who will act as the senior responsible officer, keep developments aligned and on track, and who will be held to account.

The abovementioned Champion should keep in routine contact with the relevant EDI team(s) to follow the EDS process and ensure that issues and concerns are heard and shared at Board and Committee levels promptly.

The overall responsibility for the EDS lies with the Executive Board within each organisation. This responsibility may be discharged to the EDI team/Senior Responsible Officer within the organisation, but board members retain overall responsibility.

## 4. Domain details

Domain 1: Commissioned or provided services

1A: Patients (service users) have required levels of access to the service

1B: Individual patients (service user's) health needs are met
1C: When patients (service users) use the service, they are free from harm
1D: Patients (service users) report positive experiences of the service

Domain 2: Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source
2D: Staff recommend the organisation as a place to work and receive treatment

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed
3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

**5. Annual Reporting requirement.**

EDS reviews should be carried out annually with the result of the review published on organisation websites by 28th February (or the following working day). Any justification for late publication must be provided and signed off at Board level.

Within each organisation, the planning and conduct of EDS reviews should be identified and handled as a 'project' that requires dedicated resources at the appropriate level.

EDS activity should be included in the reporting of the specific duties of the PSED in January of each year. This should include:

- The carrying out of the EDS reviews,
- recommendations, improvement plans and early impacts of the implementation of those plans
- results and progress from previous years' plans.

## NHS Equality Delivery System (EDS)

| EDS Lead | Jackie Railton/Mano Jamieson/Karl Portz | | At what level has this been completed? | |
|---|---|---|---|---|
| | | | | *List organisations |
| EDS engagement date(s) | 19/12/23 | | Individual organisation | |
| | | | Partnership* (two or more organisations) | Hull University Teaching Hospitals NHS Trust<br>Northern Lincolnshire & Goole NHS Foundation Trust |
| | | | Integrated Care System-wide* | |

| Date completed | 22/02/2024 | Month and year published | February 2024 |
|---|---|---|---|
| | | | |
| Date authorised | | Revision date | |
| | | | |

## EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

| | |
|---|---|
| **Undeveloped activity** – **organisations score out of 0** for each outcome | Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** |
| **Developing activity** – **organisations score out of 1** for each outcome | Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** |
| **Achieving activity** – **organisations score out of 2** for each outcome | Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** |
| **Excelling activity** – **organisations score out of 3** for each outcome | Those who score **33,** adding all outcome scores in all domains, are rated **Excelling** |

| | | |
|---|---|---|
| **Total NLAG scoring for all 3 Domains added together** | **15** | **Developing Activity** |
| **Total HUTH scoring for all 3 Domains added together** | **18-19** | **Developing Activity** |

## Domain 1: Commissioned or provided services (HUTH)

### Maternity – Antenatal Services

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***Domain 1: Commissioned or provided services*** | 1A: Patients (service users) have required levels of access to the service | • Direct access service available for pregnant people to self-refer either through use of a digital form or via the telephone.<br>• HUTH and Local Maternity System websites have Reachdeck software which provides translations of website content into alternative languages. It also supports people with visual impairment to view the information in a way which meets their needs or to play back via audio.<br>• Antenatal education sessions are held via face to face, individual or group learning, or via online learning programme. Face to face sessions held weekdays, evenings and weekends to make them as accessible as possible.<br>• Baby Carousel - A multi-agency event held at the Women and Children's Hospital on a monthly basis. It includes information on a range of topics, such as: Labour and birth, healthy lifestyles, infant feeding, care of the newborn, car seat safety, baby massage, prenatal and postnatal exercise, home and fire safety, safe sleeping, demonstrations of bathing and nappy changing, and more. Bookings for this event can be made online, via alternative means (as required), or patients can attend without booking.<br>• 'Ask the Midwife' service provided via Facebook, Instagram and X (formerly 'Twitter'), which offers a platform for patients and service users to ask non-urgent questions about birthing, pregnancy and care of the newborn.<br>• Guide for pregnant people from ethnic minorities developed via LMS and circulated to the Humber All Nations Alliance.<br>• Targeted work with migrant workers at Cranswick Foods including making available a pregnancy package for the workers.<br>• Information leaflet available to Trans and Non-binary people.<br>• Service works closely with City Healthcare Partnership regarding migrant population accessing health care.<br>• Work undertaken with Hull Sisters - a charity working with women who are uncomfortable using mainstream services, a source of confidential support to help Black and minority women feel safe, confident, and part of their community. | 1-2 | Head of Midwifery |

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| | | • Utilisation of technology e.g. videos on website to visualise the maternity unit; use of virtual reality headsets to get prior experience of hospital environment and equipment.<br>• One to one discussions and visits arranged for people who are neuro-diverse<br>• Access to perinatal mental health team and development of strategies<br>• Surrogacy pathway in place.<br>• The Parent Education midwife has taken posters in 15 different languages to be displayed in posters and pharmacies around the city, in areas with BAME communities. These posters offer guidance on the monitoring of foetal movements, and how to access services if required.<br>• Following feedback from service users that had experienced previous baby loss, service users are now able to access 1:1 sessions, or sessions as a small group. | | |
| | 1B: Individual patients (service users) health needs are met | • Feedback is regularly received from patients and service users, through a variety of means:<br>  • Discussions held directly with patients<br>  • Surveys held within the service<br>  • PALS/ complaints<br>  • Healthwatch<br>  • Maternity and Neonatal Voices Partnership<br>  • Local Maternity Service Choice and Personalised Care Working Group<br>• Feedback from these areas informs the service development.<br>• Healthwatch colleagues advised that main issues raised with them relate to postnatal care e.g. breastfeeding support and mental health support.<br>• HUTH previously part of NHSE pilot project regarding perinatal mental health. Feedback was that was very successful. One year's funding from ICS, however funding discontinued at end of pilot as not a key priority for the ICS. Pregnancy people have access to other mental health service provision within the system. | 1-2 | Head of Midwifery |
| | 1C: When patients (service users) use the service, they are free from harm | • Maternity Incident reviews are held three times per week.<br>• MDT has oversight of themes/trends and ongoing actions.<br>• MTAC – chaired by interim chief nurse – assurance committee with oversight of CDC actions.<br>• Action taken to separate planned and unplanned care in the Antenatal Day Unit. Antenatal triage established. Review underway to see if needs to be extended to cover 24/7 (labour ward provides triage out of hours), | 2 | Head of Midwifery |

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| | | • Live dashboard available which shows how many pregnant people are waiting to be seen, waiting times, etc. Positive feedback from patients in terms of reduced waiting times. | | |
| | 1D: Patients (service users) report positive experiences of the service | • Feedback is regularly received from patients and service users, through a variety of means:<br>• Discussions held directly with patients<br>• Surveys held within the service<br>• PALS/ complaints<br>• Healthwatch<br>• Maternity and Neonatal Voices Partnership<br>• Local Maternity Service Choice and Personalised Care Working Group<br>• Feedback from these areas informs the service development.<br>• Friends and Family Test – 91.68% of those who responded, reported a positive experience. Negatives reported related to staff attitude, environment and communication. Organisational development work underway. Changes made to antenatal triage and planned care in ADU.<br>• The Fifteen Steps initiative has been undertaken twice and a further iteration is planned for March 2024 with Maternity Voice Partnership representatives to look at key areas for improvement.<br>• Recognition of need to increase patient engagement opportunities and obtain feedback on different parts of the maternity journey.<br>• CQC Maternity Survey 2022 – antenatal care results showed further work required in respect of provision of information to service users, including choice of place of birth. | 1 | Head of Midwifery |
| **Domain 1: Commissioned or provided services overall rating** | | | 5-7 | |

## Domain 1: Commissioned or provided services (NLAG)
## Maternity – Antenatal Services

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| *Domain 1: Commissioned or provided services* | 1A: Patients (service users) have required levels of access to the service | **Referral**<br>• Service users can self-refer into the Maternity Services by phone directly at all sites DPOW/SGH/Goole<br><br>**Antenatal Education**<br>**North Lincs(LN)**<br>• Antenatal classes are offered at Goole, Brigg, Epworth, Ashby, via Teams or face to face.<br>• 1-2 hours, monthly in Town , Brigg / Epworth every 8 weeks.<br>• This is discussed at Antenatal appointments to remind women to access.<br>• Midwifery Support Worker (MSW) offer 1:1 care in the home or at the requested venue for vulnerable families.<br>• Work alongside 0-19 Service to deliver this.<br>• Peer Supporters offer groups and deliver sessions on Infant Feeding within the Family Hubs too at various venues.<br>**North East Lincs (NEL)**<br>• Antenatal education is offered at the booking appointment and re visited at other appointments to remind users of access.<br>• Posters are in the AN clinic and in all the Family Hubs to raise the profile.<br>• Also advertised on Maternity Facebook page / Webpage<br>• Information in Booking information pack is also offered.<br>• Booked via telephone.<br>• There are group sessions / face to face every 2 weeks at alternate venues. I week is labour and delivery and the other week delivered by the MSW doing practical aspects including feeding, safe sleeping.<br>• Sessions are 2 hours long and offered on different days. Partner or other can attend too.<br>• Louth Hospital offer a session monthly. 2 hours long - alternate weeks covering labour and delivery and then practical aspects. | 2 | Nicola Foster |

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| | | • Infant Feeding classes are offered at a weekend every month for 2 hours if necessary, as some of these women are from out of town.<br>• Local Maternity and Neonatal System (LMNS)<br>• Labour and delivery session for Teenagers once a month including a tour of the unit by the Teenage Pregnancy Link Midwife are also available.<br>• Perinatal Health Midwife also offers one to one session and tour of the unit to meet individual needs.<br>• The Bereavement Midwife also provides 1-1 sessions on labour and delivery etc including a tour to meet individual needs.<br>• MSW also offer 1-1 sessions to those more vulnerable or with complex needs in the home or at a designated venue ie Family Hub<br>• Individual sessions for those whose non-English speaking users - using the interpreter services (by telephone, face to face or videolink)to ensure that their needs are met. This includes BSL.<br>• Also have access to LMNS Ask the Midwife sessions for any non -urgent questions.<br>• The Local Maternity and Neonatal System (LMNS) also offer information on services on their dedicated website (in different languages) | | |
| | | • There is Language Line/ video interpreters, face to face interpreter to offer support to those users whose first language is not English or having issues with communication (including BSL)<br>• Leaflets are available on different subjects in various languages to meet individual needs to access Antenatal education.<br>• There are various services in the community for non-English speaking women and they can access support.<br>• Working alongside Family Hubs, support offered or Non -English speaking families, will support with housing, benefits, food vouchers. Access to Bluedoor (DV) 'We Are With You' (drug support service) health visiting support. Family liaison officers and any further social support required.<br><br>**NL**<br>• The Forge – offer support re homelessness, sofa surfing, alcoholics, drug dependency support.<br>**NELincs** | 2 | Nicola Foster |

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<td>• Access to YMCA/ ‘Doorstep’ offer support re housing and other support re benefits to meet individual needs.<br>• NL & NE Lincs have a ‘We Are With You’ drug misuse support service.<br>• Women’s Refuge offer help to those suffering any form of abuse.<br>• Children’s Social care support with individual pathways of support pre-birth and ensure Early Help is in place where needed.<br>• Perinatal Mental Health support offer leaflets in various languages and face to face support and use interpretation services as required for those users who need additional communication.<br>• Holistic maternal healthy weight and healthy lives programme Trust wide.<br><br>NL –<br>• Parent and Infant Emotional Wellbeing team (PIEW) will work with a family antenatally or postnatally up to the age of 2 years. Any concerns relating to bonding and attachment/relationship with the child is supported. Also, users who are high risk for having issues with bonding and attachment. Also, mild to moderate mental health issues for parents can be referred through.<br>• Women’s Refuge offer help to those suffering any form of abuse.<br>• Children’s Social care support with individual pathways of support pre-birth and ensure Early Help is in place where needed.<br>• Learning Disability Team within the Trust is available to offer support to those with learning issues or other complex needs.<br>• Weight Management support is also available for those users with a high BMI to help them feel included and can offer support re feeding etc.<br>• Smoking Cessation services are available in various venues where the midwives are to be able to offer support not just in relation to smoking but other individual aspects and know where to refer on to. They can offer information in relation to the impact of smoking not just in pregnancy but within the home and risks like Sudden Infant Death Syndrome. They offer support to other family members too.<br>• Ask the Midwife is also available to offer non-urgent support or can sign post as necessary.<br>• NLAG Facebook page is available to offer up to date information and highlight changes such as visiting etc.<br>• Deaf / blind assistance, sign language etc. is also available.</td>
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| | | • There is a new guideline for non- binary users, so they don't feel excluded from services and their individual needs are met.<br>• MSW offer 1:1 support for more vulnerable families as required, offer antenatal education including practical skills feeding safe sleeping routine as well as hand holding etc. to other groups.<br>• Access to Rainbow clinic / Bereavement Midwife who will see the family in either a clinic setting or home dependant on need and use relevant translation services as required.<br>• Religious needs identified and supported. Maternity services and chaplaincy team work in partnership.<br>• Infant feeding support is available in the hospital and in the community as required.<br>• There is an in house Frenulotomy clinic available to support mothers who are having issues with feeding due to Tongue Tie.<br>• Access to interpretation services as necessary to ensure all the needs of families are met.<br>• Feedback- discussion with the users provide relevant information to improve services where changes can be made.<br>• Family and friends test offer feedback.<br>• Evaluation forms from Ante natal sessions and feeding classes offer relevant ways to improve delivery and shape services.<br>• Surveys – CQC , Picker (action plan coproduced with maternity services and MNVP lead), Teenage Pregnancy -Maternity Survey all offer opportunities for users to inform of the care they received and what was positive or negative so these issues can be addressed as necessary.<br>• 15 steps programme.<br>• PALS / complaints/ compliments offer feedback so needs can be discussed and met as required.<br>• Maternity and Neonatal Voices Partnership (MNVP) offer feedback from patients and involve them in leaflet production / Guideline development to shape the services to meet user need. MNVP undertaking specific service user surveys (e.g. Triage service)<br>• Posters / Displays in Family Hubs /AN clinic settings provide relevant information on aspects like safe sleeping / infant feeding so users can access support. | | |

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| | | • Media within the Family Hubs promote feeding / safe sleeping etc for users to see while awaiting appointments. .<br>• LMNS Website is available for information locally and users can access to find more information on various aspects of the Maternity and Neonatal services.<br>• Personalised Care and support plans (PCSP) in use. | | |
| | | • Incident reporting is encouraged and near misses too are followed up and fed back to those involved to close the loop.<br>• Incident review meetings are held weekly to address issues in a timely manner and report any significant issues so they can be monitored or addressed appropriately.<br>• There is a robust Governance system in place and any changes to guidelines and leaflets are approved. MDT and service user involvement (including MNVP)<br>• Maternity Triage Service is now in place using a red / amber / green flag to ensure women are seen appropriately and in a timely manner (BSOTS prioritisation)<br>• This is audited and monitored to ensure targets are being met and safety maintained.<br>• Risk assessments are undertaken to prioritise care<br>• There is robust preceptorship, care camp and supernumerary period in place to support newly qualified Midwives and International Midwives.<br>• There is close working with the University to offer support for the midwifery students during training. Close links in place with university and maternity service leads.<br>• CQC report – action plan in place and monitored regularly.<br>• There are regular monthly Divisional Quality Improvement and Monitoring meetings where all action plans are presented and actions monitored.<br>• There are local (Maternity Services Risk Management Framework) and Trustwide Risk Management Policy – identifies potential risks and sets out staff responsibilities and the appropriate processes for identifying and reporting potential risks. This policy also details the current reporting arrangements within the organisation for all risks.<br>• Training sessions re Risk Management and Incident Reporting are discussed on the Mandatory training days. | 2 | Nicola Foster |

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| | | • Patient Safety Newsletter is shared with staff with any relevant information of note.<br>• Safety Huddles take place at shift handover to disseminate information.<br>• Learning Lessons Newsletter is also shared with staff.<br>• Up2Date- electronic access for all staff to all newsletters, learning (Trust, National and LMNS)<br>• Perinatal Mortality Review Tool (PMRT) newsletter shared with all staff.<br>• All areas have their own ways of sharing information to staff via media sources in house or have regular team meetings. .<br>• Women are supported following complex cases or unexpected outcomes with a debrief.<br>• Staff support offered following complex cases/poor outcomes by hot/cold debriefs and support from managers and Professional Midwifery Advocates (PMA)<br>• Services are open and transparent and discussed with the women and her family and follow ups arranged for after care.<br>• Antenatal checks follow ups /DNA for scans / Screening etc. are all followed up in a timely manner, as per policy, so no harm becomes of these missed opportunities of care.<br>• Vaccinations and information e.g. Flu, Whooping Cough, MMR encouraged.<br>• Safeguarding - Midwives attend Case Conferences core groups and feedback any significant harm that could occur to the user or staff. | | |
| | | • Positive PALS feedback information is shared widely.<br>• Family and Friends share any relevant feed back<br>• MNVP offer positive feedback and services can be developed were applicable.<br>• Feedback via Ask the Midwife service shows this a well accessed service and women are positive about having this available to them.<br>• Positive feedback via NLAG Maternity Facebook<br>• Feedback from Users of the service are always sought via a range of sources:<br>• Evaluation Forms<br>• Surveys<br>• BFI Audits and feedback as part of the assessment process determine future services etc. | 1 | Nicola Foster |

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| | | • Cards and messages are received in all clinical areas and community services.<br>• LMNS – Choice and Personalised care focus group. | | |
| **Domain 1: Commissioned or provided services overall rating** | | | 7 | |

Domain 1: Commissioned or provided services (HUTH)
Tobacco Cessation Service

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| *Domain 1: Commissioned or provided services* | 1A: Patients (service users) have required levels of access to the service | • Patients are identified as smokers during the course of receiving inpatient treatment in the hospital, and are referred to the Tobacco Dependency Team on an 'opt out' basis.<br>• All relevant Maternity patients are referred on an 'opt out' basis. These patients are then provided with Nicotine Replacement Therapy throughout pregnancy.<br>• Support is also offered to partners and significant family members of patients (e.g. those accompanying patients to appointments).<br>• The Tobacco Dependency Service now engage directly with members of the public smoking on hospital sites, and are offered to swap cigarettes for a vape.<br>• Communication and other issues are resolved as per ward processes<br>• Mandatory question as part of admission questionnaire should capture any communication needs.<br>• Clinics held in areas of deprivation, local businesses, homeless, migrant workers, local Mosque.<br>• As of January 2024, a total of 2870 patients have received interventions from the Tobacco Dependency Team. This includes:<br>  • 465 maternity patients and significant others<br>  • 1065 inpatients<br>  • 1447 interventions by the engagement team outside of HRI (service began in October 2023).<br>• 72.3% of patients came from Quintile 1 (most deprived)<br>• 15.4% of patients came from Quintile 2<br>• 7.7% of patients came from Quintile 3<br>• 4.6% of patients came from Quintile 4<br>• 0 patients came from Quintile 5 (least deprived)<br>• Data published by NHSE shows that in April – September 2023, a total of 662 people from Hull set a quit date, with 428 self-reporting as having successfully quit after 4 weeks. Of those patients that set a quit date: | 3 | Tobacco Dependency Team Leader |

| | | | | |
|---|---|---|---|---|
| | | • 97% were of White ethnicity<br>• 0.5% were of Asian or Asian British ethnicity<br>• 0.8% were of mixed ethnicity<br>• 2% were of 'other' ethnicity.<br>• Insufficient data relating to uptake by protected characteristics. | | |
| | 1B: Individual patients (service users) health needs are met | • On admission, clinicians are able to offer a choice of Nicotine Replacement Therapies including patches, inhalers or lozenges, all of which can be used on the hospital ward.<br>• For patients remaining in the hospital for more than 24 hours, the patient will receive a visit from a Tobacco Dependency Treatment Advisor, who will provide behavioural support to the patient, and a medication plan to manage withdrawal symptoms.<br>• These steps enable patients to remain smoke free whilst in the hospital, which can be continued upon discharge for those wishing to quit.<br>• Health benefits to patients that successfully quit smoking:<br>• Improved physical health (including lung function, circulation, and senses of taste and smell)<br>• Reduced long-term risks of cancer, lung disease, heart disease and stroke<br>• Early data shows that approximately 32.5% of inpatients referred whilst in hospital set a quit date and went on to successfully quit smoking upon discharge. | 2 | Tobacco Dependency Team Leader |
| | 1C: When patients (service users) use the service, they are free from harm | • Risk Management Policy and processes in place.<br>• The Tobacco Dependency Team provide a harm reduction service to patients, in line with the NHS Long Term plan, and Government ambitions to achieve a smoke free generation by 2030.<br>• The service provides advice, behavioural support, and the offer of free Nicotine Replacement Therapy to enable patients to abstain from smoking during their hospital stay. Patients are also encouraged and supported to remain smoke free upon discharge, where requested.<br>• As such, there are minimal risks of patient harm as a result of using this service. | 2 | Tobacco Dependency Team Leader |

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| | | • Patients that have received services from the Tobacco Dependency Treatment Team are asked to provide feedback on their experience of the service, previous experience in quitting smoking, and future intentions on remaining smoke free. These comments are collated by the ICB, and are provided to the service on a regular basis.<br>• Patients also provide feedback directly to the team during their engagement activities on the grounds of the hospital sites.<br>• Feedback received so far has been positive regarding the manner of the staff, the support options available, and the opportunity that the Tobacco Dependency Team provide for patients to try various types of Nicotine Replacement Therapy, which often results in patients continuing to abstain beyond the duration of their inpatient stay.<br>• Some patients have been contacted following their smoke free journey and will be attending Parliament to share their stories, and to potentially influence future national policy.<br>• Patients have shared positive stories of the financial benefits of stopping smoking, e.g. financial savings, ability to afford holidays. | 3 | Tobacco Dependency Team Leader |
| | | | 10 | |

# Domain 1: Commissioned or provided services (NLAG)

## Tobacco Cessation Service

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| *Domain 1: Commissioned or provided services* | 1A: Patients (service users) have required levels of access to the service | The NLaG Long Term Plan Tobacco Dependency Service is split into 2 areas. These are for smokers in maternity and acute admission. Currently, the NLaG team are the best performing service in the region for both areas. Regarding access:<br><br>Maternity<br>All smokers who are pregnant are referred directly to the Team at booking. There are several options for the smoker including face to face and remote behavioural support with access to Nicotine replacement therapy (NRT). If there are travel issues, the smoker can be referred to their closest pharmacy or community wellbeing services. We work closely with these services to make this transition as smooth as possible. If a pregnant smoker chooses not to give up smoking, they will have several opportunities to change their minds when receiving their maternity care. Midwives will routinely check at scans and other tests and will refer back to our Team appropriately. Pregnant smokers who do not wish to quit smoking tobacco will be offered free vapes to restrict the potential harm to the baby. Their partners are also offered the same level of support as they are crucial to the pregnant smoker quitting.<br><br>Future<br>An incentive scheme has been planned at NLaG pregnant smokers from routine and manual and BAME groups will be given vouchers to support their quit attempt and verified by a carbon monoxide test to indicate smoking status.<br><br>Acute Admissions<br>All patients admitted to NLaG either on assessment units or wards have their smoking status checked. If they smoke, they are offered Tobacco Dependency support. Our Team will engage them while inpatients with behavioural support and NRT. When they are discharged, the Team organise referrals to either the community wellbeing service or participating pharmacy based on the preferred | 2 | Kaylee Hopwood/ Gary Burroughs |

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| | | choice of the patients. On agreement, the patients are also followed up by the Team to make sure they are provided with the optimum service support.<br><br>Future<br>Respiratory patients who smoke will be offered bespoke Tobacco Dependency support via Consultant/Specialist Nurse clinics by a dedicated Tobacco Dependency Advisor. We are looking at this service being established at DPOW in Feb 2024 and SGH and Goole in March 2024.<br><br>While not part of the Long Term Plan (Tobacco Dependency). The team provide Tobacco Dependency support for all patients who smoke that have been assessed for a Targeted Lung Health Check Scan. This has gone very well. As above this is fully inclusive and the service is as convenient as possible to the patient. Uptake is currently 97% | | |
| | 1B: Individual patients (service users) health needs are met | The main health needs for this service are co-morbidities related to smoking and these are being met. We also link to other Long Term Plan services such as the Alcohol Care Team. We also link to community wellbeing services to support wider health needs such as weight management, obesity, diet, mental health and finance.<br><br>We also have referral relationships with Primary Care and PCN staff such as Social Prescriber Link Workers, Mental Health Workers and Health and Wellbeing Champions where there is a benefit to the patient. | 2 | Kaylee Hopwood/ Gary Burroughs |
| | 1C: When patients (service users) use the service, they are free from harm | We follow strict Trust policies and protocols that protect all service users from harm. Support is provided that is as convenient and cost effective for the patient so we will endeavour to mitigate any cost or inconvenience to service users. There are options on where the service user can be seen such as a remote offer, in their GP practice, at their nearest pharmacist or at the Hospital or Targeted Lung Health Check scanning vehicle. We also offer a range of different day/time options including evenings and weekends where these are better for service users. | 2 | Kaylee Hopwood/ Gary Burroughs |
| | 1D: Patients (service users) report positive experiences of the service | We are currently pulling together patient/service user experience reports and are also providing case studies for NHS England. Service user feedback is routinely collected and the generally feeling is that this is very positive. Particularly from service users who have quit. Any feedback that is received | 3 | Kaylee Hopwood/ Gary Burroughs |

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| | | raising awareness of the quality of care received would be used to improve the service provided. | | |
| **Domain 1: Commissioned or provided services overall rating** | | | 9 | |

## Domain 1: Commissioned or provided services (HUTH)
## Abdominal Aortic Aneurysm (AAA) Screening Service

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| *Domain 1: Commissioned or provided services* | 1A: Patients (service users) have required levels of access to the service | • The AAA Screening service invites all eligible patients for screening, i.e. men aged 65 years. Individual needs are accommodated e.g. longer appointments for those with communication or information support needs, use of aids e.g. hoists, interpreter and translation services including British Sign Language. Services provided in localities, also prison services. Also offered to individuals that have undergone male to female gender reassignment who will retain a genetic predisposition to AAA.<br>• The service carries out screening from 36 locations including hospitals and local practices, covering:<br>  • Hull<br>  • East Riding of Yorkshire<br>  • Areas of:<br>    • Harrogate and Rural District<br>    • North East Lincolnshire<br>    • North Lincolnshire<br>    • Scarborough and Ryedale<br>    • Vale of York<br>• Clinics are held regularly, on a monthly or quarterly basis (dependent on demand). This ensures that patients are able to access screening services at a location that is near to them.<br>• The geographic spread of venues is limited in some areas, and there is competition for these facilities, due to the increasing number of services offered out in the community. This has been raised by the ICB and is under constant review. | 2 | AAA Screening Programme Manager |

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| | | • The service's current priority is in addressing the screening backlog, which is primarily affecting patients coming for a first screen (rather than a surveillance screen). Anticipated that backlog will be resolved Q1 24/25.<br>• Intentions to renew work with the traveller community once backlog is addressed.<br>• 'If you don't speak English' form is sent out to patients with their initial invitation for screening.<br>• The service regularly make changes to an individual's appointments in order to improve their access to the service (e.g. moving appointments to enable the use of Patient Transport Service, or changing the time to ensure that patients can use bus passes).<br>• All screening venues have disabled parking and rooms, height adjustable beds and sufficient space to manoeuvre wheelchairs/mobility scooter<br>• Easy read and audio versions of the information leaflet are available. BSL translators available to attend screening clinics. Pre-screening visits are offered to enable patients to familiarise themselves with the room and equipment, to reduce anxiety during the actual screening appointment.<br>• Utilisation of Browsealoud on local AAA website, enabling patients to access information in a more accessible format, or alternative languages<br>• 'One stop' clinics where patients without capacity to consent are able to attend with advocates to hold a best interests meeting, with immediate access to screening (where appropriate).<br>• Patient letters encourage patients to get in touch regarding any specific requirements (e.g. longer appointment slots)<br>• Outreach work via Humber All Nations Alliance (HANA), who have added an advert for the screening service to their website<br>• The service have collaborated with the Trust LGBT Support Group to identify suitable actions to support this patient group | | |
| | 1B: Individual patients (service users) health needs are met | • The mobility needs of patients are met through the provision of ground floor accommodation, hoists, and disabled facilities.<br>• The service also consider the availability of transport options (e.g. bus routes) when choosing suitable venues.<br>• Case study where screening revealed urgent health problem. Patient referred to Emergency Department and received timely treatment.<br>• Backlog and need for input to traveller community impact. | 2 | AAA Screening Programme Manager |

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| | 1C: When patients (service users) use the service, they are free from harm | • Staff are trained in the use of equipment.<br>• Health and safety checks undertaken at venues, including room assessments prior to booking.<br>• Infection prevention and control procedures in place.<br>• No patient harm incidents listed on Datix. | 2-3 | AAA Screening Programme Manager |
| | 1D: Patients (service users) report positive experiences of the service | • A prospective survey was carried out in November 2019 to determine levels of user satisfaction with the North Yorkshire and Humber AAA Screening Service. The survey was carried out across the region covered by the service, gaining responses from patients that had visited a variety of clinical settings.<br>• As well as multiple choice questions, the survey also offered the opportunity for respondents to provide additional free text comments on the service.<br>• 90 comments were received from this survey, of which 85 were positive reflections of the patient's experience with the service.<br>• The survey is due to be repeated in May 2024. | 1 | AAA Screening Programme Manager |
| **Domain 1: Commissioned or provided services overall rating** | | | 7-8 | |

## Domain 1: Commissioned or provided services (NLAG)
## Abdominal Aortic Aneurysm (AAA) Screening Service

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***Domain 1: Commissioned or provided services*** | 1A: Patients (service users) have required levels of access to the service | • The AAA Screening service invites all eligible patients for screening, i.e. men aged 65 years. Individual needs are accommodated e.g. longer appointments for those with communication or information support needs, use of aids e.g. hoists, interpreter and translation services including British Sign Language. Services provided in localities, also prison services. Also offered to individuals that have undergone male to female gender reassignment who will retain a genetic predisposition to AAA.<br>• The service carries out screening from 36 locations including hospitals and local practices, covering:<br>  • Hull<br>  • East Riding of Yorkshire<br>  • Areas of:<br>    • Harrogate and Rural District | 2 | AAA Screening Programme Manager |

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|---|---|---|---|---|
| | | • North East Lincolnshire<br>• North Lincolnshire<br>• Scarborough and Ryedale<br>• Vale of York<br>• Clinics are held regularly, on a monthly or quarterly basis (dependent on demand). This ensures that patients are able to access screening services at a location that is near to them.<br>• The geographic spread of venues is limited in some areas, and there is competition for these facilities, due to the increasing number of services offered out in the community. This has been raised by the ICB and is under constant review.<br>• The service's current priority is in addressing the screening backlog, which is primarily affecting patients coming for a first screen (rather than a surveillance screen). Anticipated that backlog will be resolved Q1 24/25.<br>• Intentions to renew work with the traveller community once backlog is addressed.<br>• 'If you don't speak English' form is sent out to patients with their initial invitation for screening.<br>• The service regularly make changes to an individual's appointments in order to improve their access to the service (eg moving appointments to enable the use of Patient Transport Service, or changing the time to ensure that patients can use bus passes).<br>• All screening venues have disabled parking and rooms, height adjustable beds and sufficient space to manoeuvre wheelchairs/ mobility scooter<br>• Easy read and audio versions of the information leaflet are available. BSL translators available to attend screening clinics. Pre-screening visits are offered to enable patients to familiarise themselves with the room and equipment, to reduce anxiety during the actual screening appointment.<br>• Utilisation of Browsealoud on local AAA website, enabling patients to access information in a more accessible format, or alternative languages<br>• 'One stop' clinics where patients without capacity to consent are able to attend with advocates to hold a best interests meeting, with immediate access to screening (where appropriate).<br>• Patient letters encourage patients to get in touch regarding any specific requirements (e.g. longer appointment slots) | | |

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| | | • Outreach work via Humber All Nations Alliance (HANA), who have added an advert for the screening service to their website<br>• The service have collaborated with the Trust LGBT Support Group to identify suitable actions to support this patient group | | |
| | 1B: Individual patients (service users) health needs are met | • The mobility needs of patients are met through the provision of ground floor accommodation, hoists, and disabled facilities.<br>• The service also consider the availability of transport options (e.g. bus routes) when choosing suitable venues.<br>• Case study where screening revealed urgent health problem. Patient referred to Emergency Department and received timely treatment.<br>• Backlog and need for input to traveller community impact. | 2 | AAA Screening Programme Manager |
| | 1C: When patients (service users) use the service, they are free from harm | • Staff are trained in the use of equipment.<br>• Health and safety checks undertaken at venues, including room assessments prior to booking.<br>• Infection prevention and control procedures in place.<br>• No patient harm incidents listed on Datix. | 2-3 | AAA Screening Programme Manager |
| | 1D: Patients (service users) report positive experiences of the service | • A prospective survey was carried out in November 2019 to determine levels of user satisfaction with the North Yorkshire and Humber AAA Screening Service. The survey was carried out across the region covered by the service, gaining responses from patients that had visited a variety of clinical settings.<br>• As well as multiple choice questions, the survey also offered the opportunity for respondents to provide additional free text comments on the service.<br>• 90 comments were received from this survey, of which 85 were positive reflections of the patient's experience with the service.<br>• The survey is due to be repeated in May 2024. | 1 | AAA Screening Programme Manager |
| **Domain 1: Commissioned or provided services overall rating** | | | 7-8 | |

## Domain 2: Workforce health and well-being (HUTH)

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***Domain 2: Workforce health and well-being*** | 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions | • We have mature offerings in relation to General Health for staff, Up Wellbeing programme (includes Tai Chi & Blood Pressure Checks), Coaches, Mentors, Mediators.<br>• Dedicated psychologists for Staff Support in ED, ICU<br>• OH can refer for counselling and Staff can self-refer | 2 | Lucy Vere<br>Director of Learning & Organisational Development |
| | 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | • We have the Staff Conflict Resolution & Professionalism Policy and the Zero Tolerance to Racism Framework & Reporting tool to Support staff and tackle issues with colleagues and patients, but August launch means it remains in Developing as Staff Survey scores don't yet reflect improvements, still awaiting staff survey feedback<br>• The Trust launched a Period Dignity with discreet support, for topics such as menopause, domestic violence & women's health.<br>• We have launched Zero Tolerance to Ableism framework and will launch Zero Tolerance to LGBTQ+ Discrimination February 2024 | 1 | Mano Jamieson<br>Equality, Diversity & Inclusion Manager |
| | 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | • The Freedom to Speak up Guardian has more frequent contact with staff and has established a network of Champions and attends numerous committee meetings.<br>• All Staff Networks are active and provide support with all network chairs actively involved in representing individuals and promoting their wellbeing<br>• Staffside are also influential in providing impartial support to staff<br>• Also support is available from Occupational Health, Psychological Counselling services, Coaching networks and Mentoring networks<br>• We have independent support groups led by some ethnic minority staff | 3 | Mano Jamieson<br>Equality, Diversity & Inclusion Manager |
| | 2D: Staff recommend the organisation as a place to work and receive treatment | • Taken from the most recent staff survey, 48% of staff recommend the Trust as a place to work and 52% are happy with the care provided for a friend or relative. | 1 | Myles Howell<br>Director of Communications |
| **Domain 2: Workforce health and well-being overall rating** | | | 7 | |

## Domain 2: Workforce health and well-being (NLAG)

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***Domain 2: Workforce health and well-being*** | 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions | • We have offerings in relation to general health for staff including: Health and Wellbeing Ambassadors, wellbeing programme/conversations, coaches, mentors and cultural ambassadors in some areas.<br>• Occupational Health can refer for counselling and staff can self-refer via Employee Assistance and Viv Up.<br>• We have a menopause peer to peer support group.<br>• We have a Health and Well Being Steering Group (which incorporated Equality, Diversity and Inclusion) however, we have recently formed an independent Equality, Diversity and Inclusion steering group which still needs embedding.<br>• We use Schwartz Rounds to explore, share and learn from experiences.<br>• Stress risk assessments are available for staff if required.<br>• Mental Health First Aiders in some areas<br>• During the year we promote a number Health Awareness Campaigns to support a variety of health conditions. | 1 | Karl Portz Equality, Diversity and Inclusion Lead |
| | 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | • We have recently signed up to a sexual harassment charter.<br>• We promote a just and learning culture.<br>• We challenge poor behaviour and to give staff the support to achieve this we provide Unconscious Bias training. Currently over 100 staff have received this training.<br>• We collect data Workforce Race Equality Standard which shows BME staff are 9.6% more likely to experiencing bullying from the public and 9.4% more likely to experience bullying from staff compared to white staff.<br>• We collect data Workforce Disability Equality Standard which shows disabled staff are 9.2% more likely to experiencing bullying from the public and 7.7% more likely to experience bullying from staff compared to non-disabled staff. | 1 | Karl Portz Equality, Diversity and Inclusion Lead |

| | 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | • The Freedom to Speak up Guardian has frequent contact with staff and has established a network of Champions in some areas and attends numerous committee meetings.<br>• All Staff Networks are set up but still need to be more accessible to staff and grow in their membership.<br>• Trade unions are also influential in providing impartial support to staff and a Trade Union Partnership is in place.<br>• Also, support is available from Occupational Health and through Vivup.<br>• An HR helpline is in place and staff can access HR team support. | 1 | Karl Portz Equality, Diversity and Inclusion Lead |
|---|---|---|---|---|
| | 2D: Staff recommend the organisation as a place to work and receive treatment | Taken from the most recent staff survey, 44.8% of staff recommend the Trust as a place to work and 45% are happy with the care provided for a friend or relative | 1 | Karl Portz Equality, Diversity and Inclusion Lead |
| **Domain 2: Workforce health and well-being overall rating** | | | 4 | |

## Domain 3: Inclusive leadership (HUTH)

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***Domain 3: Inclusive leadership*** | 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities | • CMO Established & Chairs Health Inequalities Steering Group<br>• A Board Development session was held on the subject of Health Inequalities<br>• EDI Steering Group chaired by CEO<br>• Trust adopted an official policy of being Anti-Racist. | 1 | Lucy Vere Director of Learning & Organisational Development |

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| | 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | Health Inequalities Steering Group established in Board governance process Workforce Education & Culture Committee (WECC) consider all EDI related papers | 1 | Jackie Railton Deputy Director, Strategy & Planning |
| | 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | Gender Pay Gap, WRES, WDES, Accessible information Standards & EDS 2022 all not only go to EDI Steering Group & WECC but are also reviewed and approved at Trust Board. | 2 | Mano Jamieson Equality, Diversity & Inclusion Manager |
| **Domain 3: Inclusive leadership overall rating** | | | 4 | |

## Domain 3: Inclusive leadership (NLAG)

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***Domain 3: Inclusive leadership*** | 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, | • The NLaG Trust Board have previously received a development session on Equality, Diversity and Inclusion which included the subject of Health Inequalities<br>• An independent Equality Diversity and Inclusion Steering Group has recently been formed – meetings for 2024 are to be arranged.<br>• We have the Tailored Adjustment Form to support staff with long term conditions and disabilities and also a disability policy is in place.<br>• We have a small staff disability staff network. | 1 | Karl Portz Equality, Diversity and Inclusion Lead |

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| | equality and health inequalities | | | |
| | 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | The Workforce Committee consider all Equality, Diversity and Inclusion related papers.<br><br>The Trust has an Equality Impact Assessment policy and framework to ensure Policies, Procedures and Functions identify and address equality and health inequalities. | 1 | Karl Portz Equality, Diversity and Inclusion Lead |
| **Domain 3: Inclusive leadership overall rating** | | | 3 | |

| | **Third-party involvement in Domain 3 rating and review** | |
|---|---|---|
| **HUTH** | **Trade Union Rep(s):** Rachel Waters, Staffside Chair. Javed Salim, LNC Chair. | **Independent Evaluator(s)/Peer Reviewer(s):** Karl Portz (EDI Manager) Northern Lincolnshire & Goole NHS Foundation Trust |
| **NLAG** | **Trade Union Rep:** Helen Loving Unite Equalities Representation (NLaG) | **Independent Evaluator(s)/Peer Reviewer(s):** Mano Jamieson (EDI Manager) Hull University Teaching Hospitals NHS Trust |

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| **Total NLAG scoring for all 3 Domains added together** | **15** | **Developing Activity** |
| **Total HUTH scoring for all 3 Domains added together** | **18-19** | **Developing Activity** |

| EDS Action Plan (HUTH) | |
|---|---|
| **EDS Lead** | **Year(s) active** |
| Jackie Railton/Mano Jamieson/Lucy Vere | 1 |
| **EDS Sponsor** | **Authorisation date** |
| Simon Nearney, Group Chief People Officer | |

| Domain | Outcome | Objective | Action | Completion date |
|---|---|---|---|---|
| Domain 1: Commissioned or provided services | 1A: Patients (service users) have required levels of access to the service | Antenatal services – Digital exclusion: Look to extend ways in which pregnant people can self-refer to the service where they do not have access to online or telephone services. | Extend the publicising of the Baby Carousel events to enable people to attend and self-refer in person<br>Consider utilisation of paper-based referrals where online is not an option. | June 2024 |
| | | Tobacco Dependency Service – Ascertain the extent to which services are offered by protected characteristic | Annual review of anonymised patient data by protected characteristic | May 2024 |
| | | AAA Screening Service – Eliminate backlog for first screenings | Recruitment to vacant posts and completion of training to enable increase in screening capacity. | Q1 2024/25 |
| | | AAA Screening Service – Resume screening service to traveller community | Re-establish contacts with the traveller community to ensure that potential patients are aware of the service | Q1 2024/25 |
| | 1B: Individual patients (service users) health needs are met | N/A | N/A | |
| | 1C: When patients (service users) use the service, they are free from harm | Antenatal services – Assess whether there is demand for 24/7 antenatal triage service. | Undertake a data review of antenatal unplanned attendances and the date/time of attendance. | July 2024 |

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| | 1D: Patients (service users) report positive experiences of the service | Antenatal Services – Increase the level of service user engagement in the development of services.<br><br>Antenatal Services – Increase service user awareness of choices in relation to place of birth<br><br>AAA Screening Service – Obtain service user feedback on service. | Maternity Service, Healthwatch (Hull and East Riding) and Maternity Voice Partnership to collaborate in engagement activities.<br><br>Review staff face to face and virtual interactions with service users, including information leaflets/online information to ensure awareness of choice.<br><br>Participate in Public Health AAA Screening Survey 2024 and utilise survey results to inform service improvement | Sept 2024<br><br>Sept 2024<br><br>May 2024<br><br>Sept 2024 |

| Domain | Outcome | Objective | Action | Completion date |
|---|---|---|---|---|
| Domain 2: Workforce health and well-being | 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions | To identify what support is needed for each condition and scope out what capacity is needed to offer the level of support required. | • To complete capacity and demand exercise for each condition<br>• To prioritise interventions using the Health and Wellbeing Committee to identify and allocate resources<br>• Roll out or promote interventions identified | June 2024 |
| | 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | To reduce number of staff reporting experiences of abuse, harassment, bullying & physical violence in the staff survey | Introduce distinct Zero Tolerance to LGBTQ+ Discrimination frameworks & reporting tools<br><br>To create clear roles and responsibilities for line managers in protecting their staff form harm, including supporting them to upskill and increase their confidence in dealing with challenging situations<br>To roll out the Inclusivity Academy including our in house more in depth EDI mandatory training model for the whole group. | February 2024<br><br>December 2024<br><br>May 2024 |

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|---|---|---|---|---|
| | 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | To ensure that a full range of support is available that enables staff to speak up, get support and get their issue resolved without having a permanent impact on their work life and health. | To fully review current routes of advice and ensure that they are fully accessible.<br><br>To fully maximise the Freedom to Speak Up Guardian Services including the network of FTSU Champions with a focus on EDI related complaints.<br><br>To further embed and support our Network Chairs and Vice Chairs to offer support and advice including creating a regular supervision and support sessions for them led by the FTSUG and the Director of Learning and OD.<br><br>To encourage our staff from protected characteristics to join a union to allow them access to external and impartial support. | September 2024<br><br>June 2024<br><br>March 2024<br><br>May 2024 |
| | 2D: Staff recommend the organisation as a place to work and receive treatment | Develop a values led culture that ensures all staff feel valued, welcome and creates a safe working environment, which ultimately translates into better and safer patient care. | Engaging with staff to create a clear set of Group Values and a specific Staff Behaviours Charter.<br><br>Create a strong leadership development and people management approach that is compassionate and inclusive through a wide range of interventions:<br>• Development programmes<br>• Bespoke work with teams<br>• Coaching and mentoring<br>• Clear metrics and feedback to managers on their progress<br><br>Create and rollout a group wide Professionalism and Civility Programme (PACT) to ensure all staff understand what is expected of them in creating a healthy work culture. | April 2024<br><br>December 2024<br><br>September 2025 |

| Domain | Outcome | Objective | Action | Completion date |
|---|---|---|---|---|
| **Domain 3: Inclusive leadership** | 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities | To embed Equality, Diversity and Inclusion, and Health Inequalities into the personal performance objectives for our Band 9 and VSM leaders. | Include Care Group measures on EDI, staff survey scores in accountability to Trust Board along with Action Plans for improvement<br><br>All relevant managers have EDI and Health Inequality objectives built into their appraisals.<br><br>Care Group and Director Level WRES/WDES/LGBTQ objectives and progress tracking built into reporting and governance structures for the Group | June 2024<br><br>January 2025<br><br>January 2025 |
| | 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | Introduce accountability for Equality, Diversity and Inclusion activity and Health Inequalities at Board Committee level | Ensure Equality and Health Inequality impact assessments are reviewed at relevant Board Committee when service changes are introduced<br><br>Training and Coaching for NED's to ensure that they are able to critically challenge the Exec team when impact assessments are being discussed and agreed at committees and Trust Board. | March 2024<br><br>July 2024 |
| | 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | To demonstrate that we have clear metrics and governance in place that allow both executives and non-executives to identify and track improvements for both staff and patients. | To ensure that the new Group Structure governance arrangements are able to identify improvements, hold our Care Groups and Corporate Directorates to account for both remedial and proactive actions required.<br><br>To work with executive and site teams to ensure that they are pursuing performance for these objectives as part of their routine performance meetings and structures. | May 2024<br><br>September 2024 |

| EDS Action Plan (NLAG) | |
|---|---|
| **EDS Lead** | **Year(s) active** |
| Jackie Railton/Karl Portz (Domain 1)<br>Karl Portz/Lucy Vere (Domains 2 and 3) | 1 |
| **EDS Sponsor** | **Authorisation date** |
| Simon Nearney, Group Chief People Officer<br>Ivan McConnell, Group Director of Strategy and Partnerships | |

| Domain | Outcome | Objective | Action | Completion date |
|---|---|---|---|---|
| **Domain 1: Commissioned or provided services** | 1A: Patients (service users) have required levels of access to the service | Antenatal Services - Consider other ways to access antenatal services | Discuss with Maternity and Neonatal Voices Partnership | June 2024 |
| | | Tobacco Dependency Service – Ascertain the extent to which services are offered by protected characteristic | Annual review of anonymised patient data by protected characteristic | May 2024 |
| | | AAA Screening Service – Eliminate backlog for first screenings | Recruitment to vacant posts and completion of training to enable increase in screening capacity. | Q1 2024/25 |
| | | AAA Screening Service – Resume screening service to traveller community | R-establish contacts with the traveller community to ensure that potential patients are aware of the service | Q1 2024/25 |
| | 1B: Individual patients (service users) health needs are met | N/A | N/A | |

| | | | | |
|---|---|---|---|---|
| | 1C: When patients (service users) use the service, they are free from harm | N/A | N/A | |
| | 1D: Patients (service users) report positive experiences of the service | Antenatal Services – Increase the level of service user engagement in the development of services.<br><br>Antenatal Services – Increase service user awareness of choices in relation to place of birth<br><br>AAA Screening Service – Obtain service user feedback on service. | Maternity Service, Healthwatch (North Lincolnshire and North East Lincolnshire) and Maternity Voice Partnership to collaborate in engagement activities.<br><br>Review staff face to face and virtual interactions with service users, including information leaflets/online information to ensure awareness of choice.<br><br>Participate in Public Health AAA Screening Survey 2024 and utilise survey results to inform service improvement | Sept 2024<br><br>Sept 2024<br><br>May 2024<br><br>Sept 2024 |

| Domain | Outcome | Objective | Action | Completion date |
|---|---|---|---|---|
| **Domain 2: Workforce health and well-being** | 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions | To identify what support is needed for each condition and scope out what capacity is needed to offer the level of support required. | • To complete capacity and demand exercise for each condition<br>• To prioritise interventions using the Health and Wellbeing Committee to identify and allocate resources<br>• Roll out or promote interventions identified | June 2024<br>July 2024<br><br>September 2024 |
| | 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | To reduce number of staff reporting experiences of abuse, harassment, bullying & physical violence in the staff survey | Introduce distinct Zero Tolerance to Race, Disability and LGBTQ+ Discrimination frameworks & reporting tools,<br><br>To create clear roles and responsibilities for line managers in protecting their staff form harm including supporting them to upskill and | April 2024 |

| | | | | |
|---|---|---|---|---|
| | | | increase their confidence in dealing with challenging situations<br><br>To roll out the Inclusivity Academy including our in house more in depth EDI mandatory training model for the whole group.<br>Continue to deliver unconscious bias training. | May 2024 |
| | 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | To ensure that a full range of support is available that enables staff to speak up, get support and get their issue resolved without having a permanent impact on their work life and health. | To fully review current routes of advice and ensure that they are fully accessible.<br><br>To fully maximise the Freedom to Speak Up Guardian Services including the network of FTSU Champions with a focus on EDI related complaints.<br><br>To further embed and support our Network Chairs and Vice Chairs to offer support and advice including creating a regular supervision and support sessions for them led by the FTSUG and the Director of Learning and OD.<br><br>To encourage our staff from protected characteristics to join a union to allow them access to external and impartial support. | September 2024<br><br>June 2024<br><br>March 2024<br><br>May 2024 |
| | 2D: Staff recommend the organisation as a place to work and receive treatment | Develop a values led culture that ensures all staff feel valued, welcome and creates a safe working environment, which ultimately translates into better and safer patient care. | Engaging with staff to create a clear set of Group Values and a specific Staff Behaviours Charter.<br><br>Create a strong leadership development and people management approach that is compassionate and inclusive through a wide range of interventions:<br>• Development programmes<br>• Bespoke work with teams<br>• Coaching and mentoring | April 2024<br><br>December 2024 |

| | | | Action | Completion date |
|---|---|---|---|---|
| | | | • Clear metrics and feedback to managers on their progress<br>Create and rollout a group wide Professionalism and Civility Programme (PACT) to ensure all staff understand what is expected of them in creating a healthy work culture. | September 2025 |

| Domain | Outcome | Objective | Action | Completion date |
|---|---|---|---|---|
| **Domain 3: Inclusive leadership** | 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities | To embed Equality, Diversity and Inclusion, and Health Inequalities into the personal performance objectives for our Band 9 and VSM leaders. | Include Care Group measures on EDI, staff survey scores in accountability to Trust Board along with Action Plans for improvement | June 2024 |
| | | | All relevant managers have EDI and Health Inequality objectives built into their appraisals. | January 2025 |
| | | | Care Group and Director Level WRES/WDES/LGBTQ objectives and progress tracking built into reporting and governance structures for the Group | January 2025 |
| | 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | Introduce accountability for Equality, Diversity and Inclusion activity and Health Inequalities at Board Committee level | Ensure Equality and Health Inequality impact assessments are reviewed at relevant Board Committee when service changes are introduced | March 2024 |
| | | | Training and Coaching for NED's to ensure that they are able to critically challenge the Exec team when impact assessments are being discussed and agreed at committees and Trust Board. | July 2024 |

| | | | | |
|---|---|---|---|---|
| | 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | To demonstrate that we have clear metrics and governance in place that allow both executives and non-executives to identify and track improvements for both staff and patients. | To ensure that the new Group Structure governance arrangements are able to identify improvements, hold our Care Groups and Corporate Directorates to account for both remedial and proactive actions required.<br><br>To work with executive and site teams to ensure that they are pursuing performance for these objectives as part of their routine performance meetings and structures. | May 2024<br><br>September 2024 |

**Trust Boards-in-Common Front Sheet**

**Agenda Item No: BIC(24)106**

| | |
|---|---|
| **Name of the Meeting** | Trust Boards-in-Common - Public |
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Simon Parkes and Jane Hawkard, Non-Executive Directors / Chairs of Audit, Risk and Governance Committees-in-Common |
| **Contact Officer/Author** | Simon Parkes / Jane Hawkard |
| **Title of the Report** | **Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – April 2024** |
| **Executive Summary** | The attached highlight / escalation report summarises the key matters presented to, and discussed by the inaugural meeting of the Audit, Risk and Governance Committees-in-Common on 25 April 2024.<br><br>The Trust Boards are asked to:<br><br>• Note the highlight report from the ARG CiC.<br><br>• Approve the recommendation from the ARG CiC that the 2023/24 statutory annual accounts for both Trusts are prepared on a 'Going Concern' basis. |
| **Background Information and/or Supporting Document(s)** (if applicable) | Audit, Risk and Governance Committees-in-Common Agenda Papers – 25 April 2024 |
| **Prior Approval Process** | - |
| **Financial implication(s)** (if applicable) | - |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | - |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>☐ Discussion ☐ Review<br>✓ Assurance ☐ Other – please detail below: |

**Committees-in-Common Highlight / Escalation Report to the Trust Boards**

| | |
|---|---|
| | 13 June 2024 - Public |
| | Audit, Risk and Governance Committees-in-Common |
| | 25 April 2024 |
| | Yes |

## 1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Audit, Risk and Governance Committees-in-Common (ARG CiC) at their meeting held on 25 April 2024 including those matters which the Committees specifically wish to escalate to either or both Trust Boards.

## 2.0 Matters considered by the committees

2.1 The ARG CiC considered the following items of business:

- Accounting Policies 23/24 – HUTH & NLAG
- Going Concern Reports 23/24 – HUTH & NLAG
- Draft Annual Accounts 23/24 – HUTH & NLAG
- Draft Annual Governance Statements 23/24 – HUTH & NLAG
- Draft Head of Internal Audit (IA) Opinions 23/24 – HUTH & NLAG
- External Audit Planning Reports and Updates – HUTH & NLAG
- Internal Audit Progress Report / Overdue recommendations – HUTH & NLAG
- HUTH IA Report - Discharge Management Action Plan
- NLAG IA Report – Change Control Management
- Group Internal Audit Plan 24/25
- Group LCFS Update
- Group Annual Counter Fraud Operational Plan 24/25
- Group Information Governance (IG) Highlight Report
- Group eRostering Rollout Update
- Group Assurance Map
- Group Waiving of Standing Orders Report 23/24
- Group Losses and Compensations Report 23/24
- Group Standards of Business Conduct Declarations 23/24
- Salary Overpayments 23/24 – NLAG
- Document Control Report – NLAG
- HUTH Declaring Gifts & External Interests Policy
- HFMA NHS Audit Committee Handbook Review

*[*Items marked with an asterisk are on the boards' agenda as a standalone item in accordance with the board reporting framework – as applicable]*

## 3.0 Matters for reporting / escalation to the Trust Boards

3.1 The ARG CiC agreed the following matters for reporting / escalation to the Trust Boards:

a) **Going Concern Reports 23/24 – HUTH & NLAG** – The Going Concern reports for both HUTH and NLAG were received and accepted by the ARG CiC who endorsed the recommendations that the HUTH and NLAG Trust Boards can assume the 2023/24 statutory annual accounts for both Trusts are prepared on a 'Going Concern' basis.

b) **Draft Annual Accounts 23/24 – HUTH & NLAG** – Both sets of draft annual accounts were received by the Committees, with key points highlighted in writing and discussed by the Assistant Director of Finance – Planning and Control. The Committees were assured that the accounts were being completed to the agreed central NHS timescales and that variance between years could be explained appropriately. The Committee commended the Finance team for both the quality of the draft financial statements for the two Trusts and the speed of their production, adding that it was a tribute to the quality of financial management in place. The External Auditors at both Trusts will commence their audits of the draft accounts.

c) **Draft Annual Governance Statements 23/24 – HUTH & NLAG** – The Committees received the initial drafts for both Trusts, noting that some sections required further updates. The Committee recommended that the section in the report on risks was enhanced in terms of the significance of the issues that the Trust is dealing with. Any comments/corrections are to be supplied to the Group Director of Assurance for consideration. The final drafts will be received by the Committees in due course for approval and inclusion in the Trust's Annual Reports for 2023/24.

d) **Internal Audit Recommendations Follow-Up Status Reports** – The HUTH Committee was assured that progress was being made on closing down its overdue actions, hearing that further progress had been made since the report was produced for the ARG CiC papers, with only two overdue recommendations at the time of the meeting. The HUTH ARG CiC Chair had confirmed with the Trusts Information Governance lead that ten further actions had been closed since the report was produced. The NLAG Committee noted that there were six overdue recommendations at 27.3.24, however 31 recommendations had recently become overdue at 31.3.24. The ARG CiC was however assured that there was a process in place for sending regular reports to Executive Directors for review/action and that overdue recommendations were also monitored by the monthly operational Group Risk and Assurance Committee.

e) **Group Internal Audit Plan 2024/25** – the Committees received, considered and approved the draft Internal Audit Plan 2024/25 for the Group. The Committees were pleased to see that the two Trusts Internal Auditors had collaborated well to produce a plan of audit work for the coming year, with a number of audits to be undertaken jointly at both Trusts, working to one agreed scope and producing a single audit report. The Committees thanked Audit Yorkshire and RSM for their work on a Group Internal Audit plan.

f) **Provision of Financial Services** – the Committees noted the financial challenges for the Group for 2024/25 and the potential impact of CIP targets on the ability of the Finance team to maintain effective corporate service provision to the wider organisation as a consequence. Automated processes are to be explored to enhance processes where possible. A further update will be received at the July 2024 ARG CiC meeting.

g) **Group IG Highlight Report** – One action that sits on both Trusts Data Security and Protection Toolkit (DSPT) improvement plan (and is the only item remaining outstanding for NLAG) is the requirement for 95% compliance with mandatory DSP training. At 31.3.24 HUTH were 89.1% compliant and NLAG 86%. 95% compliance must be achieved by 30 June 2024 in order to complete this improvement action for both Trusts for the DSPT annual submission. Work continues to look at ways to ensure staff complete this mandatory training and that this DSPT requirement is achieved.

h) **eRostering Rollout** – The Committees received an update from the Director of People Services on the position with the rollout of eRoster for doctors within the two Trusts. There is a need to look at rostering across the Group and the Committees heard about the work being done by the team to develop a joint plan, but this comes with many challenges due to the complexities of some multi-specialty rosters. There is a need for the team involved in compiling the rosters to now engage closely with Clinical Directors to determine how they want the rosters designed and for them to engage and take ownership of roster design to ensure that they deliver what is needed. The Committees agreed that this is a complex piece of work which needs clinical leads to take ownership. It was agreed to escalate this matter to both the Workforce, Education and Culture Committees-in-Common and the Trust Boards-in-Common.

i) **HUTH Declaring Gifts and External Interests Policy** – the HUTH ARG CiC approved minor updates to the existing HUTH policy.

j) **HFMA NHS Audit Committee Handbook Review** – The Healthcare Financial Management Association (HFMA) published its latest version of the Handbook on 21.3.24, having undergone a complete re-write since it was last published in 2018. The Committees discussed a limited number of items for adjustment in its aligned Terms of Reference and workplan as a result. These adjustments will be presented to the Group Boards-in-Common for review and approval at its June 2024 meeting as part of the three-month review of all CiCs.

k) **Review of ARG CiC Meeting** – The Committees noted the ARG CiC was the third CiC meeting on consecutive days that week and members raised concerns that the volume of papers and preparation for three such significant meetings in one week was considerable. The Committees considered how such difficulties could be effectively addressed in general terms across all CiC's, through the timing of the various CiC meetings, the level of detail in reports and the effectiveness of executive summaries. The Group Director of Assurance agreed to consider this issue further.

## 4.0 Matters on which the committees have requested additional assurance:

4.1 The Committees made no specific requests for additional assurance during the meeting.

## 5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

5.1 The Board Assurance Framework (BAF) was not received at this meeting.

## 6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the highlight report from the ARG CiC.
- Approve the recommendation from the ARG CiC that the 2023/24 statutory annual accounts for both Trusts are prepared on a 'Going Concern' basis.

**Simon Parkes**
**NLAG ARG CiC Chair / NED**

**Jane Hawkard**
**HUTH ARG CiC Chair / NED**

**29 April 2024**

## Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)107**

| **Name of Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Lee Bond – Group Chief Financial Officer |
| **Contact Officer / Author** | Sally Stevenson – Assistant Director of Finance – Compliance and Counter Fraud |
| **Title of Report** | **HUTH Annual Accounts and Reports 2023/24 – Delegation of Authority** |
| **Executive Summary** | In order to ensure the timely sign off of Hull University Teaching Hospitals NHS Trust (HUTH) audited accounts and reports by the Chief Executive and the External Auditor, prior to submission to NHS England on 28 June 2024, the Trust Board is requested to delegate formal authority to the HUTH Audit, Risk and Governance Committee at its meeting on 21 June 2024 to sign off the audited accounts and reports on its behalf.<br><br>The Trust Board is asked to:<br><br>• Note the key dates in the final accounts process.<br>• Delegate formal authority to the HUTH Audit, Risk and Governance Committee to sign off the HUTH 2023/24 audited accounts on behalf of the Trust Board. |
| **Background Information and/or Supporting Document(s)** (if applicable) | NHS England 20234/24 Accounts Timetable |
| **Prior Approval Process** | None. |
| **Financial Implication(s)** (if applicable) | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | None |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

## Report to the Hull University Teaching Hospitals NHS Trust Board – June 2024

## ANNUAL ACCOUNTS & REPORTS 2023/24 - DELEGATION OF AUTHORITY

### Introduction

The Audit, Risk and Governance Committee for Hull University Teaching Hospitals NHS Trust (HUTH) reviewed the HUTH draft accounts and associated reports in detail at its meeting on 25 April 2024, prior to submission to the External Auditor to commence their statutory audit work.

In line with section 3.1 of the HUTH Standing Financial Instructions the Audit, Risk and Governance Committee also reviews the audited accounts and makes a recommendation to the Trust Board for approval, before final submission to NHS England (NHSE) in line with the required deadline. The key dates for the 2023/24 audited accounts are as follows:-

| | |
|---|---|
| Thursday 13 June 2024 | Trust Board meeting. |
| Friday 21 June 2024 | Audit, Risk and Governance Committee meeting where the final audited accounts and reports will be reviewed and any significant changes to the previously viewed draft accounts discussed. The Group Chief Executive and Trust Chair are invited to attend this meeting. |
| Monday 24 June 2024 | Chief Executive expected sign off date (TBC).<br><br>Once signed will be passed to External Auditor for their formal sign off prior to return and submission to NHSE. |
| Friday 28 June 2024 | Final audited accounts and reports to be formally submitted to NHSE by noon. |

Given that the June 2024 Trust Board meeting is scheduled early in the month, the audited accounts will not be ready for final review by that point. The Trust Board can therefore consider delegating formal authority to the HUTH Audit, Risk and Governance Committee at its meeting on 21 June 2024 at which the Group Chief Executive and Trust Chair are invited to attend, to approve the final accounts and reports on its behalf before submission to NHSE by 28 June 2024.

### Recommendation

The Trust Board is asked to note the key dates in the final accounts and reports process and is requested to delegate formal authority to the HUTH Audit, Risk and Governance Committee at its meeting on 21 June 2024 to sign off the 2023/24 audited accounts and reports on behalf of the Trust Board, prior to formal signing by the Chief Executive and the External Auditor and submission to NHSE.

**Lee Bond**
**Group Chief Financial Officer**
**June 2023**

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)109**

| **Name of the Meeting** | **Trust Boards-in-Common** |
|---|---|
| **Date of the Meeting** | **13 June 2024** |
| **Director Lead** | **Gill Ponder and Mike Robson, Non-Executive Directors and Capital & Major Projects Committees-in-Common Chairs** |
| **Contact Officer/Author** | **Alison Hurley, Deputy Director of Assurance** |
| **Title of the Report** | **Capital and Major Projects Committees-in-Common Highlight / Escalation Report** |
| **Executive Summary** | The attached highlight / escalation report provides an overview of the key matters presented to, discussed and escalated at the Capital & Major Projects Committees-in-Common meeting held on 23 April 2024 |
| **Background Information and/or Supporting Document(s)** (if applicable) | **Capital & Major Projects Committees-in-Common Terms of Reference for HUTH and NLaG** |
| **Prior Approval Process** | The report has been approved by the Committee Chairs |
| **Financial implication(s)** (if applicable) | N/a |
| **Implications for equality, diversity and inclusion, including health inequalities** | N/a |
| **Recommended action(s) required** | ☐ Approval ☐ Information<br>☐ Discussion ☐ Review<br>✓ Assurance ☐ Other – please detail below: |

**KEY:**
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

**Committees-in-Common Highlight / Escalation Report to the Trust Boards**

| | |
|---|---|
| | 13 June 2024 |
| | **Capital and Major Projects Committees-in-Common** |
| | 23 April 2024 |
| | The Capital and Major Projects (CaMP) Committees-in-Common (CiC) meeting held on 23 April 2024 was quorate |

## 1.0 Purpose of the report

1.1 This report sets out the items of business considered by the CaMP CiC at their meeting held on 23 April 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

## 2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

- Risk Register (verbal progress update)
- Review & Evaluation of New Business Cases, Investments & Dis-Investments within Delegated Limits and / or Endorsement for Trust Board Approval
  - New Build at Hull Royal Infirmary (HRI) short form business case - HUTH
- Capital Contract Approvals
  - North East Lincs Community Diagnostic Centre (CDC) Fit Out & Materials - NLaG
  - Castle Hill Hospital (CHH) Day Surgery (DSU) Phase 2 & 3 - HUTH
- Group Monthly Capital Finance Report (NLaG/HUTH)
- Draft Capital Programme 2024/25 (NLaG/HUTH)
- Major Service Change/Transformation
  - Humber Acute Services Review Update
  - Community Diagnostic Centre Programme Update
- Digital Plan Delivery (bi-monthly update)

## 3.0 Matters for reporting / escalation to the Trust Boards

3.1 The Committees agreed the following matters for reporting / escalation to the Trust Boards:

a. **Risk Register** – the Committees noted the plan to provide a draft Risk Register for the next meeting which raised concerns about the possible lack of appropriate oversight for the committees in 2024. It was agreed to refer this issue for review to the Audit Risk and Governance (ARG) CiC on behalf of all other CiCs (to be addressed upon receipt and prior to the next CaMP meeting in June 2024, as agreed at the meeting with the ARG CiC Chair). The review requested is to consider whether there is an assurance gap with the Committees not having recent sight of the Risk Register and to what extent any gap is mitigated by other arrangements including the Group Cabinet Risk and Assurance Committee.

b. **Terms of Reference** – the revised CaMP CiC terms of reference were approved by the Committee for submission to the Board for approval.

c. **Draft Capital Programme** – the CaMP CiC endorsed the draft Capital Plan for 2024/25 and recommended approval by the Trust Boards-in-Common. However, a number of risks were discussed by the Committees, including the risk that the Electronic Patient Record (EPR) funding could not be spent in 2024/25. A request had therefore been submitted to defer it until 2025/26 to allow time for a contract to be awarded and further funding to be secured. Risks of insufficient capital being available to complete all planned schemes in year due to a lack of contingency reserves and a potential risk arising from the validity of warranties where CDC funds had been transferred to Hull City Council, who would then place contracts with Sub-Contractors, were also discussed.

d. **North East Lincs CDC** – the NLaG Committee reviewed and endorsed the NE Lincs CDC Fit Out and Materials contract for Board approval.

e. **Digital Plan Delivery –** The delivery date for BadgerNet at NLaG was being replanned as there were three different maternity systems on the south bank requiring data cleansing and some concerns were expressed about the level of resources available in the Digital Team to deliver all of the priority programmes, alongside supporting Business as Usual requirements.

## 4.0 Matters on which the committees received assurance:

4.1 The Committees received assurance on the following items of business:

a. **Group Capital Finance** – The Committees were assured that the Group Capital programme had been delivered for 2023/24 and that the Capital Departmental Expenditure Limit (CDEL) had been achieved, but noted that £4.0 million of Public Dividend Capital (PDC) relating to the underspends on the Community Diagnostic

Centres (CDCs) had been deferred to 2024/25 and that £3.8 million had been transferred from NLaG to HUTH, which would be repaid in 2024/25.

b. **Humber Acute Services Review (HASR) –** the Committees were assured about the level of public engagement involved in the review and the progress made to date.

c. **Community Diagnostic Centre (CDC) Programme** – assurance on the progress and pace of the CDC Schemes was noted by the Committees.

## 5.0 Matters on which the committees have requested additional assurance:

5.1 The Committees requested additional assurance on the following item of business:

a. **Digital Plan Delivery -** The Committees sought additional assurance on the lack of timely and appropriate reporting functionality following the data migration to Lorenzo. A report was requested to be presented to the May 2024 Performance, Estates and Finance (PEF) CiC meeting to note where the gaps were and the mitigations and timescales identified to address them. The patient safety risk had been mitigated by the operational teams, but this required a number of manual workarounds.

## 6.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

6.1 The Committees received the BAF risks relating to its scope for information which included a progress update regarding the harmonisation and rationalisation of the BAFs for HUTH and NLAG.

## 7.0 Trust Board Action Required

7.1 The Trust Boards are asked to note:

- the contents of the escalation report;
- that the CaMP CiC have referred a risk relating to the lack of oversight of the Risk Register to the ARG CiC for review;
- that the CaMP CiC have requested a Digital Plan Delivery report be presented to the May 2024 meeting of the PEF CiC with an update on mitigations and timescales to address the requirement for timely and appropriate operational data reporting following the migration to Lorenzo;
- the revisions to the CaMP CiC Terms of Reference and to approve those changes;
- the Committees' endorsement of the 2024/25 draft Capital Programme, which will require Board approval;
- The Committees' endorsement of the NE Lincs CDC Fit Out contract, which the Board will be asked to approve.

**Gill Ponder,**
**Capital & Major Projects Committees-in-Common Chair** for the meeting on 23 April 2024

## Boards-in-Common Front sheet

**Agenda Item No: BIC(24)110**

| **Name of the Meeting** | **Boards-in-Common (BIC)** |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | David Sharif, Group Director of Assurance |
| **Contact Officer/Author** | Rebecca Thompson, Deputy Director of Assurance |
| **Title of the Report** | Group Board Assurance Framework – 2023/24 Q4 closure and 2024/25 Q1 ratings |
| **Executive Summary** | This report includes the Q4 HUTH/NLaG BAF for 2023/24, at Appendix 1.<br><br>Whilst both trusts exceeded their targets scores at year-end for performance and quality scores, reflecting the long waiting times and lists across specialties and north and south, some risks met or exceeded their targets scores:<br>• HUTH BAF risks 2 (workforce) and 7.1 (in-year finance position)<br>• NLaG BAF risk 3.1 (in-year finance position)<br><br>Work has been carried out with the Executive leads to ensure the current BAF risk ratings are current and that the controls and gaps in controls are up to date. Work is planned to help rationalise the strategic risks with the new strategy from July and in advance where appropriate. The Group Chief Nurse is leading on the Quality risk work for both Trusts of a more root and branch nature to help strengthen risk management and as part of the refreshed risk strategy for the Group. In addition, the Group Medical Director and Group Chief Digital Officer have reviewed the digital risk (formerly NLAG risk 1.6).<br><br>Appendix 2 attached includes detail on the Group BAF 2024/25 Q1 risks, for which the current scores are:<br>• Workforce - 16<br>• Cutlure and Leadership - 16<br>• **Finance - 25**<br>• Estates - 20<br>• IT failure and cyber security - 15<br>• Performance – 20<br>• Strategy – 12<br>• Group Strategic Capital – 15<br>• Strategic Partnerships and Collaboration – 12<br>• Business Continuity - 12<br>• HUTH and NLaG Quality risks (1.1 - deliver treatment, care and support consistently – 15, 3.1 – not meeting Quality objectives - 16, 3.2 - unintended or avoidable harm – 20)<br>• Research and Innovation - 12<br><br>The Boards-in-Common (BIC) are asked to note that the strategic risks will be updated further once the Group Strategic Objectives are launched in July 2024.<br><br>Recommendations<br>The BIC is asked to:<br>• Approve the Q4 year-end risk ratings for the HUTH/NLAG BAF Risks |

| | |
|---|---|
| | • Approve the Q1 Group BAF risks noting the further updates to follow. |
| **Background Information and/or Supporting Document(s)** (if applicable) | • The full updated Q4 Board Assurance Framework is attached at Appendix 1.<br>• Included in the updated 2024/25 BAF at Appendix 2 is a summary of the Q1 risk ratings. |
| **Prior Approval Process** | All of the BAF risks have been ratified at the Group's Committees in Common with the exception of:<br>• Group Strategy<br>• Strategic Capital<br>• Strategic Partnerships and Collaboration<br><br>The BAF as a whole is also considered monthly at the Group Cabinet Risk and Assurance Committee. |
| **Financial implication(s)** (if applicable) | The actions being taken to mitigate the risks should produce more efficient systems and processes across the Group. |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | There are no immediate EDI concerns identified in any of the BAF risks. |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>✓ Discussion ✓ Review<br>✓ Assurance ☐ Other – please detail below: |

**Boards in Common**
**13 June 2024**

**Group Board Assurance Framework –**
**2023/24 Q4 closure and 2024/25 Q1 ratings**

## 1. Purpose of the Report

The purpose of the report is to update the Boards-in-Common regarding the Q4 Board Assurance Framework 2023/24 formal year-end position and the Q1 Board Assurance Framework which now includes merged risks for workforce, leadership, finance, performance, estates, digital and strategy.

## 2. Background

During 2023/24 the Board Assurance Frameworks for HUTH and NLAG were merged into a Humber Partnership Group BAF except for the quality risks, due for review completion by end of Q1. The Board will undertake a further review of strategic risks after the Strategic Objectives are launched in July 2024.

## 3. Board Assurance Risks 2023/24

The Boards-in-Common are to approve the year-end risk ratings below prior to the Q4 BAF close. Common to both trusts are the performance and quality scores that exceeded their targets scores at year-end, reflecting the long waiting times and lists across specialties, north and south.

The Q4 risk ratings for **HUTH** are:

| Ref | Risk Summary | Executive Lead | Assurance Committee | Q4 risk (LxC) | Change from previous Qtr | Target Risk Score |
|---|---|---|---|---|---|---|
| 1 | The Trust does not make progress towards further improving a positive working culture this year | Group Chief People Officer | Workforce Education and Culture Committees in Common | 16 (4 x 4) | ↔ | 12 |
| 2 | The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust | Group Chief People Officer | Workforce Education and Culture Committees in Common | 12 (3 x 4) | ↔ | 12 |
| 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 | Group Chief Nurse | Quality and Safety Committees in Common | 16 (4 x 4) | ↔ | 12 |
| 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 | Group Chief Medical Officer | Quality and Safety Committees in Common | 20 (4 x 5) | ↔ | 16 |
| 4 | There is a risk to access to Trust services due to long waiting lists and demand and capacity issues. | Group Chief Delivery Officer | Performance Estates and Finance Committees in Common | 20 (4 x 5) | ↔ | 16 |
| 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 | Group Chief of Strategy and Partnerships | Group Board, Group Cabinet Risk and Assurance Committee | 20 (4 x 5) | ↔ | 6 |
| 6 | There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment | Group Chief Medical Officer | Quality and Safety Committees in Common | 12 (3 x 4) | ↔ | 8 |
| 7.1 | There is a risk that the Trust does not achieve its in-year financial plan | Group Chief Financial Officer | Performance Estates and Finance Committees in Common | 8 (2 x 4) | ↔ | 8 |

| 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 2023/24 | Group Chief Financial Officer | Performance Estates and Finance Committees in Common | 4 | ⟷ | 20 |
|---|---|---|---|---|---|---|
| 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 | Group Chief Financial Officer | Capital and Major Projects Committees in Common | 15<br>(3 x 5) | ⟷ | 10 |

The Q4 risk ratings for **NLAG** are:

| Ref | Risk Summary | Executive Lead | Assurance Committee | Current risk (LxC) | Change from previous Qtr | Target Risk Score |
|---|---|---|---|---|---|---|
| **1.1** | **Patient Harm**<br>The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience | Chief Medical Officer & Chief Nurse | Quality & Safety Committees in Common (CiC) | **15<br>(3 x 5)** | ⟷ | 15 |
| **1.2** | **Timely Access to Care**<br>The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care | Chief Delivery Officer | Performance, Estates & Finance CiC | **20<br>(4 x 5)** | ⟷ | 15 |
| **1.3** | **Clinical Strategy**<br>The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care, which is high quality, safe and sustainable | Chief of Strategy & Partnerships | Trust Boards in Common | **12<br>(3 x 4)** | ⟷ | 8 |
| **1.4** | **Estate, Infrastructure and Equipment**<br>The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high-quality care and/or a safe and satisfactory environment for patients, staff and visitors | Chief Financial Officer | Performance, Estates Finance & CiC | **20<br>(4 x 5)** | ⟷ | 20 |
| **1.5** | **Digital Infrastructure**<br>The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches | Chief Medical Officer | Audit, Risk and Governance CiC & Trust Boards in Common | **6<br>(2 x 3)** | ⟷ | 6 |
| **1.6** | **Business Continuity**<br>The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure) | Chief Delivery Officer | Performance, Estates & Finance CiC | **12<br>(3 x 4)** | ⟷ | 8 |
| 2 | **Workforce**<br>The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients | Chief People Officer | Workforce, Education & Culture CiC | **20<br>(4 x 5)** | ⟷ | 15 |
| **3.1** | **In Year Finance Target**<br>The risk that either the Trust or the Humber and North Yorkshire Integrated | Chief Financial Officer | Performance, Estates & Finance CiC | **4** | ⟷ | 8 |

| Ref | Risk Summary | Executive Lead | Assurance Committee | Current risk (LxC) | Change from previous Qtr | Target Risk Score |
|---|---|---|---|---|---|---|
| | Care System fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse | | | | | |
| **3.2** | **Major Capital** The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades | Chief Financial Officer & Chief of Strategy & Partnerships | Trust Boards in Common | **15 (3 x 5)** | ↔ | 15 |
| **4** | **Partnership & Collaboration** The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment | Chief of Strategy & Partnerships | Trust Boards in Common | **12 (3 x 4)** | ↔ | 8 |
| **5** | **Leadership** The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives | Chief Executive | Workforce, Education & Culture CiC & Trust Boards in Common | **16 (4 x 4)** | ↔ | 8 |

The Boards in Common are asked to approve the Q4 year-end risk ratings for the HUTH/NLAG BAF Risks.

## 4. Board Assurance Framework Development

Since April 2024 meetings have been held with all the Executive leads and the following HUTH/NLAG BAF Risks have been merged:

- Workforce
- Culture and Leadership
- Performance
- Digital (IT)
- Cyber security
- Finance
- Estates
- Group Strategy
- Strategic Capital
- Strategic Partnerships and Collaboration

## 5. Group Quality Risks

The BAF quality risks have been reviewed for HUTH/NLAG and updated from an assurance point of view. Further work is underway with the Group Chief Nurse, Group Chief Medical Officer and Group Quality Governance Director of a more root and branch nature to help strengthen risk management and as part of the refreshed risk strategy for the Group.

## 6. Capital Risks

The Boards-in-Common should note that the nature of the estates risk and a strategic capital risk are heavily aligned and further work will be undertaken to align these.

## 7. Other changes

Other changes to the Board Assurance Framework in Q1 2024/25 include:

- Reviewing the the original key controls – some have been updated to ensure they cover the control systems in place to assist in addressing the risk.
- Checking the sources of assurance to ensure that the controls are having an impact, are effective and comprehensive.

## 8. Next Steps

During June actions will be assigned to any gaps in controls highlighted and again submitted for review by the Committees-in-Common. Regular catch up meetings will be established with Board members or key personnel to ensure risks are updated in a timely way.

## 9. Recommendations

**The Boards in Common are asked to:**

- Approve the Q4 year-end risk ratings for the HUTH/NLAG BAF Risks (above at 3)
- Approve the Q1 Group BAF risks noting the further updates to follow.

**Rebecca Thompson**
**Deputy Director of Assurance**
**June 2024**

## Appendix 1 – Q1 2024-25 BAF Summary

| No | Description of Risk | Lead | Committees in Common | Current Risk Rating | Movement since last Qtr | Target Risk Rating |
|---|---|---|---|---|---|---|
| **Group** | | | | | | |
| 1 | **Group Workforce** – The Group does not effectively manage its risks around staffing levels, both quantitative and qualitative and does not provide quality of care to its patients | Group Chief People Officer | Workforce, Education and Culture Committees in Common | 16<br>4 x 4 | | 12<br>3 x 4 |
| 2 | **Group Culture and Leadership** – The Group does not make progress towards further improving a positive working culture this year and must have leadership capacity to develop an outstanding working environment | Group Chief People Officer | Workforce, Education and Culture Committees in Common | 16<br>4 x 4 | | 12<br>3 x 4 |
| 3 | **Group Finance** – There is a risk that the Group does not achieve delivery of the in-year financial plans or manage the underlying position appropriately | Group Chief Financial Officer | Performance, Estates and Finance Committees in Common | 25<br>5 x 5 | | 5<br>1 x 5 |
| 4 | **Group Estates** - The risk that the Group's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) | Group Chief Financial Officer | Performance, Estates and Finance Committees in Common | 20<br>4 x 5 | | 15<br>3 x 5 |
| 5 | **Group Digital (IT Failure)** – There is a risk that the Group will suffer a major failure of its digital systems, leading to loss of life, finance and reputation through inability to maintain business continuity | Group Chief Medical Officer | Capital and Major Projects Committees in Common | 15<br>3 x 5 | | 10<br>2 x 5 |
| 6 | **Group Digital (Cyber Security) –** There is a risk that the Group will suffer a Cyber-Attack, leading to loss of life, finance and reputation through inability to maintain business continuity | Group Chief Medical Officer | Capital and Major Projects Committees in Common | 15<br>3 x 5 | | 10<br>2 x 5 |
| 7 | **Group Performance –** The risk is that the Group fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care | Group Chief Delivery Officer | Performance, Estates and Finance Committees in Common | 20<br>4 x 5 | | 16<br>4 x 4 |
| 8 | **Group Strategy -** There is a risk that the Group Strategy is not effective and does not allow the Group to deliver high quality and sustainable care and that the list of priorities do not align to investments, causing conflict | Group Chief of Strategy and Partnerships | Boards in Common | 12<br>3 x 4 | | 8<br>2 x 4 |
| 9 | **Group Strategic Capital -** The risk that the Group fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades | Group Chief of Strategy and Partnerships/Group Chief Financial Officer | Capital and Major Projects Committees in Common | 15<br>3 x 5 | | 15<br>3 x 5 |
| 10 | **Group Strategic Partnerships and Collaboration -** There is a risk that the Group does not prioritise actions at PLACE and ICB to fulfill its Anchor role which increases health inequalities, competition and competition in workforce. The Group also fails to work collaboratively to innovate and change pathways | Group Chief of Strategy and Partnerships | Boards in Common | 12<br>3 x 4 | | 8<br>2 x 4 |
| 11 | **Business Continuity**<br>The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure) | Group Chief Delivery Officer | Performance, Estates and Finance Committees in Common | 12<br>3 x 4 | | 8<br>2 x 4 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **HUTH/NLAG** | | | | | | |
| | **HUTH – Quality** – There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' CQC rating | Group Chief Nurse | Quality and Safety Committees in Common | 16<br>4 x 4 | | 12<br>3 x 4 |
| | **HUTH – Patient Harm** – 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. | Group Chief Medical Officer/Group Chief Nurse/Group Chief Delivery Officer | Quality and Safety Committees in Common | 20<br>4 x 5 | | 16<br>4 x 4 |
| | **HUTH – 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 | Group Chief Medical Officer | Quality and Safety Committees in Common | **12**<br>**3 x 4** | | 8<br>2 x 4 |
| | **NLAG – Quality of Care** - The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience | Group Chief Medical Officer/Group Chief Nurse | Quality and Safety Committees in Common | **15**<br>**3 x 5** | | 15<br>3 x 5 |

**Appendix 2 – Q1 BAF for 2024-25**
This appendix contains the Board assurance framework updated to Q1 of 2024-25.

| **Group BAF - Workforce** | | | | 16 |
|---|---|---|---|---|
| The Group does not effectively manage its risks around staffing levels, both quantitative and qualitative and does not provide quality of care to its patients. | | | | |
| Executive Lead | Group Chief People Officer | Assurance Committee | Workforce Education and Culture Committees in Common | |
| Executive Group | Group Cabinet Risk and Assurance Committee | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | Honest, caring and accountable culture | | Partnership and integrated services | | Link to BAF and CRR | **NLAG**<br>• CRR 1851 - Shortfall in Capacity within the Ophthalmology Service - 15<br>• CRR 2550 - Pharmacy Staffing = 15<br>• CRR 2898 - Medical Staff - Mandatory Training Compliance = 16<br>• CRR 2960 - Risk of inability to safely staff maternity unit with Midwives = 16<br>• CRR 3015 - Insufficient estate resources to manage the workload demand = 20<br>• CRR 3045 - Medical Workforce Vacancies in Gastroenterology = 16<br>• CRR 3048 - Challenges to recruitment of acute care physician vacancies in Acute = 16<br>• CRR 3063 - Doctors Vacancies within Medicine Division = 16<br>• CRR 2976 - High registered nursing vacancy levels = 25<br>• CRR 3209 - Risk to Junior Medical Cover - Recruitment Delays to Acute TG CT = 16<br>• CRR 3217 - Breast Imaging Workforce Depletion, and delays to deliver care occurring to cancer standards = 15<br>**HUTH**<br>• CRR 3439 – Crowding in the ED<br>• CRR 4166 – Risk to patient safety and achievement of organisational falls<br>• CRR 3044 – Shortage of Breast Pathologists |
| | Well-led, skilled and sufficient workforce | ✓ | Research and innovation | | | |
| | High Quality Care | | Financial Services | | | |
| | Great Clinical Services | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | | | | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 4 | | | | | 4 | 12 |
| Consequence | 4 | | | | | 5 | |
| Risk Score | 16 | | | | | 20 | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances |
| • HUTH Current People Strategy<br>• NLAG Current People Strategy<br>• Group Workforce Plan 2024/25<br>• Annual National Staff Survey | Internal<br>• Development of the new Group People Strategy<br>• Group Workforce Transformation Committee in development<br>• Group Executive Management Committee will receive escalation reports from the Group Workforce Transformation Committee<br>• Workforce, Education and Culture Committees in Common<br>• Remuneration Committees in Common<br>• Integrated Performance Report (Sickness, vacancy, appraisal rate, retention)<br>• International recruitment drives<br>• Certificate of Eligibility for Specialist Registration (CESR Programme) – specialist qualification before becoming a consultant<br><br>External<br>• HNY and Care Partnership ICB Workforce Board<br>• Internal Audits<br>• HR Director Chairs meeting (NHS Employers)<br>• HR Network |
| | **Gaps in Assurance**<br>**NLAG**<br>• Vacancy position reducing overall<br>• Nursing vacancies reducing<br>• Consultant vacancy position remains high.<br>• Agency spend remains high<br>• Turnover reducing, but above target |
| **Gaps in controls and assurances** | |
| • Hard to recruit roles in medical specialties<br>• Attract, recruit and retain staff to work in the geographical area<br>• Culture and staff engagement | |

| **Actions planned** | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Group People Strategy to be developed and launched 2025 | SN | January 2025 | |
| Launch new recruitment drives using the Group name to attract high caliber candidates | SN | | |

## Group BAF – Culture and Leadership

| Group BAF – Culture and Leadership | | | | 16 |
|---|---|---|---|---|
| The Group does not make progress towards further improving a positive working culture this year and must have leadership capacity to develop an outstanding working environment | | | | |
| Executive Lead | Group Chief People Officer | Assurance Committee | Workforce Education and Culture Committees in Common | |
| Executive Group | Group Cabinet Risk and Assurance Committee | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | Honest, caring and accountable culture | ✓ | Partnership and integrated services | | Link to BAF and CRR | • None at present |
| | Well-led, skilled and sufficient workforce | | Research and innovation | | | |
| | High Quality Care | | Financial Services | | | |
| | Great Clinical Services | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | | | | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 4 | | | | | 4 | 12 |
| Consequence | 4 | | | | | 5 | |
| Risk Score | 16 | | | | | 20 | |

| Controls and Assurance | |
|---|---|
| **Key controls** | **Assurances** |
| • HUTH Current People Strategy<br>• NLAG Current People Strategy<br>• Group Workforce Plan 2024/25<br>• Annual National Staff Survey<br>• NLAG Leadership Strategy<br>• CQC Well Led Framework | Internal<br>• Development of the new Group People Strategy<br>• Group Workforce Transformation Committee in development<br>• Group Executive Management Committee will receive escalation reports from the Group Workforce Transformation Committee<br>• Workforce, Education and Culture Committees in Common<br>• Disability Network<br>• BAME Network<br>• Group Leadership quarterly events<br>• Group Values workshops<br>• Circle Group<br>• Care Group Recruitment<br>• Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Integrated Care System<br><br>External |

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- HNY and Care Partnership ICB Workforce Board
- Internal Audits
- HR Director Chairs meeting (NHS Employers)
- HR Network

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**Gaps in Assurance**

- Risk around the New Care Group coming together and going live.  There is an Organisational Development plan being developed to support the development of the 14 Care Groups

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<tr><td colspan="2">Gaps in controls and assurances</td></tr>
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- Group Staff Survey Results 2023

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| **Actions planned** | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Group People Strategy to be developed and launched 2025 | SN | | Monitored through WEC CIC |
| Organisational Development Plan being developed to support the new Care Groups | SN | | Monitored through WEC CIC |

| Group BAF - Finance | | | | 25 |
|---|---|---|---|---|
| There is a risk that the Trust does not achieve delivery of the in-year financial plan or manage the underlying position appropriately | | | | |
| Executive Lead | Group Chief Financial Officer | Assurance Committee | Performance Estates and Finance Committees in Common | |
| Executive Group | Performance Estates and Finance Committees in Common | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | Honest, caring and accountable culture | | Partnership and integrated services | | Link to BAF and CRR | • CRR 3162 - quality of patient care and patient safety based on nurse staffing position and increase in use of bank and agency nurses and escalation beds = 20<br>• CRR 3174 - Trust does not receive SystmOne information to be able to submit costs at a patient level as per mandatory requirements of NHSE = 15<br>• CRR 3202 - Non-delivery of Medicine Divisional Finance CIP = 16<br>• CRR 3221 - Badgernet Implementation, due to potential failure to obtain funding, may result in an adverse impact on patient safety and Trust reputation = 15<br>• CRR 3226 - Risk of not being able to support delivery of new work relating to quality and audit workstreams, due to PAS/Lorenzo development freeze, may result in negative impact on patients quality of care and financial loss = 16 |
| | Well-led, skilled and sufficient workforce | | Research and innovation | | | |
| | High Quality Care | | Financial Services | ✓ | | |
| | Great Clinical Services | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | | | | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 5 | | | | | 5 | 5 |
| Consequence | 5 | | | | | 5 | |
| Risk Score | 25 | | | | | 25 | |

| Controls and Assurance | |
|---|---|
| **Key controls** | **Assurances** |
| • Operational and Financial Plan 2024/25<br>• Group Executive to Triumvirate Performance Review meetings<br>• NHS E/ICS engagement<br>• Group Counter Fraud and Internal Audit Plans<br>• Group Budgetary Control System | **Internal**<br>• Minutes of Audit Risk and Governance Committees in Common (Quarterly)<br>• Minutes of Performance, Estates and Finance (Monthly)<br>• Highlight reports to the Trust Board (Monthly)<br><br>**External**<br>• Internal Audit Reports<br>• Financial planning updates to ICS<br>• Meetings with NHSE Regional Team<br>• Benchmarking |

| | Gaps in Assurance |
|---|---|
| | **Gaps in Assurance**<br>• £84m Cost Improvement Programme<br>• Underlying deficit 2024/25<br>• Bed Pressures<br>• ERF Delivery<br>• Profile of EPR vs funding allocation<br>• CQC Quality issues – financial implications<br>• Junior Doctors strike implications |
| **Gaps in controls and assurances** | |
| • Ongoing development of accountability of Care Groups<br>• Industrial Action<br>• Cost Improvement Programme not fully formed.<br>• Delivery plan to support activity targets not fully formed.<br>• Clinical strategy required to inform Finance Strategy<br>• As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process<br>• Month on month adverse variants against operational budgets<br>• Inability to recruit and retain staff to meet financial planning assumptions | |

**Actions planned**

| Action | Lead | Due date | Progress update |
|---|---|---|---|
| Cost Improvement Plan to be developed 2024/25 | LB | | Monitored through PEF CIC |
| | | | |

## Group BAF Estates

| Group BAF Estates | |
|---|---|
| The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors. | 20 |

| Executive Lead | Chief Financial Officer | Assurance Committee | Performance, Estates Finance Committees in Common |
|---|---|---|---|
| Executive Group | Performance, Estates Finance Committees in Common | Latest review date | 03/06/24 |

### Strategy and Risk Register

| Link to Strategy | | | | |
|---|---|---|---|---|
| To give great care | ✓ | To provide good leadership | |
| To be a good employer | | | |
| To live within our means | ✓ | | |
| To work more collaboratively | | | |

**Link to BAF and CRR**

- CRR 1620 - Medical Gas Pipeline System = 20
- CRR 2038 - Fire Compliance = 20
- CRR 2623 - Failure of windows - Trustwide = 20
- CRR 2088 - Building Management Systems (BMS) Controller failure/upgrade = 20
- CRR 2719 - Water Safety Compliance: Oversized water distribution pipes = 20
- CRR 2951 - Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
- CRR 2655 - SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
- CRR 3015 - Insufficient estate resources to manage the workload demand - Trustwide = 20
- CRR 1774 - Poor condition of Fuel Oil Storage Tanks - SGH = 16
- CRR 2035 - Equality Act 2010 compliance - Trustwide = 16
- CRR 2272 - EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
- CRR 2905 - Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
- CRR 295 - Water Safety Compliance: Fire ring main - Trustwide = 16
- CRR 2953 - Water Safety Compliance: Sensor taps - Trustwide = 16
- CRR 2959 - Replacement/Repairs of flat roof - Trustwide = 16
- CRR 2036 - Ventilation and Air Conditioning - HVAC - Trustwide = 15
- CRR 2955 - Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide = 15

### Risk Scoring (Current)

| Quarter | Q1 (2024/25) | | | | Change from previous quarter | Inherent Risk | Target Risk |
|---|---|---|---|---|---|---|---|
| Likelihood | 4 | | | | | 3 | **15** |
| Consequence | 5 | | | | | 5 | |
| Risk Score | 20 | | | | | 20 | |

### Controls and Assurance

| Key controls | Assurances |
|---|---|
| • Captial Programme in place and risk assessed<br>• Comprehensive maintenance programme | • External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts<br>• Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark) |

| Controls and Assurance | |
|---|---|
| **Key controls** | **Assurances** |
| in place<br>• Group Capital and Major Projects Committees in Common<br>• Service level business continuity plans in place | • Premises Assurance Model<br><br>Internal:<br>• Minutes of Performance, Estates and Finance Committees in Common, Audit Risk & Governance Committees in Common, Capital and Major Projects Committees in Common<br>• Non-Executive Director Committee Chair Highlight Report to Trust Board<br>• Specialist Technical Groups<br><br>External:<br>• ERIC (Estates Return Information Collection) |
| **Gaps in controls and assurances** | |
| **Gaps in Controls:**<br>• Lack of ICS Funding aligned for key infrastructure needs/requirements<br>• Insufficient Capital funding | **Gaps in Assurance:**<br>• Integrated Performance Report - Estates and Facilities (development in progress) |

| Actions planned | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Capital Programme 2024/25 | LB | | Monitored through PEF CIC |

## BAF Digital – IT Failure

| BAF Digital – IT Failure | | | | 15 |
|---|---|---|---|---|
| There is a risk that the Group will suffer a major failure of its digital systems, leading to loss of life, finance and reputation through inability to maintain business continuity. | | | | |
| Executive Lead | Chief Medical Officer | Assurance Committee | Capital and Major Projects Committees in Common | |
| Executive Group | Capital and Major Projects Committees in Common | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | To give great care | ✓ | To provide good leadership | | Link to BAF and CRR | CRR 3294 - Unstable Multitone System - Emergency Bleeps<br>CRR 3238 - Workstation on Wheels Charging Units<br>CRR 3224 - Risk of flooding and water damage to SGH Data Centre from flat roof leaking |
| | To be a good employer | | | | | |
| | To live within our means | | | | | |
| | To work more collaboratively | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 3 | | | | ↔ | | 10 |
| Consequence | 5 | | | | | | |
| Risk Score | 15 | | | | | | |

| Controls and Assurance | |
|---|---|
| **Key controls** | **Assurances** |
| • Up to date Organisational and Digital / IT policies, procedures and guidelines.<br>• Infrastructure investment and improvement plan in progress, but with scope to expand.<br>• Up to date software and hardware, with procedures for patching and replacement once at end of life<br>• Robust EPRR links with up to date, exercised BC/DR plans across all care groups.<br>• Digital Strategy Board<br>• Digital Solutions Delivery Group<br>• Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation. | • NLAG N08/2024 IT Disaster Recovery Plan – Limited Assurance. Tracked at Internal Audit, Risk and Governance Committee.<br>• NLAG N12/2024 Change Control Management – Limited Assurance. Tracked at Internal Audit, Risk and Governance CIC.<br>• Internal Audit, Data Security and Protection Toolkit 2023/24<br><br>**Planned**<br><br>Internal:<br>• Board awareness session around responsibilities under NIS 2018 (Maintenance of critical infrastructure) to be scheduled.<br>• Digital strategy to be produced for the group, laying down our investment case for Group Digital Foundations.<br><br>External:<br>• TBC |

| | |
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| | |
| **Gaps in controls and assurances** | |
| **Gaps in Controls:**<br>● Legacy systems that cannot be retired and modernised due to reliance on out of date software and equipment (i.e, WebV and NLAG door access system).<br>• Lack of policies and governance on HUTH estate. | **Gaps in Assurance:**<br>● No oversight of major digital systems that sit outside of the digital directorate.<br>• Not currently compliant with industry standards such as ITIL V4, COBIT and ISO27001 |

| **Actions planned** | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Complete our DSPT Audit to identify gaps in controls across the Group and develop a robust remediation plan. | CMO | Q1 24/25 | On track to deliver |
| Plan to align digital governance across the Group | GCDO / GCTO | Q3 24/25 | This is being monitored at the C&MP CIC |

| **BAF Cyber Security** | | | | 15 |
|---|---|---|---|---|
| There is a risk that the Group will suffer Cyber-Attack, leading to loss of life, finance and reputation through inability to maintain business continuity. | | | | |
| Executive Lead | Chief Medical Officer | Assurance Committee | Capital and Major Projects Committees in Common | |
| Executive Group | Capital and Major Projects Committees in Common | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | To give great care | ✓ | To provide good leadership | | Link to BAF and CRR | **CRR 3277** – No recurrent revenue to continue the Imprivata Single SignOn and Fairwarning System<br>**CRR 3278** - No recurrent revenue to continue the Cynerio IoT Cyber Management System after 3 year contract ends at 07-03-2025 |
| | To be a good employer | | | | | |
| | To live within our means | | | | | |
| | To work more collaboratively | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 3 | | | | ↔ | | 10 |
| Consequence | 5 | | | | | | |
| Risk Score | 15 | | | | | | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances |
| ● Up to date Organisational and Digital / IT policies, procedures and guidelines<br>• Up to date software and hardware, with procedures for patching and replacement once at end of life<br>• Cyber security partner to provide support in the event of an attack.<br>● Digital Strategy Board<br>• Digital Solutions Delivery Group in NLAG<br>● Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.<br>● Annual Penetration Tests<br>● Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication | **Positive**<br>● Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023<br><br>**Planned**<br><br>Internal:<br>● Board awareness session on Cyber-Security and Board statutory responsibility.<br>• Digital strategy to be produced for the group, laying down our posture and approach to cyber security.<br><br>External:<br>● Data Security and Protection Toolkit (DSPT) audit Apr-Jun this year to assess our cyber and information governance performance and plans for the future. |

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| | |
| **Gaps in controls and assurances** | |
| **Gaps in Controls:**<br>• Legacy systems that cannot be retired and modernised due to reliance on out of date software and equipment (i.e, WebV and NLAG door access system).<br>• Variation in cyber-resilience across the two organisations within the Group.<br>• Incomplete rollout of Multi-Factor Authentication (MFA) to secure our accounts from being compromised.<br>• Lack of dedicated cyber personnel across the group.<br>• Low levels of cyber awareness and digital maturity in some staff groups. | **Gaps in Assurance:**<br>• No oversight of major digital systems that sit outside of the digital directorate.<br>• Lack of Data Security Mandatory Training ( critical that operational managers across all divisions ensure that staff completed the training)<br>• No organizational wide preparation or exercising of BCDR plans in relation to a cyber-attack. |

| **Actions planned** | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Complete our DSPT Audit to identify gaps in controls across the Group and develop a robust remediation plan. | CMO | Q1 24/25 | On track to deliver |
| Roll out MFA across the Group. | CMO | June 24 | On track to deliver |
| Conduct Board Cyber Awareness training, highlighting Board and wider organizational accountability. | CMO | Q1 24/25 | To be added to the Board Development Programme |
| Conduct organizational EPRR cyber-attack exercise | TBC | Q2 24/25 | Monitored through the EPRR Board |

| BAF Performance | | | | 20 |
|---|---|---|---|---|
| The risk is that the Group fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care | | | | |
| Executive Lead | Group Chief Delivery Officer | Assurance Committee | Performance Estates and Finance Committees in Common | |
| Executive Group | Performance Estates and Finance Committees in Common | Latest review date | 03/06/24 | |

**Strategy and Risk Register**

| Link to Strategy | | | | | Link to BAF and CRR | |
|---|---|---|---|---|---|---|
| | Honest, caring and accountable culture | | Partnership and integrated services | ✓ | | CRR 3439 – Crowding in Emergency Department<br>CRR 4179 – Delivering the operational plan to reduce backlog of long waits<br>CRR 4178 – Delivering improvement trajectories for screening programmes<br>CRR 3994 – Discharges and patient flow with impact on quality and safety<br>CRR 2982 – Lack of Anesthetic cover for under 2's out of hours<br>CRR 3997 – Persistent failure of A&E 4 hour target<br>CRR 3998 – Quality issues identified due to handover delays<br>CRR 4211 – Patient safety risks due to multiple factors in the Antenatal Day Unit<br>CRR 4048 – Risk to continuity of service due to ageing radiotherapy Linac<br>CRR 4166 – Risk to patient safety and achievement of organisational falls<br><br>CRR 1851 - Shortfall in capacity with Ophthalmology service = 15<br>CRR 2244 - Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16<br>CRR 2245 - Risk to Overall Performance: Non-compliance with RTT incomplete target = 16<br>CRR 2562 - Failure to meet constitutional targets in ECC = 20<br>CRR 2347 - Risk to Overall Performance: Overdue Follow-ups = 15<br>CRR 2592 - Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16<br>CRR 2773 - Lack of scanning capacity s leading to a risk of delayed diagnosis = 16<br>CRR 2949 - Oncology Service = 20<br>CRR 3129 - Overdue follow-up and new patients waiting lists for paediatric patients at SGH = 15<br>CRR 3131 - Delay in paediatric assessment being carried out (multi-agency assessment for under five years of age = 16<br>CRR 3201 - Clinical capacity within colposcopy = 15 |
| | Well-led, skilled and sufficient workforce | | Research and innovation | | | |
| | High Quality Care | ✓ | Financial Services | | | |
| | Great Clinical Services | ✓ | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | CRR 3204 - One year wait for new referrals to see a Consultant Paediatrician into the ADHD post diagnostics support service = 15<br>CRR 3217 - Breast Imaging Workforce Depletion, and delays to deliver care occurring to cancer standards = 20<br>CRR 3196 - Breast Imaging Service loss of capacity = 15<br>CRR 3048 - Challenges to recruitment of acute care physician vacancies in Acute = 16<br>CRR 3063 - Doctors Vacancies within Medicine Division = 16<br>CRR 304 - Medical Workforce Vacancies in Gastroenterology = 16<br>CRR 3114 - Delays in Children being reviewed in DPOW Paediatric Endocrine Service = 20<br>CRR 2576 - Paediatric Medical Support Pathway for ECC - 'Fastrack' = 16<br>CRR 2775 - Scunthorpe MRI scanner past end of 7 year life, lack of capital availability, impact will be reduced capacity to deliver scans for some cancer pathways = 20<br>CRR 3168 - Newborn hearing screening service cross-site (reduced management time / no management cover) = 16 |

**Risk Scoring (Current)**

| Quarter | Q1 (2024/25) | Q2 | Q3 | Q4 | Change from previous quarter | Inherent Risk | Target Risk |
|---|---|---|---|---|---|---|---|
| Likelihood | 4 | | | | ↔ | 5 | 16 |
| Consequence | 5 | | | | | 5 | |
| Risk Score | 20 | | | | | 25 | |

**Controls and Assurance**

| Key controls | Assurances (Positive, Negative and Planned) |
|---|---|
| • External scrutiny from NHSE/ICB/CQC<br>• Constitutional performance targets<br>• Operational Plan 2024/25<br>• Access Policy<br>• Capacity and Demand planning<br>• Unplanned Care Board<br>• Cancer Improvement Plans<br>• Primary and Secondary Care Collaborative Outpatient Transformation Programme<br>• Planned Care Board<br>• Emergency Department and Medicine Specialties Quality & Safety Groups<br>• Planning and Performance<br>• **Cancer Delivery Group**<br>• **Diagnostic Delivery Group**<br>• **RTT Delivery Group** | • Urgent Treatment Centre<br>• Same Day Emergency Care review ongoing<br>• Revised Cancer trajectories submitted to ICB and further funding received<br>• CQC visit to ED in April 2025<br>• Benchmarking reports<br>• Internal Audit Reports<br>• Completed job plans for relevant clinicians for 2024/25<br>• Waiting List Assurance Meetings<br>• Winter Planning Group<br>• Policies, procedures, guidelines, pathways supporting documentation & IT systems<br>• MDT Business Meetings<br>• Risk stratification<br>• Emergency Care Quality & Safety Group |

| | |
|---|---|
| | • System-wide Ambulance Handover Improvement Group<br>• Executive to Triumvirate meetings<br>• Executive Management Committee to be developed<br>• Care Group Structure development<br>• Performance, Estates and Finance Committees in Common challenge<br>• Performance report to the PEF CIC<br>• Integrated performance Report<br>• **Cancer Delivery Group**<br>• **Diagnostic Delivery Group**<br>• **RTT Delivery Group**<br>• **Planned Care Board**<br>• **Unplanned Care Board**<br><br>External:<br>• Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited<br>• NHSE Intensive Support Team<br>• Independent Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022<br>• ECIST & GIRFT Support Team Visits Scheduled for Nov 2023 |
| **aps in controls and assurances** | |
| • Mismatch between demand and capacity<br>• Flow through the ED department<br>• Patients with NCTR<br>• Ambulance handover position<br>• Cancer performance<br>• Increase in GP referrals - referral triage and Advice and guidance<br>• Impact of Industrial Action<br>• IPC risks<br>• Patient Choice and willingness to accept alternative providers<br>• Quality of reports to board assurance committees<br>• Quality and timeliness of data<br>• Recruitment and development of Consultants, specialist nurses | • Evidence of compliance with 7 Day Standards<br>• Capacity to meet demand for Cancer, RTT/18 weeks, over 64 weeks, over 52 week waits and Diagnostics Constitutional Standards<br>• Diagnostic capacity and capital funding to be confirmed.<br>• Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations<br>• High levels of staff sickness<br>• High levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas |

**Actions planned**

| Group Actions | Lead | Due date | Progress update |
|---|---|---|---|
| Consultant job plans to be signed off for 2024/25 | CDO | Q3 24/25 | This is being monitored through the WEC CIC |

## BAF Group Strategy

| BAF Group Strategy | | | | 12 |
|---|---|---|---|---|
| There is a risk that the Group Strategy is not effective and does not allow the Group to deliver high quality and sustainable care and that the list of priorities do not align to investments, causing conflict. | | | | |
| Executive Lead | Chief of Strategy & Partnerships | Assurance Committee | Trust Boards in Common | |
| Executive Group | Trust Boards in Common | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | To give great care | ✓ | To provide good leadership | | Link to BAF and CRR | None at present |
| | To be a good employer | | | | | |
| | To live within our means | | | | | |
| | To work more collaboratively | ✓ | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 3 | | | | ↔ | 3 | 8 |
| Consequence | 4 | | | | | 4 | |
| Risk Score | 12 | | | | | 12 | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances |
| • Integrated Care Board meetings<br>• PLACE meetings<br>• Group Structure/Governance<br>• Collaboration of Acute Provider Boards<br>• Humber Cancer Board<br>• Acute and Community Care Collaborative<br>• Health Overview and Scrutiny Committees | **Positive**<br>● NHSE Assurance and Gateway Reviews.<br>● OSC Engagement.<br>● Clinical Senate formal review<br>● The Consultation Institute (assurance on the engagement process) |
| | **Planned**<br><br>Internal:<br>● Minutes from Capital and Major Projects Committees in Common<br>● Humber and North Yorkshire Integrated Care System<br>● ICS Leadership Group<br>● OSC Feedback<br>● Outcome of public, patient and staff engagement exercises.<br>● Executive Director Report to Trust Board<br>● Non-Executive Director Committee Chair Highlight Reports to Trust Boards in Common<br><br>External:<br>● Clinical Senate Reviews.<br>● Independent Peer Reviews re; service change (ie Royal Colleges) |

| | |
|---|---|
| | • Citizens Panel (Humber).<br>• The Consultation Institute |
| **Gaps in controls and assurances** | |
| **Gaps in Controls:**<br>• A shared vision for the HAS programme is not understood across all staff/patients and partners | **Gaps in Assurance:**<br>• Feedback from public, patients and staff to be widespread and specific in cases, that is benchmarked against other programmes<br>• Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time<br>• Alignment of strategic capital |

| Actions planned | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Leadership at System level and PLACE 2024/25 | Group Chief of Strategy and Partnerships | | Progress will be monitored at the C&MP CIC and the Boards in Common |

| **BAF Group Strategic Capital** | | | | 15 |
|---|---|---|---|---|
| The risk that the Group fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades. | | | | |
| Executive Lead | Group Chief Financial Officer and Group Chief of Strategy & Partnerships | Assurance Committee | Capital and Major Projects Committees in Common | |
| Executive Group | Capital and Major Projects Committees in Common | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | To give great care | ✓ | To provide good leadership | | Link to BAF and CRR | None at present |
| | To be a good employer | | | | | |
| | To live within our means | ✓ | | | | |
| | To work more collaboratively | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 3 | | | | ↔ | 3 | **15** |
| Consequence | 5 | | | | | 5 | |
| Risk Score | 15 | | | | | 15 | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances (all negative) |
| • Capital Investment Board (Internal Capital)<br>• Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly<br>• Trust Boards in Common<br>• Trust Committees in Common<br>• ICS Strategic Capital Advisory Group | • No strategic plan for all sites<br>• Deteriorating infrastructure 10% per year<br>• No money to fund major changes to sites HUTH £100m required, Scunthorpe £50m required.<br><br>**Planned**<br>Internal:<br>● Minutes of Internal Trust Meetings<br><br>External:<br>● NHSE attendance at AAU / ED Programme Board<br>● CiC Minutes<br>● PLACE Boards |
| **Gaps in controls and assurances** | |
| **Gaps in Controls:**<br>● Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend<br>● Control environment whilst comprehensive may not have ability to influence availability of | **Gaps in Assurance:**<br>● ICS CDEL not sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers |

| | |
|---|---|
| Strategic Capital - investment funding/affordability<br>• Control environment may not be able to eliminate or reduce risk of estates condition in the short term | |

| Actions planned | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Develop a strategic capital planning framework aligned with joint Board and integrated Place Strategies | Group Chief Financial Officer/Group Chief of Strategy and Partnerships | | In progress but off track (with mitigation) |

| BAF Group Strategic Partnerships and Collaboration | | | | 12 |
|---|---|---|---|---|
| There is a risk that the Group does not prioritise actions at PLACE and ICB to fulfill its Anchor role which increases health inequalities, competition and competition in workforce. The Group also fails to work collaboratively to innovate and change pathways. | | | | |
| Executive Lead | Group Chief of Strategy & Partnerships | Assurance Committee | Trust Boards in Common | |
| Executive Group | Trust Boards in Common | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | To give great care | | To provide good leadership | | Link to BAF and CRR | None at present |
| | To be a good employer | | | | | |
| | To live within our means | | | | | |
| | To work more collaboratively | ✓ | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 3 | | | | ↔ | 3 | **8** |
| Consequence | 4 | | | | | 4 | |
| Risk Score | 12 | | | | | 12 | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances (Positive, Negative and Planned) |
| • Audit Risk & Governance Committee (ARGC)<br>• Finance and Performance Committee (F&PC)<br>• Capital Investment Board (CIB)<br>• HAS Executive Oversight Group<br>• HNY ICS<br>• ICS Leadership Group<br>• Wave 4 ICS Capital Committee<br>• Executive Director of HAS and HAS Programme Director appointed<br>• Committees in Common<br>• Acute and Community Collaborative Boards<br>• Clinical Leaders & Professional Group<br>• Council of Governors<br>• Joint Overview & Scrutiny Committees<br>• MP cabinet and LA senior team briefings<br>• Primary/Secondary Interface Group (Northbank&Southbank)<br>• Place Boards | **Positive**<br>• HAS Governance Framework.<br>• Clinical Senate review approach and process<br>• Consultation Institute Review<br>• Place Boards and Place Working Groups established |
| | **Planned**<br>Internal:<br>• Minutes of HAS Executive Oversight Group, HNY ICS, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, CIB, CoG<br>• Non-Executive Director Committees in Common Chair Highlight Report to Trust Board |

| | |
|---|---|
| | • Executive Director Reports to the Trust Boards in Common<br><br>External:<br>• Clinical Senate Reviews.<br>• Independent Peer Reviews re; service change (ie Royal Colleges).<br>• NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.<br>• Councillors / MPs / Local Authority CEOs and senior teams<br>• Place Boards and Place Working Groups established<br>• Collaborative of Acute Providers Board |
| **Gaps in controls and assurances** | |
| **Gaps in Controls:**<br>• Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.<br>• Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)<br>• ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed | **Gaps in Assurance:**<br>• Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.<br>• Lack of integrated plan and governance structure. |

| **Actions planned** | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Collaboration and Leadership within the Group to form strong partnership arrangements | Group Chief of Strategy and Planning | | |

## BAF Business Continuity

| BAF Business Continuity | | | | 12 |
|---|---|---|---|---|
| The risk that the Group's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure). | | | | |
| Executive Lead | Group Chief Delivery Officer | Assurance Committee | Performance, Estates & Finance CiC | |
| Executive Group | Performance, Estates & Finance CiC | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | To give great care | | To provide good leadership | ✓ | Link to BAF and CRR | • CRR 2562 - Constitutional A&E targets = 20<br>• CRR 3164 - Nurse staffing = 20<br>• CRR 2976 - Registered nursing vacancies = 25<br>• CRR 3063 - Doctor vacancies = 16 |
| | To be a good employer | | | | | |
| | To live within our means | | | | | |
| | To work more collaboratively | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 3 | | | | ↔ | 2 | 8 |
| Consequence | 4 | | | | | 4 | |
| Risk Score | 12 | | | | | 12 | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances (Positive, Negative and Planned) |
| • Emergency Preparedness, Resilience and Response Board<br>• Emergency Preparedness, Resilience and Response Group<br>• Winter Planning Group<br>• A&E Delivery Board<br>• Director of People - Senior Responsible Owner for Vaccinations<br>• Ethics Committee<br>• Clinical Reference Group<br>• Influenza vaccination programme<br>• Public communications re: norovirus and infectious diseases<br>• Group Chief Delivery Officer is the Accountable Emergency Officer<br>• South Bank UEC Board<br>• North Bank UEC Board<br>• Unplanned Care Board<br>• Discharge System Improvement Group<br>• Planned Care Board<br>• Industrial action planning (Strategic and Tactical Group)<br>• Bank Holiday Planning Group<br>• Local Health Resilience Partnership (LHRP)<br>• Humber Local Resilience Forum (LRF) | **Positive**<br>• Half yearly tests of the Major incident response cascades completed<br>• Annual review of business continuity plans<br>• Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance<br>• EMAS annual CBRN audit for 2024 successful<br><br>**Planned**<br><br>Internal:<br>• National and Regional exercises testing emergency plans, business continuity and planning assumptions<br>• Business continuity management system and business continuity plans under review to relaunch with new Group-wide BCMS<br>• Minutes of various planning and oversight groups listed in the controls section<br><br>External:<br>• Emergency Planning self-assessment tool and peer review against the NHSE EPRR Core |

| | |
|---|---|
| ● Humber LRF Sub-Groups<br>● Executive Led Bed Occupancy and Length of Stay Review | Standards rated non-compliant for HUTH and NLAG for 2023/24. 2024/25 compliance process due to commence from July 2024<br>● Internal audit of emergency planning and business continuity compliance<br>● YAS annual CBRN audit for HRI for 2024<br>● Upcoming launch of new Health Commander Portfolios |
| **Gaps in controls and assurances** | |
| **Gaps in Controls:**<br>● Capacity to meet demand (workforce).<br>● Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into 2024/25.<br>● Lower than expected uptake of influenza vaccination. | **Gaps in Assurance:**<br>● BC Plans that are tested or implemented during exercises/incidents are not specifically named or captured within reports to evidence testing.<br>● Challenge in releasing workforce to attend specialist training (e.g. CBRN/HAZMAT).<br>● Recruitment pipeline to address medical staffing shortfalls and reduce reliance on agency.<br>● Inconsistent level of training for Health Commanders until new Health Commander Portfolios are embedded and training prioritised |

**Actions planned**

| Action | Lead | Due date | Progress update |
|---|---|---|---|
| Launch of new Group-wide EPRR Group | GCDO | Apr-24 | Complete – First meeting was 04/04/2024 |
| Launch of new Group-wide EPRR Board | GCDO | May-24 | Complete – First meeting will be 17/05/2024 |
| Review and integration of Group-wide EPRR Policy | GCDO | May-24 | Document created. Going for approval May 2024 |
| Review and integration of Group-wide Incident Coordination SOP | GCDO | Jun-24 | Document created. Going for approval May 2024 |
| Review and integration of Group-wide Major Incident Plan | GCDO | Jul-24 | Document in development |
| Review and integration of Group-wide Adverse Weather Plan | GCDO | May-24 | Document created. Going for approval May 2024 |
| Review and integration of Group-wide Excess deaths and Mass Fatalities Plan | GCDO | May-24 | Document created. Going for approval May 2024 |
| Changes to Senior Manager On-Call arrangements to align North and South Banks | GCDO | Jun-24 | Approved by Cabinet 29/04/2024. Changes to commence from 01/06/2024 |
| Review and integration of weekend and Bank holiday planning | GCDO | May-24 | New process now in place. Debrief to take place after May Bank Holiday to validate |
| Review, integration and relaunch of Business Continuity Management System with alignment to new Group structure | GCDO | Oct-24 | Review of existing BCMS at each Trust commenced |
| Inclusion of details of BC plans tested/implemented during exercises/incidents documented in reports | GCDO | Oct-24 | Review of existing BCMS will incorporate this process |
| Launch of new NHSE Health Commander | GCDO | Jun-24 | Portfolio template now |

| | | | |
|---|---|---|---|
| Portfolios | | | provided from NHSE. Support and guidance wraparound in development prior to launch |
| Ongoing participation in LRF planning and exercises | GCDO | Ongoing | Active participation ongoing |
| Ongoing participation in LHRP planning and exercises | GCDO | Ongoing | Active participation ongoing |
| Schedule of Major Incident table top training exercises with Strategic and Tactical Health Commanders | GCDO | Jul-24 | NLAG commenced during 2023 however on hold until new Group-wide Major Incident Plan in place |
| Full review of all EPRR Risk Registers | GCDO | Dec-24 | Review to commence in Q2 2024/25 to align with LHRP risk register process |
| Participate in regional hospital evacuation exercise to validate our Evacuation Plans | GCDO | Dec-24 | Regional exercise planned for Nov 2024 at Y&SH |
| NHSE Core Standard for EPRR 2024/25 compliance and assurance process | GCDO | Dec-24 | Awaiting national release |
| Winter Planning Group for 2023/24 | GCDO | Nov-24 | Completed. Debrief to take place to identify lessons for next cycle |
| Winter Planning Group for 2024/25 | GCDO | Aug-24 | Group to commence from August 2024 |

| BAF 3.1 | | | | 16 |
|---|---|---|---|---|
| There is a risk that the quality improvement measures set out in the HUTH Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' CQC rating. | | | | |
| Executive Lead | Group Chief Nurse | Assurance Committee | Quality and Safety Committees in Common | |
| Executive Group | Quality and Safety Committees in Common | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | Honest, caring and accountable culture | | Partnership and integrated services | | Link to BAF and CRR | CRR 3994 – Discharges and patient flow with impact on quality and safety<br>CRR 2982 – Lack of Anesthetic cover for under 2's out of hours<br>CRR 3997 – Persistent failure of A&E 4 hour target<br>CRR 3998 – Quality issues identified due to handover delays<br>CRR 4211 – Patient safety risks due to multiple factors in the Antenatal Day Unit<br>CRR 4048 – Risk to continuity of service due to ageing radiotherapy Linac |
| | Well-led, skilled and sufficient workforce | | Research and innovation | | | |
| | High Quality Care | ✓ | Financial Services | | | |
| | Great Clinical Services | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 4 | | | | ↔ | 4 | 12 |
| Consequence | 4 | | | | | 4 | |
| Risk Score | 16 | | | | | 16 | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances (Positive, Negative and Planned) |
| • Quality committee structure & work-plans;<br>• Health Group Governance Performance Management meetings;;<br>• Patient Safety Specialist role;<br>• Infection Prevention and Control (IPC) arrangements<br>• Safeguarding processes<br>• Fundamental Standards Nursing programme<br>• Quality Strategy/Quality Improvement Plan<br>• Serious Incident Management/ early adopter of PSIRF<br>• Annual Clinical Audit programme<br>• CQC improvement plans, overseen by Executive Check and Challenge process and Maternity Transformation Assurance Committee (MTAC).<br>• External agency register and process | **Positive Assurances**<br>***Emergency Department***<br>• ICB quality team visit report (15 December 2023);<br>• CQC ED engagement visit (non inspection/rating) positive feedback and observations including mental health (9 April 2024).<br>• ED national Patient Safety award for a Quality improvement initiative (November 2023);<br>• Friends and Family (FFT) monthly data demonstrating improvement since November 2023.<br>***Maternity***<br>• CQC Maternity action plan progress reported monthly;<br>• Healthwatch HRI 'Big Push' Maternity review concluding "many improvements to |

| | |
|---|---|
| • Horizon scanning Integrated Performance Report – BI Reporting<br>• CQC Action Plans in place<br>• Patient Safety Alert process | patient experience since inspection" (April 2023);<br>• FFT Birth score of 100% (maintained);<br>***Other prominent external assurances***<br>• Internal Audit CQC Action Plan Audit (Jan 24) – 35/35 (100%) of actions closed through Executive oversight corroborated to evidence supporting closure.<br>• CQC IR(MER) inspection – report received (October 2023) with no residual actions.<br><br>*Internal Measures*<br>• Nursing staff (Registered Nurses) recruited to a level 2.5% over budget (April 2024), with turnover reduced to 7.1%, facilitating greater ward staffing.<br>• Falls resulting in both number and rate of moderate or major harm remaining below the mean in 23/24. (QSC deep dive February 2024).<br>• Pressure Ulcers within control limits and harm reducing (QSC deep dive March 2024).<br>• Backlog of longstanding complaints addressed, quality sustained since August 2024 with limited reopened.<br><br>• PSII after action reviews established. |
| | **Negative**<br>• The Trust is an outlier in HSMR (116 Jan 24) and its SHMI mortality data is higher than expected (having increased to1.1391 to Dec 23)<br>• CQC Maternity Year 5 CNST declaration was not full compliance.<br>• Emergency Department failed to deliver the 76% target by end of March 2024 (61%).<br>• Ambulance turnaround times impacting on patients<br>• VTE compliance rate is below the Trust's 95% target. Additional QI support is being provided to identify improvement actions<br>• Infections due to rise in respiratory, norovirus, measles and diphtheria. |
| | **Planned**<br>• CQC ED action plan full delivery;<br>• CQC Maternity action plan full delivery;<br>• Weekly patient safety summit continuation.<br>• Development of the virtual ward and staff to support the falls team;<br>• Delivery of 23/24 CQUIN;<br>• Delivery of Group wider Quality Priorities for 2024/25 to support consistent delivery across End of Life, Deteriorating patient; Sepsis; Medication safety; and Mental capacity. |

| Gaps in controls and assurances | |
|---|---|
| Maternity Leadership Interim reliance.<br>VTE Compliance<br>CQC Maternity Section 31 two conditions | |

| Actions planned | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Delivery of 23/24 CQUIN programme | ADQG | Q4 23/24 | In progress – 7/12 on target to fully achieve |
| Implementation of HUTH Patient Safety Incident Response Plan by April 2024 | CNO | Q1 23/24 | Completed |
| Deliver Improvements of Fundamental Standards Programme | CNO | Q4 23/24 | Improvements noted quarterly. |
| VTE Quality Improvement Programme | CMO | Q3 24/25 | QI team supporting targeted wards. |
| Mortality Strategy – The implementation of a refreshed Mortality Strategy to direct the work of the Mortality Improvement Group in responding to the Trust's higher than average SHMI. | CMO | Q2 24/25 | In progress, targeted work at Castle Hill and against the three condition groups highlighted as an outlier. |
| Maternity Governance Structure – implement enhanced governance structure to expedite completion of Section 31 (two conditions) and CQC inspection actions | CNO | Q1 24/25 | On track to establish enhanced governance oversight (May 2024) |
| Quality improvement project initiation in Emergency Department targeting the number of patients outside patient spaces, ambulance handover times and the length of time people are waiting to be seen. | CDO | Q1 24/25 | Commences 20 May 2024. |
| Development of Group (HUTH and NLAG) consistent Quality priorities for 2024/25 to focus on<br><br>• End of Life;<br>• Deteriorating patient;<br>• Sepsis;<br>• Medication safety; and<br>• Mental capacity | CNO | Q1 24/25 (approval) – delivery throughout. | 24/25 Group Quality Priorities and measures approved – now in delivery. |

| BAF 3.2 | | | | 20 |
|---|---|---|---|---|
| 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. | | | | |
| Executive Lead | Group Chief Medical Officer/Group Chief Nurse | Assurance Committee | Quality and Safety Committees in Common | |
| Executive Group | Quality and Safety Committees in Common | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | Honest, caring and accountable culture | | Partnership and integrated services | ✓ | Link to BAF and CRR | CRR 3439 – Crowding in Emergency Department<br>CRR 4179 – Delivering the operational plan to reduce backlog of long waits<br>CRR 4178 – Delivering improvement trajectories for screening programmes<br>CRR 4180 – Risk of avoidable harm for patients who have waited 63+ days for a 1st definitive cancer treatment<br>CRR 4166 – Risk to patient safety and achievement of organizational falls |
| | Well-led, skilled and sufficient workforce | | Research and innovation | | | |
| | High Quality Care | ✓ | Financial Services | | | |
| | Great Clinical Services | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 4 | | | | ↓ | 5 | 16 |
| Consequence | 5 | | | | | 5 | |
| Risk Score | 20 | | | | | 25 | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances (Positive, Negative and Planned) |
| • Clinical harm review process<br>• Prioritisation of P1 patients<br>• Fundamental Standards programme<br>• System and Community meetings<br>• Patient Access Team<br>• Weekly Patient Safety Summit<br>• Quality Strategy<br>• Rossmore rehabilitation facility<br>• Emergency Care Standards<br>• Ambulance Handovers waiting over 60 minutes | **Positive**<br>• ICB quality team assurance visit report (15 December 2023);<br>• CQC ED engagement visit (non inspection/rating) positive feedback and observations including mental health (9 April 2024).<br>• ED national Patient Safety award for a Quality improvement initiative (November 2023);<br>• Friends and Family (FFT) monthly data demonstrating improvement since November 2023.<br>• Urgent Treatment Centre opening (Feb 24) |

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| | and subsequent opening hour extension (April 24) provided additional capacity.<br><br>• Elective – HUTH removed from NHSE Tiering (April 2024)<br><br>• Friends and Family (FFT) data for Rapid Diagnostics, Radiology and Day Case all >95% positive responses for 2023/24.<br><br>Same Day Emergency Care review ongoing<br>• AMU HOB<br>• |
| | **Negative**<br>• HUTH (and HNY system) remains in NHSE Tier 1 for cancer.<br>• Over crowding in ED<br>• Patients with no criteria to reside is the single largest factor affecting performance with up to 211 patients per day remaining within the hospital who have no medical need for acute services<br>• GP capacity and increased referrals<br>• Ambulance turnaround times – the Trust achieved the revised trajectory for type 1 and 3 performance at 59% (trajectory 50%) |
| | **Planned**<br>• Aim to grow the Patient Safety Champion network and number of Learning Response Leads<br>• Discharge to assess model pilot to<br>• Trajectory of achieving zero 78 week waits by March 2024.<br>• Cultural work between ED and Acute medicine ongoing<br>• UEC GIRFT Deep Dive December 2023<br>  • Direct admissions to wards – work with 111 Frailty SDEC staffing to provide 70 hours per week over 7 days |
| **Gaps in controls and assurances** | |
| • ED 4 hour performance below 76% March 2024 requirement.<br>• Ambulance handover<br>• Trust failing to achieve all cancer standards with the exception of combined Faster Diagnosis Standard<br>• Patients with No Criteria to Reside<br>• 12 Hour Trolley breaches | |

| **Actions planned** | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Hull and East Riding MADE event | CDO | Q4 23/24 | Held 25 March to 5 April 2024 – actions being taken forward. |
| Quality improvement project initiation in Emergency Department targeting the number of patients | CDO | Q1 23/24 | Commences 20 May 2024. |

| | | | |
|---|---|---|---|
| outside patient spaces, ambulance handover times and the length of time people are waiting to be seen. | | | |
| Embed Group leadership arrangements across the Humber Health Partnership, including:<br>• Site Executives;<br>• Urgent and Emergency Services Care Group leadership model; | CDO | Q2 23/24 | New leadership in place effective 1 April 2024 (Site Exec and Care Group level). |

| BAF 6 | | | | 12 |
|---|---|---|---|---|
| There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment | | | | |
| Executive Lead | Group Chief Medical Officer | Assurance Committee | Quality and Safety Committees in Common | |
| Executive Group | Quality and Safety Committees in Common | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | Honest, caring and accountable culture | | Partnership and integrated services | | Link to BAF and CRR | No high risks on the Corporate Risk Register |
| | Well-led, skilled and sufficient workforce | | Research and innovation | ✓ | | |
| | High Quality Care | | Financial Services | | | |
| | Great Clinical Services | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 3 | | | | ↔ | 4 | 8 |
| Consequence | 4 | | | | | 4 | |
| Risk Score | 12 | | | | | 16 | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances |

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|---|---|
| • trengthened partnership with the University of Hull<br>• Infection Research Group<br>• ICS Research Strategy<br>• Health Research Authority | **Positive**<br>• Continued working with HYMS and ICS<br>• Joint working with NLAG<br>• Academic Renal Research team – Lead role for renal studies and currently in the top third of recruiters nationally<br>• GONDOMAR study – unique cohort platform providing data on diagnosis, treatment and outcomes of over 4,000 patients with Crohn's perianal fistula.<br>• HUTH first site to be activated and first to enroll a patient for the AZUR-2 study, which relates to colon cancer.<br>• HUTH is the top recruiting centre for SNAP study. The trial aims to identify which treatment options for Staphylococcus aureus bacteraemia results in the fewest patients dying within the first 90 days after an infection.<br>• HUTH is the top recruiting site for the PACeS study which aims to determine whether the addition of blood thinners to anti-platelet drugs improves treatment outcomes in patients who develop AF after CABG surgery<br>**Negative**<br>• Funding availability<br>• Research capacity hindered by the recovery plan<br>• Demand for IT and Digital innovations are increasing |
| | **Planned**<br>• Joint strategy discussions have commenced with the Group Chief Medical Officer and the Group Chief of Strategy and Partnerships |
| **Gaps in controls and assurances** | |
| Reduction in support services due to activity delivery<br>Loss of commercial research income<br>Capital developments will need to ensure research and innovation schemes can be accommodated and staff appropriately housed<br>Demand for IT and Digital innovation is increasing | |

| **Actions planned** | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Group R&I strategy development | KW | Q3 2024 | In development |

| BAF 1.1 | | | | 15 |
|---|---|---|---|---|
| The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience | | | | |
| Executive Lead | Chief Medical Officer and Chief Nurse | Assurance Committee | Quality & Safety Committees in Common (CiC) | |
| Executive Group | Quality & Safety Committees in Common (CiC) | Latest review date | 03/06/24 | |

| Strategy and Risk Register | | | | | | |
|---|---|---|---|---|---|---|
| Link to Strategy | To give great care | ✓ | To provide good leadership | | Link to BAF and CRR | • CRR 2347 - Deteriorating patient risk, Surgery = 15<br>• CRR 2992 - Lack of Changing Places facility at SGH = 16<br>• CRR 3036, - Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS = 16<br>• CRR 3114 - Delays in children being reviewing in Paediatric Endocrine Service, may lead to failure to treat and manage the child's condition, leading to significant physical, mental issues, that could be life limiting = 20<br>• CRR 3144 - Paediatric Audiology Service, risk of harm to babies where hearing loss diagnosis is delayed or incorrect = 16<br>• CRR 3158 - Risk of not being able to view scans on Badgernet, patient safety risk to high-risk pregnancies = 15<br>• CRR 3161 - Risk of patient deterioration not being recognised and escalated on NEWS = 15<br>• CRR 3162 - Quality of care and patient safety based on nurse staffing position in Medicine = 20<br>• CRR 3164 - Nurse Staffing, high number of registered nurse and support worker vacancies = 20<br>• CRR 3168 - Newborn hearing screening service cross-site (reduced management time / no management cover) = 16 (Risk closed on Ulysses due to incorrect risk rating).<br>• CRR 3196 - Breast imaging service loss of capacity, will impact on delivery of 2ww service and delay patient pathways = 15<br>• CRR 3221 - Badgernet implementation, due to potential failure to obtain funding, may result in an adverse impact on patient safety and Trust reputation = 9 (previously 15)<br>• CRR 3226 - Risk of not being able to support delivery of new work relating to quality and audit workstreams, due to PAS/Lorenzo development freeze, may result in negative impact on patients quality of care and financial loss = 16 |
| | To be a good employer | | | | | |
| | To live within our means | | | | | |
| | To work more collaboratively | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |

| Risk Scoring (Current) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Quarter | Q1 (2024/25) | Q2 (2024/25) | Q3 (2024/25) | Q4 (2024/25) | Change from previous quarter | Inherent Risk | Target Risk |
| Likelihood | 3 | | | | ↔ | 3 | |
| Consequence | 5 | | | | | 5 | |
| Risk Score | 15 | | | | | 15 | |

| Controls and Assurance | |
|---|---|
| Key controls | Assurances |
| • Operational Plan 2024/25<br>• Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems<br>• Quality Board, NHSE<br>• Place Quality Meetings - N Lincs, N E Lincs, East Riding<br>• SI Collaborative Meeting with ICB, with Place Representatives<br>• Health Scrutiny Committees (Local Authority)<br>• Serious Incident Panel, Patient Safety Specialist and Patient Safety Champions Group<br>• Nursing Metric Panel Meeting<br>• Nursing and Midwifery & AHP Board<br>• NICE Guidance implementation monitoring and reporting processes<br>• Learning from deaths process | **Positive**<br><br>External:<br>• Internal Audit - Serious Incident Management, N2019/16, Significant Assurance<br>• Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance<br>• NHSE External Review of Safe Staffing Establishment and Recommendations<br>• Maternity Birth Rate Plus Review<br>• Internal Audit - CQC action plan compliance – Significant assurance<br>• Improved ratings in CQC inspection with Good for Goole Hospital and Safe domain improved from Inadequate to Requires Improvement<br>• Maternity CNST standards compliance submission<br>• Health Scrutiny Committees (Local Authority)<br>• Quality and Safety Committees in Common<br>• Risk Management Group<br>• Patient feedback to Council of Governors<br>• SafeCare Live<br>• OPEL Nurse staffing levels and short term staffing SOP<br>• Mortality Improvement Group<br>• Vulnerabilities Group<br>• Incident control group chaired by NHSE to support Paediatric Audiology service. |
| | **Planned**<br>Internal:<br>• Minutes of Committees and Groups<br>• Integrated Performance Report<br>• Annual Safe Staffing Report, Vulnerabilities report, Annual Complaints Report, Quality Improvement Report, Infection Control Annual Report, Maternity and Ockenden Report to Trust Board, Learning from deaths annual and quarterly reports.<br>• Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board<br>• NICE Guidance Assurance Report to Q&SC<br>• IPC - Board Assurance Framework and IPCC<br>• Inpatient surveys<br>• Nursing assurance safe staffing framework NHSI<br>• Audit Outlier Report to Quality Governance Group |

| Controls and Assurance | |
|---|---|
| **Key controls** | **Assurances** |
| | • 15 Steps Accreditation Tool<br>• CQC action planning, monitoring and assurance of action completion processes |
| **Gaps in controls and assurances** | |
| **Gaps in Controls:**<br>• Estate and compliance with IPC requirements B12 – see Estates BAF<br>• Ward equipment and replacement programme see Estates BAF<br>• Attracting sufficiently qualified staff - see Workforce BAF<br>• Funded full time Transition post across the Trust<br>• Paediatric audiology service | **Gaps in Assurances:**<br>• Delays with results acknowledgement (system live, process not yet embedded)<br>• Progress with the End of Life Strategy<br>• Safety and delays on cancer pathways<br>• Patient safety risks increased due to longer waiting times (refer to BAF 1.2) |

| Actions planned | | | |
|---|---|---|---|
| **Action** | **Lead** | **Due date** | **Progress update** |
| Continue to develop metrics as data quality allows | CMO | Ongoing | On track to deliver |
| Delivery of deteriorating patient improvement plan | CN | Q4 23/24 | Sustained improvements reported in the 2023/24 Quality Account, but this will remain a priority for 2024/25. |
| Implementation of End of Life Strategy (system-wide strategy) | CMO | Q4 25/26 | In progress but off track requiring system input. Improvements reported in the 2023/24 Quality Account, but this will remain a priority for 2024/25. |
| Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays) | CMO | Q3 23/24 | Complete |
| Review and implement changes to Audiology Service | CMO | Q3 23/24 | In progress. Update due to be reported at Quality and Safety Committee in June 2024. |
| 15 steps Star Accreditation Programme commenced | CN | Ongoing | Continued application going forward. |
| Delivery of the Quality Priorities for 2023/24 improving patient outcomes in 5 specific areas. | CMO | Q4 23/24 | Improvements reported in the 2023/24 Quality Account, but priorities have been rolled followed to further embed and sustain outcomes on a Group wide basis. |
| Delivery of the 2023/24 CQUIN schemes to improve quality of care for patients | CMO | Q4 23/24 | Improvement in all schemes. 8/11 on track to fully (data confirmed in June 2024). |

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)111**

| **Name of Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | David Sharif, Group Director of Assurance |
| **Contact Officer / Author** | David Sharif, Group Director of Assurance |
| **Title of Report** | Protocol for Reserving Matters to a Private Board Meeting |
| **Executive Summary** | The Trust Boards-in-Common hold meetings in public. This paper seeks approval for the criteria by which consideration of a matter by the Boards-in-Common is conducted in private. There are inevitably some conditions where consideration in a private session is more appropriate.<br>This paper outlines the exemptions most likely to apply to material considered by the Trust Boards and to provide guidance for Directors on those matters which should be reserved for discussion within private session. It also acts as a safeguard to ensure that the default position of Boards-in-Common meetings will remain in public unless there is a clear exemption. |
| **Background Information and/or Supporting Document(s)** (if applicable) | Both trusts' constitutional documents acknowledge the legitimate need to discuss certain matters in private:<br>• The NLaG Constitution provides, at Annex 7, paragraph 6.2.3: Calling Meetings / Extraordinary Meetings of the Trust Board, that for 'special reasons', the Trust Board may resolve to meet in private session and exclude members of the public (which could include the press). This is sometimes known as 'Trust Board (Private)'.<br>• Similarly, section 3.17 of the HUTH Standing Orders: Admission of public and the press (i) Admission and exclusion on grounds of confidentiality of business to be transacted provides that: The public and representatives of the press may attend all meetings of the Trust Board, but shall be required to withdraw upon the Trust Board as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act I960". |
| **Prior Approval Process** | Annual approval update process |
| **Financial Implication(s)** | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** | N/A |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

**Group Director of Assurance ~~ate of Corporate Governance~~**

# PROTOCOL FOR RESERVING MATTERS TO A PRIVATE BOARDS-IN-COMMON MEETING

| | |
|---|---|
| Reference: | DCM100 |
| Version: | ~~1.3~~ |
| This version issued: | ~~13/10/23~~ |
| Result of last review: | Minor Changes |
| Date approved by owner (if applicable): | ~~N/A~~ |
| Date approved: | ~~03/10/23~~ |
| Approving body: | Trust Boards – NLaG and HUTH |
| Date for review: | ~~October, 2026~~ |
| Owner: | David Sharif, Group Director of Assurance~~Helen Harris, Director of Corporate Governance~~ |
| Document type: | Miscellaneous |
| Number of pages: | 7 (including front sheet) |
| Author / Contact: | Alison Hurley, Deputy Director of Assurance~~Assistant Trust Secretary~~ |

~~Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.~~

## Introduction

In accordance with the ~~Trust's Constitution,~~ Northern Lincolnshire & Goole (NLaG) NHS Foundation Trust Constitution and Hull University Teaching Hospital (HUTH) NHS Trust Standing Orders, both Trusts holds theirits ~~Trust~~ Board meetings in public. However~~, Inevitably~~, some of the Trusts' business is inevitably more appropriate forly considerationed in a private session.

The NLaG~~Trust's~~ Constitution provides, at Annex 7, paragraph 6.2.3: Calling Meetings / Extraordinary Meetings of the Trust Board, -that for 'special reasons', the Trust Board may resolve to meet in private session and exclude members of the public (which could include the press). This is sometimes known as 'Trust Board (Private).

Similarly, section 3.17 of the HUTH Standing Orders: Admission of public and the press (i) Admission and exclusion on grounds of confidentiality of business to be t~~T~~ransacted provides that: The public and representatives of the press may attend all meetings of the Trust Board, but shall be required to withdraw upon the Trust Board as follows: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act l960". ~~Inevitably, some of the Trust's business is more appropriately considered in private session.~~ The Board will usually consider as unsuitable for discussion in public, issues about the award of contracts, disciplinary matters and matters concerning staff or any identifiable patient. Given the nature of this criteria, this is not an exhaustive list~~. Other issues are harder to identify in advance~~.

In determining which matters should be reserved for private consideration, one factor that the Trusts may consider is whether the information to be discussed would be exempt from disclosure under the Freedom of Information (FOI) Act 2000. If information would be exempt from disclosure under FOI legislation~~aws~~, then it is likely that it should be considered during the private session of a Trust Board meeting.

This document has therefore been prepared in order to outline the exemptions most likely to apply to material considered by the Trust Boards and to provide guidance for Directors on those matters which should be reserved for discussion within private session. **N.B.** It should be stressed however that, in order to ensure openness and transparency of decision-~~-~~making, the default position will remain that unless there is a clear exemption; matters will be routinely considered in public.

| FOI section | Reason for Reservation | Examples |
|---|---|---|
| 14 (1) | Vexatious Requests - The Act does not oblige the Trust to comply with a request for information if the request is vexatious. Section 14(1) may be used in a variety of circumstances where a request, or its impact on a public authority, cannot be justified. | Repeatedly requesting information that has already been provided or addressed by the Board. |

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| | **Vexatious Request definition -** a request that is intended merely to create frustration or annoyance. | |
| 22* | **Information Intended for Future Publication** - Information where there is a settled intention to publish in the future. | • Annual Report (further to the NHS Foundation Trust Accounting manual, the Annual Report can only be made public once it has been laid before parliament).<br>• Draft consultation documents. |
| 24 | **Safeguarding National Security** - The information is exempt if it is required for the purposes of safeguarding national security. | • Cyber security |
| 24 | Safeguarding National Security - The information is exempt if it is required for the purposes of safeguarding national security. | • Cyber security |
| 31, (1)(a)-(c), (h) or<br><br>(1)(g)*with section | **Law Enforcement** - Where the disclosure of information would, or would be likely to prejudice:<br><br>(a) the prevention or detection of crime<br><br>(b) the apprehension or prosecution of offenders<br><br>(c) the administration of justice<br><br>(h) any civil proceedings which are brought by or on behalf of a public authority and arise out of an investigation conducted, for any of the purposes specified in s.31(2), or by virtue of powers conferred by or under an enactment)<br><br>(g) the exercise by any public authority of its functions for any of the purposes specified in s. 31(2), which include:<br><br>(a) the purpose of ascertaining whether any person has failed to comply with the law | • Professional disciplinary or legal investigations into members of staff (information about which may also be exempt under s. 40 and s. 42 - see below).<br>• Patient safety / incident investigation reports which could identify individuals Serious Untoward Incident (SUI) reports |

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| 31(2)(a)-(e), (i) or (j) | (b) the purpose of ascertaining whether any person is responsible for any conduct which is improper<br><br>(c) the purpose of ascertaining whether circumstances which would justify regulatory action in pursuance of any enactment exist or may arise<br><br>(d) the purpose of ascertaining a person's fitness or competence in relation to the management of bodies corporate or in relation to any profession or other activity which he is, or seeks to become, authorised to carry on<br><br>(e) the purpose of ascertaining the cause of an accident<br><br>(i) the purpose of securing the health, safety and welfare of persons at work, and<br><br>(j) the purpose of protecting persons other than persons at work against risk to health or safety arising out of or in connection with the actions of persons at work.<br><br>**[Section 30 only applies to public bodies that can bring criminal proceedings or has a duty to investigate whether criminal proceedings should be brought. For Trusts the relevant section is 31(1)(g) with provisions in s. 31].** | |
| 32 | Information contained in **court records** | Information that ~~iswe~~ heeld that was created explicitly for or was used in any court proceedings. |
| **Prejudice to the free and frank provision of advice, exchange of views for the purposes of deliberation, or the effective conduct of public affairs (36(2)(b)(i-ii)&(c):** | | |
| 36(2)(b)(i)* | Issues, the discussion of which in public would or would be likely to **inhibit the free and frank provision of advice**. | Matters in the initial stages of enquiry; early stages of strategic thinking; sensitive 'live' issues or 'blue sky |

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| | | thinking', for instance addressed or discussed in:<br>• rRecommendations / advice from external organisations eg. Royal Colleges;.<br>• recommendations made by more junior staff to more senior staff;.<br>• professional advice tendered by professionally qualified government employees;.<br>• advice from external sources, or advice supplied to external sources;.<br>• options papers drafted internally. |
| 36(2)(b)(ii)* | Issues, the discussion of which in public would or would be likely to **inhibit the free and frank exchange of views for the purpose of deliberation**.<br><br>i.e. Disclosure would, or would be likely to inhibit the ability of staff and others, when deliberating or providing advice, to express themselves openly, honestly and completely, or to explore extreme options 'Deliberation' tends to refer to the evaluation of the competing arguments or considerations that may have an influence on the course of action. It will include expressions of opinion and recommendations but will not include purely factual material or background information. The information must reveal the 'thinking process' or reflection that has gone into a decision. | Matters in the initial stages of enquiry; early stages of strategic thinking; sensitive 'live' issues or 'blue sky thinking' discussed in:<br>• emails<br>• minutes of committees (e.g. Audit, Risk & Governance Committee Minutes – discussion on Fraud issues).<br>• options papers drafted internally. |
| 36(2)(c)* | Issues, the discussion of which in public would or would be likely to **prejudice the effective conduct of public affairs**, wWhere the disclosure would or would be likely to prejudice the Trust's ability to offer an effective public service, or to meet its wider objectives or purpose (rather than simply to function) due to the disruption caused by the disclosure and | • Issues the Trust is 'working through', where discussion in public may cause concern/panic.<br>• Discussions about future public consultations where the Trust wishes to manage the timing and manner |

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| | the diversion of resources in managing the impact of disclosure. | in which disclosures are made. |
| 38 | **Health and Safety** - Information where disclosure would or would be likely to:<br><br>(a) endanger the physical or mental health of any individual, or<br>(b) endanger the safety of any individual | • Disciplinary or grievance issues/information.<br>• Patient safety / incident ~~SI~~ investigations.<br>• Service changes which could affect the employment status of employees. |
| 40(2) | **Personal Data - Information** containing the personal data of any living person, patient, staff member or any other person if disclosure would contravene any of the data protection principles in the Data Protection Act 2018. The first data protection principle requires that 'processing' personal data needs to be fair. | • Reports relating to the conduct of a particular employee.<br>• Patient safety / Incident investigation ~~SI~~ reports relating to a particular (living) patient which could identify the individual~~.~~ |
| 41 | **Information provided in confidence** – Information from another person or organisation, if releasing that information would lead to a successful claim for breach of confidence. | • Patient records or information contained in them (including of patients who are no longer living).<br>• Some technical information from suppliers. |
| 42* | **Legal professional privilege** - Communications with solicitors and barristers, reports imparting legal advice, and information created in order to seek legal advice or to help prepare for a legal claim. | • Legal advice. |
| 43(2)* | **Commercial Interests** - Disclosure of the information would be likely to damage the commercial interests of any person or organisations. Those interests may be those of the Trust, one of its suppliers or one of its customers. | • Current pricing information contained in contracts or tenders, prior to the conclusion of the tender.<br>• Information that would damage the Trust's negotiating position if disclosed. |
| 44 | **Prohibitions on Disclosure** - Information, disclosure of which is prohibited by law. | • Information prohibited from disclosure by a Court Order or statutory provision prohibiting disclosure. |

Those exemptions marked with an * are subject to the public interest test. This means that they will only apply if the public interest in withholding the information is stronger than the public interest in releasing it. In some cases, this may mean that the information will be considered in the public session of the Trust Boards. ~~meeting.~~

Where a matter is being reserved for discussion in private, the rationale in support of the reservation should be clearly documented on the board paper front sheet.

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*References:*

The-foundations-of-good-governance - NHS Providers

TheHealthyNHSBoard-2013- nhsleadershipacademy

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# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)112**

| | |
|---|---|
| **Name of Meeting** | Trust Boards-in-Common |
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | David Sharif, Group Director of Assurance |
| **Contact Officer / Author** | David Sharif, Group Director of Assurance |
| **Title of Report** | Division of Responsibilities Between the Group Chair and the Group Chief Executive |
| **Executive Summary** | This document sets out the respective and specific responsibilities of the Group Chair and Group Chief Executive Officer, together with their shared responsibilities.<br>In addition to drawing on the internal constitutional documents of both trusts, it also reflects the principles and practices arising from external guidance such as the NHSE code of governance and the 'foundations of good governance: a compendium of best practice' produced by NHS Providers. |
| **Background Information and/or Supporting Document(s)** (if applicable) | The NHS England (NHSE) Code of Governance for NHS Provider Trusts states that:<br>• responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision; and<br>• these responsibilities should be clear, set out in writing, agreed by the board of directors and publicly available. |
| **Prior Approval Process** | N/A |
| **Financial Implication(s)** (if applicable) | N/A – This document does not contravene any of the existing delegations set out in the Trusts' scheme of delegation. |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/A |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

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## Group Chief Executive / Group Chair~~Office~~

# DIVISION OF RESPONSIBILITIES BETWEEN THE GROUP CHAIR AND THE GROUP CHIEF EXECUTIVE

| | |
|---|---|
| Reference: | DCM121 |
| Version: | ~~1.7~~ |
| This version issued: | ~~11/04/23~~ |
| Result of last review: | Minor changes |
| Date approved by owner (if applicable): | ~~N/A~~ |
| Date approved: | ~~04/04/23~~ |
| Approving body: | Trust Board |
| Date for review: | ~~April 2026~~ |
| Owner: | Jonathan Lofthouse~~Dr Peter Reading~~, Group Chief Executive / Sean Lyons, Group~~Trust~~ Chair |
| Document type: | Miscellaneous |
| Number of pages: | 18 (including front sheet) |
| Author / Contact: | David Sharif~~Helen Harris~~, Group Director of Assurance ~~Corporate Governance~~ |

~~Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.~~

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5.0 Action Requested of the Trust Boards ........ 8~~7~~

~~6.0 Equality Act (2010)........~~ 8~~8~~

~~7.0 Freedom to Speak Up........~~ 9~~8~~

~~Appendix A - Monitor - NHS Foundation Trust Accounting Officer Memorandum~~ 10~~9~~

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## 1.0 Introduction

**1.1** T~~Within t~~he NHS England (NHSE) Code of Governance for NHS Provider Trusts states that:

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

~~1.1.2~~1.1.1 responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision; and ~~.~~

~~1.1.3~~1.1.2 these responsibilities ~~of the chair, chief executive, senior independent director if applicable, board and committees~~ should be clear, set out in writing, agreed by the board of directors and publicly available.

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

- NHS~~-~~E Code of Governance for NHS Provider Trusts

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- Trust Constitution (NLaG) & Standing Orders (HUTH)
- NHS Oversight Framework
- NHS Foundation Trust Accounting Officer Memorandum (Monitor) (last updated August 2015 ~~in light of changes to the Risk Assessment Framework~~ to strengthen the requirement to consider value for money)
- NHS Trusts: Requirement for Annual Governance Statement & Other Year-End Material
- Foundation Trust Annual Reporting Manual
- The Foundations of Good Governance: A Compendium of Best Practice~~.~~

## 2.0 Responsibilities of the Group Chair

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

**2.1.1** Reports to the Trust Boards. ~~of Directors.~~

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**2.1.2** Other than the Group Chief Executive and the Group Director of Assurance (who has a dual reporting line to the Group Chair and Group Chief Executive), no Executive reports to the Chair.

**2.1.3** Secures t~~T~~he effective running of the Trust Boards~~ of Directors~~ and Council of Governors (NLaG).~~.~~

**2.1.4** Ensures~~ing~~ that the Trust Boards~~ of Directors~~ as a whole, through a boards-in-common approach, play~~s~~ a full part in the development and determination of the ~~Trust's~~ strategy and overall objectives of the trusts / group.

**2.1.5** Is t~~T~~he guardian of the Trust Board~~ of Director~~s' decision~~-~~-making processes.

**2.1.6** Offers~~ing~~ counsel and advice on sensitive or complex issues raised by the Group Chief Executive or o~~O~~ther Executive or Non-Executive Directors.

**2.1.7** Provides g~~G~~eneral leadership of the Trust Boards ~~of Directors~~ and the Council of Governors (NLaG).

**2.1.8** Ensures~~ing~~ that the Trust Boards ~~of Directors~~ and Council of Governors (NLaG) work together effectively and enjoy constructive working relationships (including the resolution of any disagreements).

**2.1.9** Ensures~~ing~~ that the Trust Board~~ of Directors'~~ and Council of Governors' agendas take full account of the important issues facing the trusts / group. ~~e Foundation Trust.~~

**2.1.10** Ensures~~ing~~ compliance with the Trust Boards' ~~of Director's~~ approved procedures.

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

**2.1.12** Proposes~~ing~~ a schedule of matters reserved to the Trust Boards~~, of Directors~~, Terms of Reference for each of the Boards' Committees and other Board Policies and Procedures, as applicable.

**2.1.13** Facilitates~~ing~~ the effective contribution of all members of the Trust Boards~~ s of Directors~~ and the Council of Governors (NLaG) to ensure that constructive relations exist between Executive and Non-Executive members of the Trust Boards~~ of Directors~~, elected and appointed members of the Council of Governors (NLaG) and between the Trust Board~~ of Directors~~ and the Council of Governors (NLaG).

**2.1.14** Ensures that the non-executive directors are able to lead in being accountable to the C~~c~~ouncil of G~~g~~overnors (NLaG) for the performance of the Trust B~~b~~oard.~~ of directors (NLaG)~~.

**2.1.15** Leads the C~~c~~ouncil of G~~g~~overnors (NLaG) in holding the N~~n~~on-E~~e~~xecutive D~~d~~irectors to account, ensuring the accountability process works effectively.

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**2.1.16** Chairs~~ing~~, or nominates~~ing~~ another independent Non-Executive Director to chair, the Remuneration ~~and Terms of Service~~ Committees-in-~~, and~~Common and initiates~~ing~~ change and succession planning in the Boards and the appointment of effective and suitable members and Chairs of Board Committees.

**2.1.17** Contributes~~ing~~ to the agreement of the membership of Board Committees and proposing their Chairs.

**2.1.18** Works~~ing~~ with NHSE and the Council of Governors (NLaG) in respect of the appointment of new Non-Executive Directors and t~~T~~akes~~ing~~ the lead in providing a properly constructed induction programme for new Non-Executive Directors.

**2.1.19** Appraises~~ing~~ the performance of Non-Executive ~~Directors, and~~Directors and ~~repor~~reports~~ting~~ on the outcome of the appraisal to NHSE and the Council of Governors (NLaG), as appropriate.

**2.1.20** Takes~~ing~~ the lead in identifying and seeking to continually update their skills and knowledge, ~~,~~and meets the ongoing development needs both of individual Non-Executive Directors and of the Trust Boards ~~of Directors~~ as a whole.

**2.1.21** Ensures~~ing~~ periodic meetings take place with Non-Executive Directors in the absence of Executive Directors.

**2.1.22** Ensures that members of the Council of Governors (NLaG) have the skills, knowledge and familiarity with the Foundation Trust to fulfil their role.

**2.1.23** Ensures~~ring~~ that the performance of the Trust Boards ~~of Directors~~ and Council of Governors (NLaG) as a whole, their committees, and individual members of both are periodically assessed. This will include an externally-led assessment at least once in every three years.

**2.1.24** Promotes~~ing~~ the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at Trust Board ~~of Directors~~ level.

**2.1.25** Ensures~~ing~~ good information flows from and between the Trust Boards ~~of Directors~~, Committees, Council of Governors (NLaG), Senior Management and Non-Executive Directors.

## 3.0 Responsibilities of the Group Chief Executive

**3.1** The discrete responsibilities of the Group Chief Executive can be summarised as follows:

**3.1.1** Reports to the Chair and to the Trust Boards ~~of Directors~~ directly.

**3.1.2** All members of the management structure report either directly or indirectly, to the Group Chief Executive.

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**3.1.3** Executive responsibility for running the ~~Trust's~~ business of the trusts / group. **N.B.** The Group Chief Executive will be responsible for ensuring that in his / her absence, a designated Executive Director will deputise.

**3.1.4** Acts~~ing~~ as the Accounting / Accountable Officer for the two Trusts. ~~as set out in the 'NHS Foundation Trust Accounting Officer Memorandum', which is attached at **Appendix A**~~.

**3.1.5** Ensures~~ing~~ that the t~~T~~rusts and their~~its~~ staff meets all relevant statutory requirements and service obligations including as set out in the NHS Provider Licence and makes~~ing~~ sure that the ~~Trust's~~ governance framework and associated structures and processes in operation across the trusts / group are 'fit for purpose'.

**3.1.6** In conjunction with the Trust Boards ~~of Directors~~ and the Council of Governors (NLaG), is responsible for creating, developing and promoting the ~~Trust's~~ strategy for the trusts / group, taking account the needs of key stakeholders and enabled by a robust strategy for delivery of the ~~Trust's~~ overall objectives of the trusts / group.

**3.1.7** ~~Provision of~~Provides information and support to the Trust Boards ~~of Directors~~ and Council of Governors (NLaG) and ensures~~ing~~ that the decisions of the Trust Boards ~~of the Directors~~ and their ~~its~~ c~~C~~ommittees are implemented.

**3.1.8** Provides~~ing~~ input to the Trust Boards-in-Common ~~of Directors'~~ agendas from themselves and other members of the Executive Team.

**3.1.9** Ensures that~~ing~~ the Group Chair is aware of the important issues facing the t~~T~~rust / group and proposing agendas which reflect these.

**3.1.10** Ensures~~ing~~ that the Executive Team provide~~s~~ reports to the Trust Boards ~~of Directors~~ which contain accurate, timely and clear information.

**3.1.11** Ensures~~ing~~ that the Boards ~~y~~ and the Executive Team comply with the Trust Boards' ~~of Directors'~~ approved procedures.

**3.1.12** Ensures~~ing~~ that the Group Chair is alerted to forthcoming complex, contentious or sensitive issues affecting the Trust.

**3.1.13** Provides~~ing~~ input on appropriate changes to the schedule of matters reserved to the Trust Boards ~~of Directors~~ and Committee Terms of Reference.

**3.1.14** Supports~~ing~~ the Group Chair in their tasks of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive members of the Trust Boards ~~of Directors~~, elected and appointed members of the Council of Governors (NLaG) and between the Trust Board of Directors and the Council of Governors (NLaG).

**3.1.15** Provides~~ing~~ information and advice on succession planning, to the Group Chair, the Remuneration ~~and Terms of Service~~ Committees-in-Common, and other

members of the Trust Boards of Directors, particularly in respect of Executive Directors.

**3.1.16** If so appointed by the Trust Boards of Directors, servesing on any committee.

**3.1.17** Maintainsing and strengthensing effective working relationships and communications with stakeholders including staff and patients.

**3.1.18** Maximisesing the potential of the tTrusts / group 's organisation and people by ensuring an appropriate and effective tTrust / group culture, organisation and leadership, supported by effective strategies and systems to manage and develop the tTrusts / group's human and physical resources.

**3.1.19** Contributesing to induction programmes for new Executive and Non-Executive Directors and ensuresing that appropriate management time is made available for the process.

**3.1.20** Providesing leadership and development of the Executive Directors and other Senior Management reporting to him/her and ensuring that the tTrusts / group have has the capacity, capability and the effective management systems to deliver on the tTrusts' / group s objectives.

**3.1.21** Ensuresing that performance reviews are carried out at least once a year for each of the Executive Directors.

**3.1.213.1.22** Providesing input to the wider Trust Boards of Directors and Council of Governors (NLaG) evaluation process and to the Remuneration and Terms of Service Committees-in-Common as appropriate.

**3.1.223.1.23** Promotesing and conductsing the affairs of the tTrusts / group with the highest standards of integrity, probity and corporate governance. -Promotes continuing compliance across the organisation.

**3.1.233.1.24** Maintainsing and enhancesing the Trust's reputation and profile of the trusts / group with stakeholders and with the community which the tTrusts / group serves.

**3.1.243.1.25** Provision Providesfor effective information and communication systems.

## 4.0 Shared Responsibilities of the Group Chair and Group Chief Executive

**4.1** There are a number of areas where the Group Chair and the Group Chief Executive carry a joint or shared responsibility, often because there is inter-dependence between the two roles for a responsibility to be fulfilled. These areas of shared responsibility include:

**4.1.1** Leading and demonstrating the necessary behaviours that support the values of the tTrusts / group.

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**4.1.2** Ensuring that the Council of Governors (NLaG) and Trust Boards ~~of Directors~~ receive accurate, timely and clear information that is appropriate for their respective duties.

**4.1.3** Facilitating and supporting effective joint working between the Trust Board ~~of Directors~~ and Council of Governors (NLaG).

**4.1.4** Ensuring effective communication ~~by the Foundation Trust~~ with patients, members, staff and other stakeholders.

**4.1.5** Constructing the agendas for both the Trust Boards ~~of Directors~~ and Council of Governors (NLaG) (with the input of others as appropriate).

**4.1.6** Handling high profile media coverage, particularly where this could be damaging to the reputation of the t~~T~~rusts / group.

**4.1.7** Ensuring that the t~~T~~rusts / group has in place a clear schedule of matters reserved for the Boards and, for ~~the~~ other matters ~~s~~, ensuring that a Scheme of Delegation is agreed and in place.

**4.1.8** Sharing line management of the Trust Secretary (the Group Director of Assurance), who has a dual reporting line to the Group Chair and Group Chief Executive.

## 5.0 Action Requested of the Trust Boards

The Trust Boards ~~is~~ are asked to consider the division of responsibilities between the Group Chair and Group Chief Executive and, following any amendments as may be required, to approve the revised statement.

## ~~6.0 Equality Act (2010)~~

~~**6.1** Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.~~

~~**6.2** The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.~~

~~**6.3** The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.~~

~~**6.4** We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age,~~

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disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

### 6.5 Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this document, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Freedom to Speak Up Policy for the NHS (DCP126) which has been adopted by the Trust in line with national guidance. Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg-tr.ftsuguardian@nhs.net or telephone 07892764607. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian can be found on the Trust's intranet site.

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## ~~Appendix A~~

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## ~~NHS Foundation Trust Accounting Officer Memorandum~~

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**~~5 August 2015~~**

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NHS Foundation Trust Accounting Officer Memorandum

Introduction

1 The National Health Service Act 2006 (the Act) designates the Chief Executive of an NHS Foundation Trust as the Accounting Officer.

2 The principal purpose of the NHS Foundation Trust is the provision of goods and services for the purposes of the health service in England. The NHS Foundation Trust has a general duty to exercise its functions effectively, efficiently and economically.

3 The Act specifies that the Accounting Officer has the duty to prepare the accounts in accordance with the Act. An Accounting Officer has the personal duty of signing the NHS Foundation Trust's accounts. By virtue of this duty, the Accounting Officer has the further duty of being a witness before the Committee of Public Accounts (PAC) to deal with questions arising from those accounts or, more commonly, from reports made to Parliament by the Comptroller and Auditor General (C&AG) under the National Audit Act 1983.

4 Associated with these duties are the further responsibilities that are the subject of this memorandum. It is incumbent on the Accounting Officer to combine these duties with their duties to the Board of Directors of the NHS Foundation Trust.

5 It is an important principle that, regardless of the source of the funding, Accounting Officers are responsible to Parliament for the resources under their control.

Responsibilities of Monitor

2 In relation to NHS Foundation Trusts, it is the responsibility of Monitor to be satisfied that the NHS Foundation Trust is compliant with its NHS Provider Licence.

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The general responsibilities of an NHS Foundation Trust Accounting Officer

3 **The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:**

- **there is a high standard of financial management in the NHS Foundation Trust as a whole;**
- **the NHS Foundation Trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation;**
- **financial considerations are fully taken into account in decisions by the NHS Foundation Trust.**

The specific responsibilities of an NHS Foundation Trust Accounting Officer

4 **The essence of the Accounting Officer's role is a personal responsibility for:**

- **the propriety and regularity of the public finances for which he or she is answerable;**
- **the keeping of proper accounts;**
- **prudent and economical administration in line with the principles set out in *Managing Public Money* available via:www.gov.uk/government/publications/managing-public-money**
- **the avoidance of waste and extravagance; and**
- **the efficient and effective use of all the resources in their charge.**

5 **As Accounting Officer you must:**

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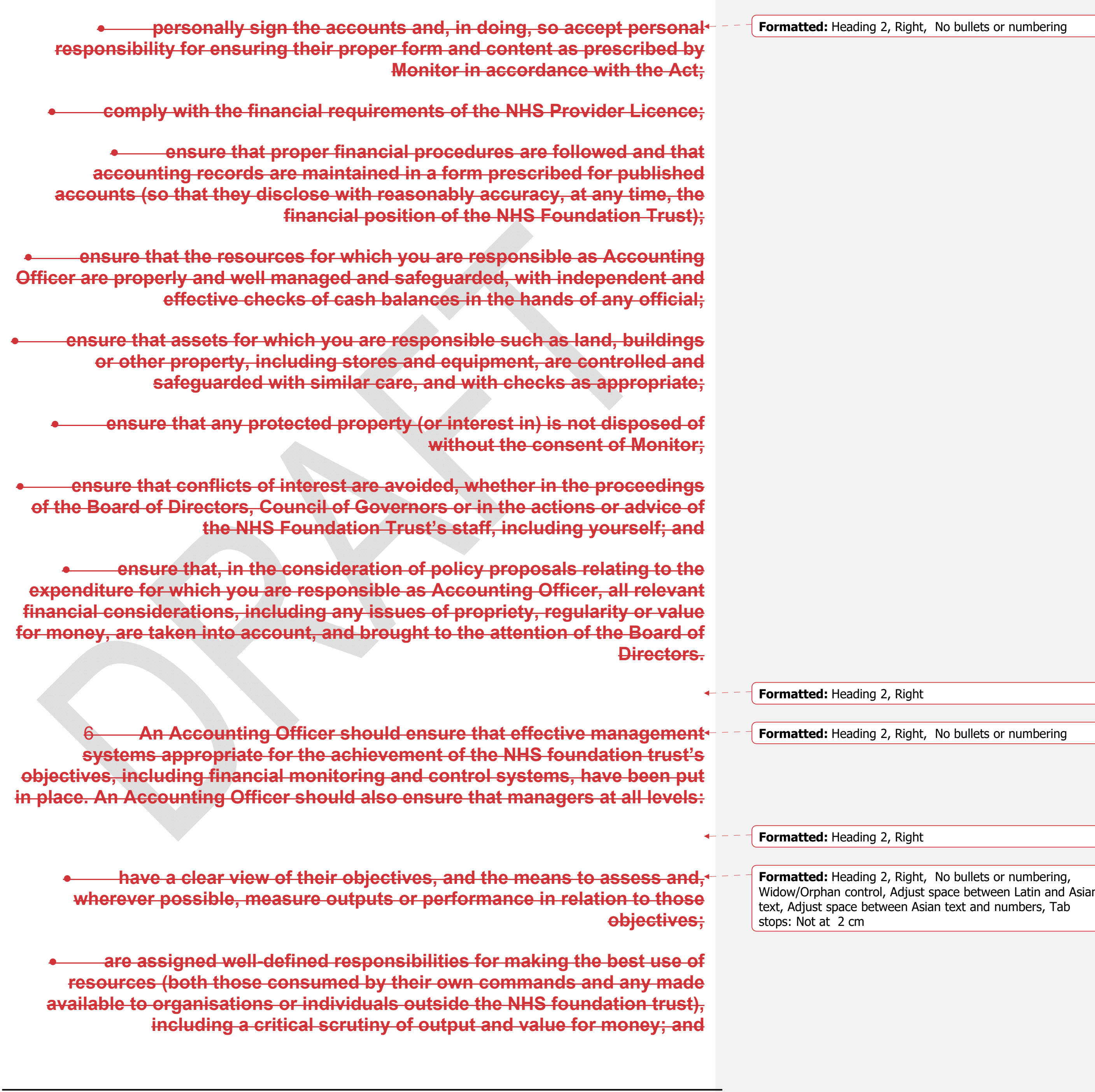

- personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor in accordance with the Act;
- comply with the financial requirements of the NHS Provider Licence;
- ensure that proper financial procedures are followed and that accounting records are maintained in a form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS Foundation Trust);
- ensure that the resources for which you are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official;
- ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate;
- ensure that any protected property (or interest in) is not disposed of without the consent of Monitor;
- ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Council of Governors or in the actions or advice of the NHS Foundation Trust's staff, including yourself; and
- ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

6 An Accounting Officer should ensure that effective management systems appropriate for the achievement of the NHS foundation trust's objectives, including financial monitoring and control systems, have been put in place. An Accounting Officer should also ensure that managers at all levels:

- have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives;
- are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money; and

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- **have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.**

7 **Accounting Officers must make sure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the *Public Sector Internal Audit Standards*.**

Advice to the Board

8 **An Accounting Officer has particular responsibility to see that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Accounting Officers will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as Accounting Officer to justify, to the Public Accounts Committee, transactions for which they are accountable.**

9 **The Board of Directors and the Council of Governors of an NHS foundation trust should act in accordance with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or the Chairman is contemplating a course of action involving a transaction which you as Accounting Officer consider would infringe these requirements, however, you should set out in writing your objection to the proposal and the reasons for this objection. If the Board of Directors, Council of Governors or Chairman decides to proceed, you should seek a written instruction to take the action in question. You should also inform Monitor of the position, if possible before the decision is taken or in any event before the decision is implemented, so that Monitor, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act. If the outcome is that you are overruled, the instruction must be complied with, but your objection and the instruction itself should be communicated without undue delay to the NHS foundation trust's external auditors and to Monitor. Provided that this procedure has been followed, the PAC can be expected to recognise that the Accounting Officer bears no personal responsibility for the transaction.**

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10 If a course of action is contemplated which raises an issue not of formal propriety or regularity but relating to your wider responsibilities for economy, efficiency and effectiveness, it is your duty to draw the relevant factors to the attention of the Board of Directors and the Council of Governors and to advise them in whatever way you deem appropriate. If your advice is overruled, and the proposal is one which as Accounting Officer you would not feel able to defend to the PAC as representing value for money, you should seek a written instruction before proceeding. Monitor should be informed of such an instruction, if possible before the decision is implemented. It will then be for Monitor to consider the matter, and decide whether or not to intervene.

11 If, because of the extreme urgency of the situation, there is no time to submit advice in writing in either of the eventualities referred to in paragraphs 13 and 14 before the decision is taken, you must ensure that, if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards.

Appearance before the Committee of Public Accounts (PAC)

12 The C&AG may, under the National Audit Act 1983, carry out examinations into the economy, efficiency and effectiveness with which the NHS foundation trust has used its resources in discharging its functions. An Accounting Officer may expect to be called upon to appear before the PAC from time to time to give evidence on the reports arising from these examinations or reports following the annual certification audit, and to answer the PAC's questions concerning expenditure and receipts for which he or she is Accounting Officer. An Accounting Officer may be supported by one or two other senior officials who may, if necessary, assist in giving evidence.

13 An Accounting Officer will be expected to furnish the PAC with explanations of any indications of weakness in the matters covered by paragraphs 8 - 15 above, to which their attention has been drawn by the C&AG or about which they may wish to question the Accounting Officer.

14 In practice, an Accounting Officer will normally have delegated authority to others, but cannot on that account disclaim responsibility or dilute his or her accountability. Nor, by convention, does the incumbent Accounting Officer decline to answer questions where the events took place before taking up appointment: the PAC may be expected not to press the incumbent's personal responsibility in such circumstances.

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15 The PAC has emphasised the importance it attaches to accuracy of evidence, and the responsibility of witnesses to ensure this, in order to ensure that relevant lines of enquiry may be pursued at its hearings. The Accounting Officer should ensure that he or she is adequately and accurately briefed on matters which are likely to arise at the hearing. The Accounting Officer may, however, ask the PAC for leave to supply information not within his or her immediate knowledge by means of a later note. Should it be discovered subsequently that the evidence provided to the PAC has contained errors; these should be made known to the PAC at the earliest possible moment.

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16 In general, the rules and conventions governing appearances of officials before parliamentary committees apply to the PAC, including the general convention that officials do not disclose the advice given to the board. Nevertheless, in a case where the procedure described in paragraph 13 was used concerning a matter of propriety or regularity, the Accounting Officer's advice, and it's overruling by the board, would be disclosed to the PAC. In a case covered by paragraph 14, where the advice of an Accounting Officer has been overruled in a matter not of propriety or regularity but of prudent and economical administration, efficiency or effectiveness, the C&AG will have made clear in the report to the PAC that the Accounting Officer was overruled. The Accounting Officer should seek to avoid disclosing the advice given to the board, though subject to their agreement the Accounting Officer should be ready to explain the reasons for their decision.

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Absence of an Accounting Officer

17 An Accounting Officer should ensure that he or she is generally available for consultation and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the NHS foundation trust who can act on his or her behalf if required.

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18 If it becomes clear to the Board of Directors that an Accounting Officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the Board of Directors should appoint an acting Accounting Officer, usually the Director of Finance, pending the Accounting Officer's return. The same applies if, exceptionally, the Accounting Officer plans an absence of more than four weeks during which he or she cannot be contacted.

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19 **The PAC may be expected to postpone a hearing if the relevant Accounting Officer is temporarily indisposed. Where the Accounting Officer is unable by reason of incapacity or absence to sign the accounts in time for submission, the NHS foundation trust may submit unsigned copies pending the Accounting Officer's return. If the Accounting Officer is unable to sign the accounts in time for printing, the acting Accounting Officer should sign instead.**

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Sources

**This document is based on the guidance outlined in *Managing Public Money*, published in July 2013 and updated in September 2022 available via: www.gov.uk/government/publications/managing-public-money**

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# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)113**

| | |
|---|---|
| **Name of Meeting** | Trust Boards-in-Common |
| **Date of the Meeting** | Thursday 13th June 2024 |
| **Director Lead** | Lee Bond – Group Chief Financial Officer |
| **Contact Officer / Author** | Simon Tighe – Group Deputy Director of Estates and Compliance & information Services |
| **Title of Report** | Health and Safety Policy Statement |
| **Executive Summary** | The Health and Safety Act 1974 states that every business must have a policy for managing health and safety. A health and safety policy is required to set out our general approach to health and safety.<br><br>Trust Board committee is recommended to approve this policy statement. |
| **Background Information and/or Supporting Document(s)** (if applicable) | None |
| **Prior Approval Process** | • Performance Estates and Finance Committees-in-Common<br>• Estates, Facilities and Development Governance and Senior management meetings. |
| **Financial Implication(s)** (if applicable) | None |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | None |
| **Recommended action(s) required** | ✓ Approval ☐ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

## Directorate of Estates, Facilities and Development

# HEALTH & SAFETY AT WORK POLICY STATEMENT

| | |
|---|---|
| Reference: | |
| Version: | 1.0 |
| This version issued: | |
| Result of last review: | N/A |
| Date approved by owner (if applicable): | N/A |
| Date approved: | |
| Approving body: | Trust Board |
| Date for review: | June, 2025 |
| Owner: | Group Deputy Director of Estates and Compliance & Information |
| Document type: | Miscellaneous |
| Number of pages: | 4 (including front sheet) |
| Author / Contact: | Bill Parkinson, Associate Director of Safety & Statutory Compliance |

NHS Humber Health Partnership Group actively seeks to promote equality of opportunity through its Trusts (Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire & Goole NHS Foundation Trust). The Group seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the “protected characteristics” as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

## HEALTH AND SAFETY AT WORK POLICY STATEMENT

The Group, through its partnering Trusts of Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS Foundation Trust recognises its health and safety duties under the Health and Safety at Work Act 1974, the Management of Health and Safety at Work Regulations 1999 (as amended) and Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

In keeping with the Trust's Group Strategic Plan, the transformation of the services and its sites the Group is committed to the health and wellbeing of employees, contractors, patients and other members of the public. This will be achieved by providing a working environment, appropriate controls and suitable training which satisfy the health and safety standards set out in regulations, practices and procedures, codes of practice, contracts and specific Group (and partnering Trust) policies.

Any major transformation projects under current construction (or nearing completion) can cause disruption to traffic, patient flow, car parking etc., however, these will be minimised and so to not adversely affect the health, safety and welfare of staff, patients, visitors, or the general public etc. All residual risks arising from any changes past or future will have mitigating actions in place to reduce the risk to as low as is reasonably practicable.

This Health & Safety Policy Statement outlines the Group and its partnering Trusts' commitment and approach to the management of health & safety and does not provide the detail on the management of specific health & safety risk topics. Policies and procedures covering the assessment and control of specific health & safety risks (e.g., Occupational Road Risk, Lone Working, Violence & Aggression etc.) are in place or being developed. These documents are maintained within a central document control system, which ensures that a consistent approach is adopted, that suitable consultation and approvals processes are in place and that documents are regularly reviewed and updated and are made available to staff as appropriate.

Whilst the Group Chief Executive is ultimately responsible for the implementation of effective health and safety arrangements, as outlined in the Trust's Risk Management Strategy, the Group Chief Financial Officer has delegated executive responsibility for all elements of in relation to health & safety (whilst accepting that the Group Medical Director and Group Chief Nurse have delegated operational responsibilities within their areas). In addition, the Site Managing Directors will also have delegated responsibilities in relation to health & safety. The Group Deputy Director of Estates and Compliance & Information Services in turn has responsibility for the central co-ordination of these arrangements, with the day-to-day management of health & safety management at local level being devolved to Directorates.

The Group Executive Directors, Site Managing Directors and Directors/Managers therefore collectively and individually accept their duties and responsibilities arising from the Health and Safety at Work Act 1974.

The Group recognises that a proactive approach to the management of health & safety risks is considered an essential element in a good safety management system. As part of its approach, the Group has in place a system of formal and

informal inspections, visits and audit processes which include Directors.
Where appropriate, the Trust also sources external verification of its health & safety management arrangements.

In complying with its duties to its employees as outlined in the Health and Safety at Work etc. Act 1974 and the Management of Health and Safety Regulations 1999 (as amended) the Trust is committed to:

- Introducing, developing and maintaining safe systems of work which employees and others working for the Group and partnering Trusts are expected to follow, supervise and manage, and to reviewing and improving existing systems to further raise standards.
- Increasing the knowledge and skill base of its employees in relation to health and safety, ensuring that staff are competent to identify, assess and manage health and safety risks within their working environment.
- Supporting Directorate/Care Groups etc. forums to ensure active involvement in health & safety matters and performance.
- Using internal data acquired from reactive sources (e.g., incident reports) as well as proactive systems (e.g. inspections, site visits and audits) together with information from managers and staff and external sources (e.g. legislation updates, etc.) to allow the Group to review the robustness of its safety management system and afford the opportunity to benchmark its performance against other Trusts
- Setting both annual and longer-term strategic objectives as part of the business planning process in order to further develop and improve health and safety arrangements/standards.
- Maintaining a robust incident/accident reporting system, which facilitates learning lessons through corrective action and re-audit and the identification of the underlying or root causes of failures identified.
- Ensuring that equipment is purchased to required specifications, meets all statutory requirements and that staff using equipment have received adequate instruction and training and importantly that inspection and maintenance occur as required.
- Maintaining a comprehensive Risk Register and Central Risk Assessment System (at Group and partnering Trust level) which includes specific health and safety risks, and which are used to assist in the setting of priorities and the allocation of resources as well as in the development of health and safety planning.
- Developing a positive safety culture throughout the Group and partnering Trusts through our vision and values and strategic objectives
- Implementing a strategy to promote and improve the mental health and wellbeing of staff across the Group.
- The provision of health surveillance for its employees where appropriate
- The appointment of competent personnel to support and advise staff in all areas of health and safety.

- The development of a safety management system to a recognises certified standard.

In accordance with statutory provisions the Group and partnering Trusts will ensure that adequate resources are allocated to achieve the above commitments.

In addition to the responsibilities of the Group and partnering Trusts as an employer, all employees and other persons working, e.g., volunteers and contractors, are expected to participate and co-operate with the systems of work implemented in order for the Group/Trusts to discharge their statutory duties. This also involves taking reasonable care of themselves and others who may be affected by their actions (or omissions), including the safe and appropriate use of equipment (including safety equipment) and reporting any safety issues appropriately.

The Group Cabinet and Boards-in-Common, both directly and through their designated sub-committees will monitor performance against agreed health & safety objectives with any issues escalated where required.

Formal monitoring of the Safety Management System is undertaken through a variety of measures as mentioned above. A formal audit plan is also in place and outcomes are reported to and are monitored by the partnering Trust's Health & Safety Committee and as required, the Performance, Estates & Finance (PEF) Committee-in-Common and Group Board.

This Health and Safety Policy Statement will be reviewed annually, or sooner should the need arise.

**Jonathan Lofthouse**
**Group Chief Executive**
**Version: 1.0**

**Lee Bond**
**Group Chief Financial Officer**

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**The electronic master copy of this document is held by Document Control.**

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)115**

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|---|---|
| **Name of the Meeting** | Trust Boards-in-Common (Public) |
| **Date of the Meeting** | Thusday 13 June 2024 |
| **Director Lead** | Sue Liburd, Non-Executive Director and Chair of Quality & Safety Committee |
| **Contact Officer/Author** | Sue Liburd, Non-Executive Director and Chair of Quality & Safety Committee |
| **Title of the Report** | Quality & Safety Committees in Common Minutes – March & April 2024 |
| **Executive Summary** | Quality & Safety Committees in Common minutes from meetings held on 28 March 2024 and 25 April 2024 are for information |
| **Background Information and/or Supporting Document(s)** (if applicable) | N/A |
| **Prior Approval Process** | Quality & Safety Committees in Common meetings held on 28 March 2024 and 25 April 2024 |
| **Financial implication(s)** (if applicable) | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/A |
| **Recommended action(s) required** | ☐ Approval ✓ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

# QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

**Minutes of the meeting held on Thursday 28 March 2024, 09:00 to 12:30 in the Main Boardroom, DPOW**

**For the purpose of transacting the business set out below:**

**Present:**

**Core Members:**

| | |
|---|---|
| Sue Liburd | Non-Executive Director NLAG (chair) |
| Una Macleod | Non-Executive Director HUTH |
| Tony Curry | Non-Executive Director HUTH |
| Ashok Pathak | Associate Non-Executive Director HUTH |
| David Sulch | Non-Executive Director HUTH |
| Kate Wood | Group Chief Medical Officer |
| Shaun Stacey | Group Chief Delivery Officer |

**In Attendance:**

| | |
|---|---|
| Melanie Sharp | Deputy Chief Nurse NLAG (Rep for Group Chief Nursing Officer) |
| David Sharif | Group Director of Assurance |
| Rob Chidlow | Interim Group Director of Quality Governance |
| Richard Dickinson | Associate Director of Quality Governance NLAG |
| Rebecca Thompson | Deputy Director of Assurance |
| Stuart Hall | Non-Executive Director (Observer) |
| Michela Littlewood | Associate Director of Quality HUTH |
| Wendy Page | Nurse Director, Major Trauma Care Group |
| Nicky Foster | Head of Midwifery NLAG (4.5.2 only) |
| Belle Baron-Medlam | Head of Compliance & Assurance (4.3.3 only) |
| Kevin Allen | Public Governor (observer) |
| Rachel Wright | PA to Group Chief Nurse (notes) |

**KEY**
HUTH - Hull University Teaching Hospitals NHS Trust
NLAG – Northern Lincolnshire & Goole NHS Foundation Trust

## 1. CORE BUSINESS ITEMS

### 1.1 Welcome and Apologies for Absence

The committee chair welcomed those present to the meeting. Apologies were noted for Jo Ledger. Kate Truscott was due to attend via TEAMs but was restricted by a Trust technical issue.

### 1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.3 **To approve the minutes of the meeting held on 29 February 2024**
The minutes of the meeting were accepted as a true and accurate record.

1.4 **Matters Arising**
The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. None were raised.

1.5 **Committees-in-Common Action Tracker**
The action tracker was updated prior to the meeting. The Committee approved the updates to the action tracker.

1.6 **Operational pressures update**
Kate Wood explained there was an outage overnight (27 March) affecting Lorenzo impacting a number of organisations nationally. Hull reverted to paper processes and were gradually returning to normal. Tony Curry asked what assurances were in place from the service providers in terms of continuity; Shaun Stacey confirmed business continuity plans became effective immediately and a review of the response will be completed post incident and an update shared at the next meeting.

Shaun Stacey explained attendance at all 3 emergency departments increased in the last month partially contributing to under delivery against the trajectory for the month (approx. 1.5%). There have been further delays with Yorkshire and East Midlands Ambulance Services in the last month and challenges with 65 and 78 week waits (South Bank relating to patient choice and North Bank relating to the planned trajectory and cancer transfers from North to South. High numbers of staff on leave have impacted and staff will be asked to spread their leave out next year.

The Lorenzo transition went well although there were ongoing issues with data transfer. The Cabinet were reviewing and taking actions to mitigate.

Infection control risks were affecting bed flow causing a loss of bed capacity. Recent MADE events demonstrated successful outcomes for no criteria to reside exit; 34 discharges were made at Hull on 26/03/24, the highest ever number. Ashok Pathak shared concern around the increasing numbers of patients in ED; Shaun Stacey explained Hull ED was the third most improved ED in the country due to validation of records, changes to processes and the opening of the new UTC and these mechanisms are now being maintained. Rob Childlow added ED Friends and Family Test data was also starting to show improvement. Tony Curry asked whether the actions taken in ED were sustainable; Shaun Stacey explained the Executive Team are confident the actions will be maintained.

## 2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**
The committee chair reported there were no matters referred.

## 3. RISK & ASSURANCE

3.1 **Board Assurance Framework (BAF)**
Rebecca Thompson is working to identify gaps and update controls and actions for both HUTH and NLAG and will present an update at a future meeting.

## 4. COMMITTEE SPECIFIC BUSINESS ITEMS

### Joint Business Items

### 4.1 Quality Priorities – 23/24 update and 24/25 proposals

The paper was taken as read. Richard Dickinson highlighted distinct improvements in the End of Life and Deteriorating Patient pathways for NLAG. Mixed responses relating to sepsis have been noted with improved assurance relating to paediatrics and slower progress with medication safety. Mental capacity work is starting to show improvement as a result of direct interaction. Richard is working to align the 5 themes across both HUTH and NLAG and to integrate workstreams. Ashok Pathak queried what the issues were with paediatrics relating to sepsis; Richard explained qualitative work was being undertaken around how things are documented and work on the national PEWS system is being progressed. Kate Wood added NLAG set the quality priorities to enable more things to be recorded electronically and children are being identified at an appropriate time and treated appropriately via the paper based system and work will continue to provide assurance that things are recorded appropriately. David Sulch asked whether improvements were sustainable; Richard Dickinson confirmed there had been engagement to improve awareness via prompts and guides; personal conversations with staff to help them understand the detail are starting to make a difference. Kate Wood added there was a gap in the work being done and in electronic recording at NLAG.

Rob Childlow reflected data had been less accessible at HUTH although more detailed work on sepsis had been achieved and particularly in relation to paediatrics ED. The Committee will be provided with further assurance in due course. HUTH has engaged with the Coroner who is satisfied with the measures that are being taken. HUTH are an outlier for sepsis regionally and nationally. Una Macleod added the quality priorities were the responsibility of both organisations.

Michela Littlewood added a number of QI projects were underway to support the 5 priorities in HUTH. Sue Liburd queried why recruitment for the NLAG palliative care consultant had been put on hold; Richard Dickinson explained NLAG have moved to 7 day end of life provision with consultant provision at Scunthorpe only. Discussions are ongoing regarding funding for the consultant post which wasn't recruited to and alternative ways of providing care are being explored. The Hospice continue to provide cover at Grimsby.

The quality priority topics were approved by the Committee.

### 4.2 Integrated Performance Report (IPR): quality & safety metrics

The NLAG report was taken as read. Kate Wood highlighted data issues with Lorenzo as a concern. Manual auditing of anticipatory medications achieved 94%. Melanie Sharp confirmed CDiff figures remained at 17 (target 20). 85% of complaints were responded to within 60 days. NLAG continue to receive the highest numbers of FFT responses in all areas and since moving to the new provider. Falls show an improving trend although there was an increase by 20 falls (11 no harm, 7 minor, 2 major). The 2 major falls were on the same ward at SGH; swarm huddles were completed with no new learning identified and care was entirely appropriate. No safeguarding concerns have been raised relating to falls.

An MRSA Bacteremia case was reported at SGH and reviewed via MDT on 14 March focusing on the appropriateness of the re-admission of the patient who was end of life and the need for multiple cannulas. An IPC nurse is leading on a QI project on cannula care; documentation is also moving to WebV. Further discussion will be held at the End of Life care group. Kate Wood confirmed a 'bare below the elbows' campaign will be launched shortly across the Group. Sue Liburd asked for 15 steps teams to flag that the campaign is coming. David Sulch asked if there was good consultant engagement with CDiff/MRSAs; Kate Wood explained hospital acquired infections were not a common event at NLAG and engagement was good.

Tony Curry queried the community acquired pressure ulcer data and adult sepsis score. An investigation was completed following a slight increase in Category 3 pressure ulcers and highlighted a seasonal trend which was also reflected in acute pressure ulcers; no specific themes or trends were identified and monitoring continues. Kate Wood added adult sepsis scores related to issues with electronic recording and gaps in care and work was ongoing. Ashok Pathak asked if patients who come into hospital with pressure ulcers are monitored. Melanie Sharp confirmed both the community and acute teams review patients to identify themes, trends and concerns.

Rob Chidlow referred the Committee to the Group IPR report which compares HUTH and NLAG data. The complaints response rate will be aligned (NLAG is currently 60 days and HUTHs 40 days). HUTH's performance declined in the last 3 months due the number of old complaints being closed. Variance in the pressure ulcers per 1000 bed days data was also highlighted.

The Committee were assured by the NLAG report and that lowlights are being managed and mitigated. The Committee noted that the Group report incorporating HUTH data was available electronically on time but had not been circulated as part of the paper pack and therefore was not all members had seen the HUTH specific data to be able to offer an assurance.

**4.3 CQC Improvement Plan**

The papers were taken as read. Rob Childlow explained there were currently 3 separate CQC papers including one for maternity tracking due to the requirement for HUTH to provide monthly reports under Section 31. The report highlighted the current status of CQC action plans and risks to delivery of CQC compliance across the Group. HUTH and NLAG Actions will be shared with the relevant Care Group in the coming weeks.

**4.3.1 HUTH CQC Improvement Plan**

The Committee were asked to note Surgery actions relating to consent, pain assessments and WHO checklists and similar themes had been identified at NLAG and HUTH. The evidence threshold to enable actions to be signed off is high and actions continue to be progressed. Michela Littlewood added the team were working to review ownership of actions. Rob Childlow felt 75% approx. of actions had been completed and updates are reported monthly to ICB and NHS England colleagues. Actions that haven't been signed off and are overdue and passed initial time period will be handed to the Care Groups with new timescales. Ashok Pathak queried which actions were lacking in compliance for Surgery; Michela Littlewood confirmed some related to theatres and will be discussed under item 4.11.

David Sharif queried the process for overdue actions. Rob Childlow explained different approaches had been taken previously and the focus was now on Care Groups taking ownership of actions and taking them forward. Rob Childlow is supporting governance teams to ensure Care Groups have the right governance provision.

The Committee agreed limited assurance.

**4.3.2 HUTH Maternity CQC Improvement Plan and S31 Update**

Progress towards maternity actions is moving at pace. The team achieved the target for Antenatal Day Unit and triage performance in October; a dip was seen in November due to processes still being embedded. Recommendations were reviewed at the last Maternity Transformation Assurance Committee with 21/37 recommendations now signed off. The latest maternity assurance report wasn't included in the board pack for today's meeting. However it will be presented at the next Board on 11 April. In terms of training performance, 17/21 competencies were compliant; challenges remain for newborn life support and fetal monitoring and will be delivered by the end of April. Ashok Patel asked whether consultant involvement was still an issue in relation to fetal monitoring; Rob Chidlow explained the issues related to staff not attending the sessions and annual leave pressures had impacted. Under Section 31, perinatal e-learning compliance has increased from 42% to 86%. Rob Chidlow confirmed that mandatory training compliance was not currently captured for those rotating into the Trusts.

Ashok Patel queried whether having one on call registrar overnight (2 registrars on call during the day) impacted on the care of patients. Kate Wood was not aware of any concerns and stressed any concerns should be highlighted through exception reporting channels.

The Committee agreed reasonable assurance.

**4.3.3 NLAG CQC Improvement Plan**

Belle Baron-Medlam informed the Committee that Maternity services at Goole were rated 'good' following a recent CQC visit. There were 3 'must do' actions 1 'should do' action and an initial action plan has been drafted. 'Must do' actions related to safeguarding training ensuring the policy and training needs analysis are linked to the intercollegiate guidance, assurance staff are being adequately trained, demonstrating governance around existing environmental checks ie regular completion of WAT tools and utilising national guidance for risk assessments. The 'should do' action related to the timely review of audits ensuring lessons are learned. Sue Liburd asked how mandatory training was being progressed; Belle explained targets were amended in 2023 and there was now improvement against the target. Overall nursing are closer to achieving the target and measures to improve medical staff compliance was raised at the Vulnerabilities Board by Christine Ramsden, Head of Education, Training and Development on 21 March.

David Sulch queried whether actions were sustained and embedded in relation to sepsis compliance. Belle explained the CCQ action related to staff using PPE correctly and assurance was provided by evidence; Divisions are also asked to provide quarterly updates on all closed actions.

**4.4 Nursing Assurance Report (including ward accreditation & fundamental**

**standards, safe staffing)**

**HUTH**
CHPPD (Care Hours per Patient Day) was 7.51 in January with a further reduction to 7.46 in February; the team are validating the data but feel the reduction relates to additional capacity over winter and operational pressures. Registered Nurse staffing was over established by 89.18 WTE and includes theatres, outpatients and specialist nurses; wards, ED and ICU were over established by 47.55 WTE. There were 47.34 non-registered vacancies. Mass recruitment events for non-registered staff will continue in the Care Groups. There were 500 applicants to the nurse apprenticeship programmes; the team are working closely with the colleges and the University of Hull to ensure the right candidates are applying ensuring right candidates apply to the right programmes.

There are now 30 pre-registration nursing and midwifery students from all from local universities; also 22 in paediatrics and 72 adult due to commence in September.

Internationally Educated Nurse recruitment has been completed with 9 awaiting NMC PINS; 2 will attempt the OSCE for a final time in June and intensive support is being provided.

There is increased focus on retention and support workshops for staff and ways to retain the workforce. The twice yearly establishment reviews have been completed and will be presented at Trust Board.

Falls work shows an improving picture overall. A weekly falls and pressure ulcer patient safety summit is now held for all Band 7s to review all moderate and above harm falls and share learning .

Ongoing concerns were highlighted in relation to fundamental standards. The Nutrition and Hydration group are focusing on documentation being completed and ways to improve. A number of areas rated red for tissue viability and infection control.

A fundamental standard for falls has been devised and will be presented in a future report.

Tony Curry queried the number of red flags and whether this correlated with staffing levels. Wendy Page explained higher numbers of complex patients were being seen and more patients were flagging due to dementia and delirium. Non-registered gaps remain an issue and staff are meeting 4 times per day and resources are moved to areas where patients have flagged as needing support.

Ashok Pathak queried why the number of falls hadn’t reduced. Wendy Page explained there was an open reporting culture and staff are encouraged to report everything. Weekly meetings with ward sisters are held to review the fundamentals and learning from falls has been successful. There are also high numbers of falls for low criteria to reside patients.

The Committee agreed reasonable assurance.

**NLAG**

A total of 114.97 WTE unregistered vacancies were reported. A deep dive is planned to gain a better understanding of the position and will be presented at a future meeting. The Trust met the NHS England target to appoint 90 Internationally Educated Nurses and recruitment will continue.

Four wards had a fill rate below 85% and seen improvement; an improvement was reported in January. Ward 27 continues to who a high fill date to due the additional staff needed to safely support patients with multiple complex needs. The figure has also improved since the e-roster template was altered. Ward 27 also reported increased pressures ulcers and 4 red flags relating to staffing incidents. Melanie Sharp meets weekly with the Associate Chief Nurse and Matron to work through an action plan. Ward 27 is also discussed at the monthly Nursing Metrics Panel.

Establishment reviews have been completed and the report will be presented at the next meeting followed by Trust Board. Amethyst ward and Ward 26 reported CHPPD below 6.0; both areas are being supported with sickness management and gaps are mitigated by employing bank/agency staff to maintain patient safety.

Hand hygiene compliance for Emergency Departments at SGH & DPOW has reduced. A detailed review has been completed along with multiple visits to the departments. The review highlighted external staff coming into the departments are not always washing their hands in alignment with best practice. Weekly monitoring is in place and Melanie Sharp also welcomed the forthcoming 'bare below the elbows' campaign. Tony Curry asked how staff were challenged if they were wearing a watch; Melanie Sharp confirmed all staff were expected to challenge any staff.

The Committee agreed reasonable assurance.

**4.5 Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents / MNSI)**

The reports were taken as read.

**4.5.1 HUTH Maternity & Neonatal Assurance Report**

This item was deferred to the next meeting. Rukeya Miah was unable to join the meeting due to technical difficulties.

**4.5.2 NLAG Maternity & Neonatal Assurance Report**

The paper was taken as read. Confirmation the Trust achieved all 10 safety actions has been received. Exit from the Maternity Services Safety Programme (MSSP) continues to progress and is in the latter stages of sign off; the Maternity Improvement Advisor will present at the next NHS England Board and finalized with a letter to Jonathan Lofthouse. The CQC report following the visit to Goole in November has been published with a rating of 'good' and work commenced on an action plan. Outstanding Estates issues are being addressed as part of the Safety Champions Improvement plan and due for completion by 05/04/24. The space team are working on space issues on the maternity corridor at DPOW.
NLAG and HUTH use different maternity triage calls and there are issues with recording calls with the NLAG system; Nicky will provide an update at the next meeting. Kate Wood added that not being able to record antenatal phone calls was a risk for NLAG and both Kate and Shaun Stacey were happy to support further discussions.

Nicky Foster escalated an issue regarding antenatal clinic capacity to the Committee. Capacity and demand work identified there are 246 antenatal clinics slots short each week across NLAG sites and is due to consultant numbers and the increase in fetal surveillance and monitoring as part of the Saving Babies Lives Care Bundle. The issue has been added to the risk register and the mitigation is that women are still seen in overrunning clinics.

Kate Wood congratulated Nicky Foster on the maternity team achievements in maintaining the good CQC rating at Goole and achieving the CNST safety actions.

**4.6 PSIRF/Serious Incidents (including Duty of Candour and lessons learned)**

The papers were taken as read. Richard Dickinson explained the report included a summary for NLAG and HUTH following a discussion at the last meeting and there is ongoing activity across both organisations to align the PSIRF plan and duty of candour processes. Ultimately NLAG and HUTH will use the same reporting system.

Tony Curry asked whether the number of deaths relating to emergency medicine correlated to pressures to delivering the service and high numbers of patient deaths in ED in Hull. Kate Wood confirmed numbers of deaths in HUTH ED weren't high comparatively but leading up to November 2023 there had been a number of incidents requiring PSII investigation which had fortunately subsequently reduced. Michela Littlewood explained Yorkshire Ambulance Service and HUTH are holding monthly harm review meetings to discuss fundamental risks of harm and learning; East Midlands Ambulance Service will be invited to join the meeting in due course. The number of open SI actions (HUTH) has reduced to 10.

Rob Chidlow brought to the Committee's attention an item documented in this agenda item in the previous month's report relating to a separate ICB investigation, but was not highlighted for discussion during the meeting. This related to a separate ICB investigation regarding a patient death in December 2021 in HUTH; the ICB report was received by the Trust in December 2023. The incident wasn't recognised by the Trust as a serious incident. The ICB highlighted 22 actions in terms of the patient care including 16 recommendations relating to fundamentals of nursing care. Despite investigations being carried out by the police, NMC and GMC the ICB concluded there wasn't causation for the patient. The delivery of these actions will be tracked as part of the Trust's tracking within this report.

Ashok Pathak referred to the number of deaths reported in thrombectomy services and whether services were now 7 days per week. Michela Littlewood explained further work was ongoing with stroke/patient safety teams. Kate Wood added the service wasn't 7 days and a business case was sat with the national team. Current funding ceases at the end of March 2024 and if funding isn't confirmed, the service will revert back to daytime hours, Monday to Friday. Incidents show that unfortunately some patients die from known complications.

**4.7 Mortality including Learning from Deaths**

Kate Wood provided a verbal update and referred to the differences in the SHMI across the North and South bank. The team are developing a strategy. A drill down into mortality statistics has highlighted the SHMI on the North bank is driven by Castle Hill Hospital. A working hypothesis is that the NLAG SHMI may have declined due to a number of interventions including sending high risk cardiology patients and sick oncology patients to the North bank. Specific workstreams for sepsis, fractured neck of femur and stroke are being established. Kate Wood will present an update to the Committee in May.

**4.8 Research, Innovation & Development Quarterly Update**

The paper was taken as read. James Illingworth was unable to present the paper due to issues dialing into the meeting. Kate Wood explained that Research and Development for HUTH and NLAG is now part of the Chief Medical Officer's portfolio and managed by James Illingworth. Current project work was detailed in the report. The team are working to develop a research strategy across the group in conjunction with the University of Hull; Kate Wood has met with the Vice and Pro-Vice Chancellor to discuss taking the strategy forward. Una Mcleod added there was a clear need to develop a research culture across the group.

**<u>NLaG Specific Business Items</u>**

**4.9 Mental Health Strategy Update**

This item was deferred to the next meeting.

**<u>HUTH Specific Business Items</u>**

**4.10 DEEP DIVE – Tissue Viability**

Wendy Page explained an issue with hospital acquired pressure ulcers (PUs) was identified post Covid. A bi-weekly task and finish group was set up with nurse directors to get traction on actions and actions are now addressed at the monthly Safe Skin Care Committee (SSCC). HUTH currently has 2.2 PUs per 1000 bed days with significant improvements over the last 2 years. Category 2,3 and 4 PUs are discussed at the SSCC; the format of the team is being restructured due to a staff member retiring which has lead to a delay in data validation. From 1 April 2024, national reporting requirements are changing and staff will be required to report category 1 PUs; this will increase PU numbers but prevent deterioration to category 2 and 3.

Medical device related PUs have increased with the team doing focussed work in specialist areas. Category 3 & 4 PU numbers are low. Weekly patient safety summits are working well and good practice is being shared. Clinical nurse educators and TVNs have standardised all training. Housekeepers are attending training which has improved ordering equipment/mattresses. The tissue viability nurse is now attending monthly triangulation meetings with community providers. A document is being trialled for patients with hospital acquired PUs or complex wounds to ensure patients have detailed discharge information for district nurses/GPs. The beside assessment has been updated and training provided. The PU fundamental standard has been updated and has raised the expected standard for staff. Face to face training has also recommenced. Further work is being carried out to improve training compliance – nursing directors have been given an expected trajectory of improvement. Considerable improvement was reported for CQUINS with 50% compliance during Q3. Melanie Sharp will pick up

a separate conversation with Wendy Page about joint working. Una Macleod noted the good work that was happening and the positive impact it was having on patients. Rob Childlow highlighted an issue with categorising PUs on the North bank in November 2022 and that significant improvements have been made since.

**4.11 DEEP DIVE – Theatres Workstream Update**

The paper was taken as read. Michela Littlewood explained a deep dive was undertaken following the CQC visit and 5 separate workstreams were developed. Good progress has been made in some areas but further work is required for NATSSIPs2. The number of theatres has increased with a total now of 51 and interventional areas are also used in ophthalmic clinics/plastic surgery to carry out theatre level procedures. There are delays around digital capacity. Work is progressing on the medicines management IPC workstreams. A number of audits have been completed on never events in theatre; the only outstanding action is from Learning from Patient Safety Events (LFPSE) update in DATIX. Michela assured the Committee that consent was being obtained appropriately and the team continue to work closely with the safeguarding team around patients who lack capacity to consent. Michela highlighted there were noticeable differences between existing and new teams in terms of culture and recently there had been more challenge coming from junior staff. Shaun Stacey added that the new care group structure would support this work. Kate Wood acknowledged the progress Michela Littlewood had made in progressing the theatre actions. The Committee agreed limited assurance.

**5. ITEMS FOR INFORMATION/TO NOTE**

The following items for information were noted:

- 5.1 Quality Governance Group NLAG
- 5.2 Mortality Improvement Group NLAG
- 5.3 Patient Safety Champions NLAG
- 5.4 Patient Experience Sub-Group HUTH
- 5.5 Patient Safety & Clinical Effectiveness Sub-Group HUTH
- 5.6 Operational Risk & Compliance Sub-Group HUTH
- 5.7 Non-Clinical Quality Sub-Group HUTH
- 5.8 Q&S CIC Workplan GROUP

**6. ANY OTHER URGENT BUSINESS**

Kate Wood informed the committee that a number of internal actions were being undertaken following an incident in the mortuary at DPOW. David Sharif added immediate security measures were taken and further measures are planned. All next of kin had been contacted and were supported by the senior nursing team. The CQC and NHS England have been informed.

**7. MATTERS TO BE REFERRED BY THE COMMITTEES**

**7.1 Matters to be Referred to other Board Committees**

There were no matters for referral to any of the other board committees.

**7.2 Matters for Escalation to the Trust Boards**

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- HUTH sepsis – needs further assurance
- NLAG –Antenatal phone call recording on the risk register
- HUTH & NLAG working together on quality priorities
- NLAG – nurse vacancies deep dive next at next meeting
- ICB patient investigation
- Mortality update in May (Kate Wood)
- Mortuary incident
- HUTH no criteria to reside highest number of patients discharged
- NLAG CDiff 17/20 cases
- Goole maternity rated good (CQC)
- NLAG CNST achieved
- HUTH tissue viability deep dive – good improvement and working on training figures
- HUTH theatres deep dive – a lot of improvement; further work on mental capacity consent
- HUTH progress towards CQC actions
- Bringing together of IPRs from HUTH and NLAG
- R&D quarterly report received – good progress noted and greater links with the university welcomed.

**8. DATE AND TIME OF THE NEXT MEETING**

**8.1 Date and Time of the next Quality and Safety CiC meeting:**
Thursday 25 April at 13.30 to 17:00, in the Boardroom, Hull Royal Infirmary

## Cumulative Record of Attendance 2024

| | | | Jan | Feb | Mar |
|---|---|---|---|---|---|
| **Core Members** | | | | | |
| Una Macleod | UM | Non Executive Director (HUTH) | | | |
| Sue Liburd | SL | Non Executive Director (NLAG) | | | |
| Ashok Pathak | AP | Non Executive Director (HUTH) | | | |
| Kate Truscott | KT | Non Executive Director (NLAG) | | | |
| Tony Curry | TC | Non Executive Director (HUTH) | | | |
| David Sulch | DS | Non Executive Director (HUTH) | N/A | N/A | |
| Kate Wood | KC | Group Chief Medical Officer | CH | | |
| Shaun Stacey | SS | Group Chief Delivery Officer | AA | AS | |
| Vacant | | Group Chief Nurse Officer | MS | JL | MS |

| Attended | Apologies/Deputy sent | Apologies |
|---|---|---|

# QUALITY & SAFETY COMMITTEES-IN-COMMON MEETING

**Minutes of the meeting held on Thursday 25 April 2024, 13.30 to 17.00 in the Boardroom, Hull Royal Infirmary**

**For the purpose of transacting the business set out below:**

**Present:**

**Core Members:**

| | |
|---|---|
| Sue Liburd | Non-Executive Director NLAG (chair) |
| Kate Truscott | Non-Executive Director (NLAG) |
| Tony Curry | Non-Executive Director HUTH |
| Ashok Pathak | Associate Non-Executive Director HUTH |
| David Sulch | Non-Executive Director HUTH |
| Shaun Stacey | Group Chief Delivery Officer |
| Amanda Stanford | Group Chief Nurse |
| Kate Wood | Group Chief Medical Officer |

**In Attendance:**

| | |
|---|---|
| Melanie Sharp | Deputy Chief Nurse NLAG |
| Jo Ledger | Deputy Chief Nurse HUTH |
| David Sharif | Group Director of Assurance |
| Rob Chidlow | Interim Group Director of Quality Governance |
| Richard Dickinson | Associate Director of Quality Governance NLAG |
| Rebecca Thompson | Deputy Director of Assurance |
| Michela Littlewood | Associate Director of Quality HUTH |
| Nicky Foster | Head of Midwifery NLAG |
| Rukeya Miah | Head of Midwifery HUTH |
| Leah Coneyworth | Head of Quality Compliance and Patient Experience |
| Zara Ridge | Head of Facilities Management |
| Vicky Thersby | Head of Safeguarding NLAG (safeguarding item only) virtual |
| Karen Harrison | Head of Safeguarding HUTH (safeguarding item only) virtual |
| Belle Baron-Medlam | Interim Head of Compliance & Assurance (CQC item only) virtual |
| Jennifer Granger | Head of Compliance & Assurance (CQC item only) virtual |
| Corrin Manaley | Public Governor (observer) virtual |
| Lesley Heelbeck | National Maternity Improvement Advisor (NHSE) |
| Rachel Wright | PA to Group Chief Nurse (notes) |

**KEY**

HUTH – Hull University Teaching Hospitals NHS Trust
NLAG – Northern Lincolnshire & Goole NHS Foundation Trust

## 1. CORE BUSINESS ITEMS

### 1.1 Welcome and Apologies for Absence

The committee chair welcomed those present to the meeting. No apologies were noted.

### 1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

### 1.3 To approve the minutes of the meeting held on 28 March 2024

The minutes of the meeting were accepted as a true and accurate record with a few minor amendments.

### 1.4 Matters Arising

The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. None were raised.

### 1.5 Committees-in-Common Action Tracker

The action tracker was updated prior to the meeting. The Committee approved the updates to the action tracker.

### 1.6 Operational pressures update

Shaun Stacey explained all 3 Emergency Departments continued to be significantly challenged around ambulance handovers in particular maintaining 30 and 45 min handovers in Hull has been an issue. Significant improvements have been seen at Scunthorpe and Grimsby EDs. NLAG and HUTH did not hit the 76% A&E performance target agreed last year but maintained on trajectory for both EDs. The number of patients waiting in ED for 12 hrs for a bed increased in Hull but decreased in NLAG due to the integrated units. The length of stay for no criteria to reside patients has reduced as a result of the recent MADE event.

The number of elective pathways over 52 and 65 weeks was higher; the volume of patients in HUTH waiting 65 and 78 weeks is being addressed. HUTH have been removed from the monitoring system for referral to treatment patients attributed to the change in size of waiting lists; NLAG were placed into tier 1 monitoring in April for cancer due to the stagnant position of patients over 104 days and the faster diagnostic target not being met in March. Ashok Pathak asked when it was expected the no criteria to reside position would improve; Shaun Stacey explained the shortening in length of stay for no criteria to reside patients was already having an impact. Work is continuing to enable teams to provide the same level of support at the weekend as during the week. Improvements are expected month on month.

Ashok Pathak asked whether no criteria to reside patients in Hull were discharged to a specific nursing home. Shaun Stacey confirmed patients follow different pathways depending on their needs; the ‘13th floor’ and Rossmore care home are also used to support these patients. Challenges in adult social care continue although engagement has improved.

Tony Curry highlighted that ambulance handover had been problematic for some time and asked what steps were being taken to address this. Shaun Stacey explained ‘drop and go’ was already in place for all YAS units. EDs rotas have

been revised and teams are focussing on patients that are unlikely to be admitted from their ED attendance.

## 2. MATTERS REFERRED

**2.1 Matters referred by the Trust Board(s) or other Board Committees**

The committee chair reported there were no matters referred.

## 3. RISK & ASSURANCE

**3.1 Board Assurance Framework (BAF)**

David Sharif explained work continues to harmonise the BAF and develop a strategy for the group and identify associated strategic risks. Rebecca Thompson will meet with Amanda Stanford, Group Chief Nurse to review the quality risk and is supporting work to merge the HUTH and NLAG BAFs.

Ashok Pathak highlighted the report referred to avoidable harm to patients in ED (HUTH) and asked whether the opening of the Urgent Treatment Centre had impacted on ED. The Committee agreed the ED deep dive paper (item 4.11) would address this question.

Rob Chidlow asked for the final version of the 2023/24 BAF to be shared with the committee at a later date for approval. Sue Liburd asked if there were likely to be significant changes in risk scoring; Rebecca Thompson confirmed the digital risk had increased but no there were no major changes.

Kate Wood added it was difficult for the executive team to have oversight of similar risks in 2 organisations and supported the work to align the BAF.

## 4. COMMITTEE SPECIFIC BUSINESS ITEMS

**<u>Joint Business Items</u>**

**4.1 Integrated Performance Report (IPR): quality & safety metrics**

Kate Wood explained that BI capability had been challenged recently with regard to reporting of metrics on the south bank due to the PAS/Lorenzo cross over and some data updates had been manually. Last year at total of 18 C.Diff cases were reported against a target of 20. Mortality figures remained within the as expected range. A national patient safety alert relating to bed rails was not complied with at either Trust. Work continues on the North bank with falls; there are challenges with mortality and a joint strategy is being developed. The QI team are supporting work on the North Bank to improve the VTE target following successful work on the South Bank. The bare below the elbows campaign has now been launched.

Melanie Sharp (NLAG) explained the new C.Diff target was expected in June. A significant decrease in acute falls and pressure ulcers was reported; referrals to the Tissue Viability nurses have significantly reduced. In total 92% of complaints were completed within timeframe (KPI 85%). There was a slight increase in community pressure ulcers; a review of nursing networks highlighted the same number of incidents were reported in patients' homes and care homes; guided training has been delivered to staff. There was a spike in mixed sex breaches; all patients were communicated to individually and were informed the breaches were due to operational pressures.

Jo Ledger (HUTH) explained good progress was being made with falls; a piece of work has been commissioned to review falls in ED and is progressing. An increase in the number of reported pressure ulcers is expected due to category 1 pressure ulcers now being reported; HUTH and NLAG are working collaboratively on falls/pressure ulcers. In total 5 MRSA bacteremia's were reported and deemed unavoidable following review and lessons to be learned identified around basic IPC fundamentals. The team are doing focused work including gram negative, catheter care and hydration of patients. Kate Truscott felt the figures around NLAG e-coli performance weren't clear as the YTD figure was 54 against annual target of 46 and in the expected range. Amanda Stanford explained further work was needed on the analysis of the charts, how they are presented and the level of detail in the narrative. Sue Liburd asked if it was possible to classify the type of falls and define the outcome of severity as the report currently only stated moderate to major harm; Jo Ledger confirmed a breakdown of the type of fall can be included in future. Rob Chidlow added the team are aiming to highlight comparable data for HUTH and NLAG in the report.

David Sulch asked whether there was an issue with VTE data collection at HUTH. Kate Wood explained NLAG implemented electronic blocking but there was no facility in EPMA at HUTH. An electronic form is being piloted on AMU and 3 other wards; work is also underway with ED staff around the transfer of in-patient records. HUTH are also working with Hull York Medical School to include VTE education for medical students.

**4.2 CQC Improvement Plan**

**4.2.1 HUTH CQC Improvement Plan**

There are 285 actions on the North Bank. Leah Coneyworth explained there were no changes in the report from ED or medicine since the previous update; issues remain in medicine relating to VTE and mental capacity. ED had 3 overdue actions; one relating to the ground floor model; the 2nd related to staff attending de-escalation training; the action will remain open until there is further improvement. Surgery had 2 overdue actions; a baseline audit of the matrons' handbook has been completed. Four staff are still to complete safeguarding training. The Respect audit action remains open. Kate Truscott asked if other staff could support the Respect audit; Jo Ledger confirmed plans were in place and an update would be shared at a future meeting.

Delivery of progress against actions has been paused; HUTH and NLAG are working to align processes and agree a consistent approach across the Group. The team continue updates on key areas in engagement meetings and are working to handover action plans to care groups. Amanda Stanford asked what length of time the actions had been overdue; Leah agreed to share the details with Amanda.

The Committee agreed limited assurance.

**4.2.2 HUTH Maternity CQC Improvement Plan and S31 Update**

The committee agreed this update would be covered under item 4.3.1.

**4.2.3 NLAG CQC Improvement Plan**

Belle Baron-Medlam explained the NLAG action plan had been reassessed and

actions with full assurance removed reducing from 122 to 72 actions. Removed actions remain tracked and monitored quarterly and aligned to core services (mapping document attached as Appendix 2). The team are engaging with the new care groups to ensure actions are progressing. Kate Wood added it was important care groups were sighted on the issues and take ownership and deliver the actions.

Sue Liburd referred to the overall action assurance rating (page 4) and the reason for the increase. Belle-Baron Medlam confirmed the increase was due to 4 actions (rated limited assurance) being added following the CQC visit to Goole in November 2023.

Sue Liburd suggested referring pharmacy recruitment (page 7) to the Workforce, Education & Culture (WEC) committee as WEC previously gave assurance pharmacy recruitment wasn't a challenge. This was agreed by the Committee.

Sue Liburd asked whether the bespoke syringe driver training was in place. Belle Baron-Medlam explained the training was already in place but was reliant on staff taking up the training offer; an update of the areas that have been targeted will be included in the next report. Kate Wood added the end of life team have been delivering excellent syringe driver training on the south bank.

Sue Liburd asked whether the new assessment approach introduced by the CQC would impact on action plans and evidence categories; Belle Baron Medlam explained actions remain aligned to core services.

Ashok Pathak was aware of a recommendation from the National Medical Director (NHS England) to cut back mandatory training for junior doctors and asked what the impact would be; David Sulch added the purpose was for training to be transferrable between Trusts rather than repeating training. Kate Wood explained the ICB were developing passporting for medical staff and training was also being aligned between HUTH and NLAG.

The Committee agreed moderate assurance.

**4.3 Maternity & Neonatal Assurance Report (including Ockenden, CNST MIS, incidents/MNSI)**

**4.3.1 HUTH Maternity & Neonatal Assurance Report**

The report was taken as read. The proposed midwifery establishment structure was outstanding and awaits executive and ICB approval. The workforce trajectory for September 2024 was 212 WTE (clinical) and less than the birth rate refresh. MIS year 6 was being operationalized by the Saving Babies Lives care bundle 3 and monitored quarterly by the LMNS; the improvement lead continues to make significant progress against elements 2 and 6. The Maternity Assurance Transformation Committee ensures monitoring and compliance of the year 6 CNST standards. Risks with the following were highlighted; (training) bespoke sessions are offered to staff; HUTH and NLAG are working collaboratively to create a structured approach; (safety actions 4/5) and (action 5 labour ward co-ordinator supernumerary status). Quality improvement initiatives are underway focusing on clinical pathways. A QI project with AQUA is also underway.

The neonatal workforce position was in a good position. The FFT (Friends &

Family Test) birth score remained at 100%. Ten CQC actions were outstanding – six will presented for approval at the next MTAC meeting. A phased approach (8-1) was introduced for triage and the process has been embedded with teams.

The training action remained open until a more robust training faculty is in place. Improvements in Newborn Life Support and Prompt training were highlighted. The maternity team are working with Lesley Heelbeck, National MIA on an integrated governance mechanism. A diagnostic report is expected by the end of April with key stakeholders will work through the recommendations; Lelsey added a secure leadership structure was essential. Ashok Pathak asked what the format of the leadership structure was; Lesley Heelbeck explained the 3-year delivery plan for maternity/neonatal services needed support from a combined workforce.

Ashok Pathak referred to difficulties with triage at night and asked what measures were being taken to improve on this and also asked for assurance around the safety of babies in incubators. Rukeya Miah confirmed all entrances were swipe access and parents are swiped in and out of the unit. Babies on the neonatal unit are given 1:1 care. A review of security is currently underway. Ashok Pathak asked if staffing issues on NICU were nursing or medical related; Rukeya Miah confirmed the issue related to consultants; Jo Ledger added additional roles (Band 8A matrons) were introduced to give 7-day cover and ensure oversight of the unit. A number of posts are currently interim and a request has gone to the ICB for additional investment and further Ockenden funding may be available. Triage is a significant issue with workforce implications. Results of capacity and demand work overnight was due to be presented at MTAC on 26 April. Sustainable leadership and overnight triage models need to be in place to HUTHs exit from Section 31. Rukeya Miah explained different approaches had been taken to sustain overnight capacity and separate pathways and prevent teams from being overwhelmed. Amanda Stanford queried the neonatal death rate from Aug 23 was 8??

**Action:- Rukeya Miah to review neonatal death data and update the Committee at the next meeting.**

David Sulch felt the action plans in the reports were not providing assurance. Rob Chidlow explained he was working with the Heads of Midwifery to streamline the reports and ultimately there would be one report.

**4.3.2 NLAG Maternity & Neonatal Assurance Report**

The paper was taken as read. Workforce showed an improving position with 16.9 WTE vacancies Trust wide. Assurance and monitoring will continue for CNST year 6 and fortnightly meetings have commenced. Exit from the Maternity Special Measures Programme (MSSP) was confirmed and is in the latter stages of sign off. The maternity sustainability action plan is complete and was due for sign off at the O&G governance meeting in May and the Maternity Improvement Advisor will share with the NHS England board. The maternity team worked with compliance colleagues and submitted a completed action plan following the CQC to maternity services at Goole. Processes are now in place to enable the recording of triage calls; an update will be shared at the next meeting; Kate Wood added there had been major progress on the North Bank in recording triage calls.
Rob Chidlow explained the Heads of Midwifery were working together to present a consistent maternity reports for the Committee.

The Committee agreed south bank – significant assurance; north bank HUTH -=

limited assurance.

**4.4 PSIRF/Serious Incidents (including Duty of Candour and lessons learned)**
Richard Dickinson explained the report highlighted the current actions and any issues that were preventing completion and the current status of the case. The number of reported SIs had reduced since November. Three after action reviews were reported in the last period and the team are actively managing other MDT reviews and investigations. Richard will add the closure dates to future reports.

David Sulch asked why the maternal cardiac arrest and maternal death were still being investigated. Richard Dickinson explained the maternal death (p6) was out of the Trust's jurisdiction; the cardiac arrest (p5) was a mutli-complex case and being investigated through a multi-disciplinary/external partner approach; the case was also rejected by the family and the MNSI. Kate Wood expressed a note of concern asking that the Committee focus on assurance of process rather than discussing individual cases and asked that colleagues picked up specific queries about cases outside of the meeting to prevent patient identifiable information being released. NLAG Non-Executive Directors were familiar with these cases. Sue Liburd felt the summary description and deadline date were useful. David Sulch wasn't assured by deadline and wanted assurance on both the process and the outcomes of process and that these be qualitatively robust. Richard Dickinson explained the team were actively trying to include information to help to understand process and would add performance information metrics.

Michela Littlewood explained HUTH had 8 legacy SI actions open. The duty of candour process is completed through verbal, written and final investigation and not marked on timescale. Current thematic reviews were also included in the report. Rob Chidlow added further work with nursing teams was needed to ensure consistency across HUTH and NLAG on how duty of candour was applied to ensure a group approach. Michela Littlewood felt processes needed aligning with care groups to ensure a consistent approach.

Tony Curry asked how learning outcomes were reported. Richard Dickinson explained areas for improvement were included in the report. Areas that have been investigated have also been linked to quality improvement activities or committees with an interest in the topic.

The committee agreed significant assurance in terms of process for both the north and south banks.

**4.5 Quality Impact Assessment (QIA)**
This item was deferred to the next meeting.

**4.6 Register of External Agency Visits**
This item was deferred to the next meeting.

**4.7 Safeguarding including MCA & DOLS**
The report was taken as read. Karen Harrison shared key highlights for HUTH; training continued to improve with excellent progress over last 12 months. There was a potential risk with Oliver McGowan training due to a restrictive delivery framework and discussions were ongoing with the strategic lead. In terms of Mental capacity assessments (DOLS) and the consent process, the MCA lead supports the consent task and finish group and produced a SOP; the quality of paperwork submitted has improved since process improvements

were introduced – DOLS training compliance was 87.5%. Risks remained around mental health assessments due to not being 100% compliant although data showed month on month improvement; staff are being invited to book onto targeted sessions. HUTH were a national outlier for pain assessment in the national audit for dementia; the dementia matron post was vacant under discussion with Amanda Stanford and Jo Ledger and a process change is planned to move from paper to move from paper to digital assessment.

David Sulch asked what timescale staff had to complete Oliver McGowan training in; Karen Harrison explained the training was completed every 3 years; a trainer was in place to deliver the training but the challenge was to get 'experts by experience' ie someone with an LD/autism diagnosis to assist with delivery of the training which meant attendee numbers were limited therefore it could take years for staff to be trained. Sue Liburd asked whether the problem was recognised nationally; Karen Harrison explained it was national issue; the HUTH team are going to ask the ICB lead to ask whether 'experts by experience' could be someone without a diagnosis ie parent/carer. Kate Truscott felt it would be beneficial to get local agreement from the ICB. Shaun Stacey added there needed to be a consistent approach across all staff and shared concern around service implications with the training. Sue Liburd asked where the Committee's concerns should be taken; Amanda Stanford explained the organization needed to agree what their approach to the training would be and what was needed to deliver the training and what approach was being taken across the wider ICB. Sue Liburd asked Amanda Stanford to take this forward as an action and share an update with the Committee at a later date.

Vicky Thersby noted similar issues with Oliver McGowan training for NLAG. Work to improve level 3 safeguarding adults and children training compliance continues and remains below Trust target. The Domestic Abuse Co-ordinator is in post and engaging with areas to deliver bespoke training. The transition lead has incorporated epilepsy services and developing processes in diabetes; a transition conference is planned for November. Going forward HUTH and NLAG will work together on transition. Following the national audit for dementia (round 6 ) there was improvement from 54 to 75 at SGH and 55 to 75.6% at DPOW. The screening tool in ED is being mandated into the electronic system for patients over 75.

The Committee agreed significant assurance.

**4.8 Patient Experience Report (including learning from complaints)**

Leah Coneyworth explained HUTH were complying with 40 day complaints targets; complaints are increasing in their complexity. There was a backlog of 174 PALS and the governance team is supporting to reduce the backlog. There has been focussed work on FFT for maternity and ED; the maternity response rate was 98% and ED 72%. Next steps were to work with care groups to address the backlog and going forward supporting them as Groups and aligning process between HUTH and NLAG.

Melanie Sharp noted a spike in complex lengthy complaints on the south bank. The complaints position was positive with 92% met within the 60 day target (KPI 85%). A total of 77% PALS were answered within the 5 day target. FFT was in the best position at any time overall; there was a risk to the FFT position if the patient experience role was not funded going forward and discussions were

ongoing. Rob Chidlow highlighted the downward trend of back logged complaints at HUTH (p8) and thanked the HUTH patient experience team for their efforts; NLAG were also had the best FFT score in the region for outpatients. HUTH also improved their A&E and inpatient FFT scores. For maternity – both Trusts scored 100% on birth score but further work was needed on post and antenatal data on the north bank. Kate Truscott asked for the FFT improvements to be highlighted to Trust Board.

**4.10 Clinical Effectiveness Report (including clinical audit, NICE compliance, GIRFT, PROMS etc)**

This item was deferred to the next meeting.

**4.11 Annual PLACE Report**

Zara Ridge (HUTH) explained a joint HUTH/NLAG report would be produced for next year. PLACE is currently led by facilities in HUTH and by nursing in NLAG. HUTH assessments ran during October and November 2023. Areas were selected on a rotation basis and some of the areas visited were of an aging nature which was reflected in a reduction in the overall scoring with the exception of the food and hydration score which increased. Zara Ridge highlighted the difficulties of maintaining cleanliness in areas where condition and appearance are affected. Facilities are supporting the relevant teams with ongoing work. An additional floor maintenance programme has been implemented supported by domestic services. Improvement with food hydration scores was noted and further improvement was expected in 2025. Issues with privacy and dignity were highlighted at Castle Hill Hospital.

Melanie Sharp confirmed the NLAG scores were above the national average in all domains and improvement was seen in all domains expect cleanliness and condition, appearance and maintenance; the scores were impacted older buildings at Scunthorpe and Goole. Significant improvements in food scores were noted. The overall feedback from patient reps focused on how well they were received. A PLACE meeting is held to monitor actions. Issues with wi-fi and signage across NLAG are being reviewed. The full PLACE report will be shared at a later date.

Rob Chidlow suggested an update was shared with the committee 6 months prior to the main assessment. Both HUTH and NLAG already undertake ‘lite’ assessments prior to the main assessment. Kate Truscott asked for a focus on dementia and learning disabilities to be included in further activities and action plans and issues with wi-fi/entertainment for patients needed addressing at NLAG.

The Committee agreed significant assurance.

**NLAG Specific Business Items**
None

**HUTH Specific Business Items**

**4.10 DEEP DIVE – ED Update**

The report was taken as read. Dr Anwer Qureshi and Simon Buckley were welcomed to the Committee by the chair. Dr Qureshi explained the report focussed on performance; the team continue to focus improving the 4 hour performance. ED, medicine inpatient teams are working together on a QI project over a 2 week period in results will be implemented that are sustainable. Ambulance handover times were a concern and the team are working on a project with YAS. Work on specialty assessment areas was being taken forward. Twelve hour trolley waits remain an issue although numbers reduced in the last month. An assessor model where patients were brough directly to SDEC by ambulance was successful but not continued due to some patients not being suitable. UTC continues to work well and runs from 7.00 am – 11.00 pm and can close early due to capacity; the team are working towards at 24/7 service.

ED safety champions meetings are used to review evidence received to support closing the remaining CQC open actions. A non-elective improvement plan with defined actions is being progressed. The ground floor plan remains under review. Simon Buckley added the recent CQC engagement visit highlighted minor issues and teams acted straight away to address the issues. David Sulch asked what was being done to keep patients with long ED waits safe. Dr Qureshi explained time and performance determined quality and the ED team have clinical responsibility for the patient; the ED team are also reviewing the boarding process to ensure the right patients are being sent to the right wards.

Kate Truscott asked whether there were enough staff to support the service. Dr Qureshi explained a workforce plan was in place and being implemented. Simon Buckley added the type of care delivered in EDs was different ie ward based care and staffing felt adequate. Ashok Pathak referred to SDEC being temporary and whether it would be made permanent also that UTC were having to bring in staff from Bransholme UTC. Dr Qureshi explained SDEC was well established for medicine but further work was needed for other groups. A pilot period was undertaken where ambulances had direct access to SDEC to deflect patients from ED; this process will be reintroduced again. Shaun Stacey added there were both risks and benefits to moving staff round. The model of SDEC was separated and time consuming model need to move towards integrated urgent care and need to ensure specialty in reach in all areas.

The Committee agreed moderate assurance. The ED deep dive update completes the outstanding actions of HUTH & NLAG Quality & Safety Committees prior to Committees being held in common.

## 5. ITEMS FOR INFORMATION/TO NOTE

The following items for information were noted:

- 5.1 Quality Governance Group NLAG
- 5.2 Mortality Improvement Group NLAG
- 5.3 Patient Safety Champions NLAG
- 5.4 Patient Experience Sub-Group HUTH
- 5.5 Patient Safety & Clinical Effectiveness Sub-Group HUTH
- 5.6 Operational Risk & Compliance Sub-Group HUTH
- 5.7 Non-Clinical Quality Sub-Group HUTH

## 6. ANY OTHER URGENT BUSINESS

Kate Wood informed the committee that mechanical thrombectomy services were being delivered out of HUTH on an extended hours pilot, 7.00 am – 8.00 pm, Mon – Fri. The service has now reverted to 8.00 am – 5.00 pm since the pilot concluded at the end of March. Further funding to be agreed by the national team.

## 7. MATTERS TO BE REFERRED BY THE COMMITTEES

### 7.1 Matters to be Referred to other Board Committees

- Pharmacy recruitment referred to Workforce, Education and Culture Committee
- Oliver McGown training (HUTH & NLAG)

### 7.2 Matters for Escalation to the Trust Boards

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- CCQ action mapping exercise (HUTH & NLAG)
- Maternity triage issues overnight (HUTH)
- Maternity workforce issues (HUTH
- FFT improvements (HUTH & NLAG)
- ED deep dive (for noting)

## 8. DATE AND TIME OF THE NEXT MEETING

### 8.1 Date and Time of the next Quality and Safety CiC meeting:

Thursday 23 May, 09.00 – 12.30 in the Boardroom, Hull Royal Infirmary

## Cumulative Record of Attendance 2024

| | | | Jan | Feb | Mar | Apr |
|---|---|---|---|---|---|---|
| **Core Members** | | | | | | |
| Una Macleod | UM | Non-Executive Director (HUTH) | | | | |
| Sue Liburd | SL | Non-Executive Director (NLAG) | | | | |
| David Sulch | DS | Non-Executive Director (HUTH) | | | | |
| Ashok Pathak | AP | Non-Executive Director (HUTH) | | | | |
| Kate Truscott | KT | Non-Executive Director (NLAG) | | | | |
| Tony Curry | TC | Non-Executive Director (HUTH) | | | | |
| Kate Wood | KW | Group Chief Medical Officer | CH | | | |
| Shaun Stacey | SS | Group Chief Delivery Officer | AA | | | |
| Amanda Stanford | AS | Group Chief Nurse Officer | MS | | MS | |

| Attended | Apologies/Deputy sent | Apologies |
|---|---|---|

## Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)116**

| **Name of Meeting** | **Trust Boards-in-Common** |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Gill Ponder and Mike Robson, Non-Executive Directors (Chairs) |
| **Contact Officer / Author** | Gill Ponder and Mike Robson, Non-Executive Directors (Chairs) |
| **Title of Report** | Minutes of the Performance, Estates and Finance Committees-in-Common meetings held in March and April 2024 |
| **Executive Summary** | The minutes attached are the formal account of the meetings of the Performance, Estates and Finance Committees-in-Common from 27 March and 24 April 2024. The minutes include any actions and resolutions made |
| **Background Information and/or Supporting Document(s)** (if applicable) | Performance, Estates and Finance Committees-in-Common Terms of Reference for HUTH and NLaG |
| **Prior Approval Process** | Approval at the April and May Performance, Estates and Finance Committees-in-Common meetings |
| **Financial Implication(s)** (if applicable) | N/a |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/a |
| **Recommended action(s) required** | ☐ Approval ✓ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

# PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

**Minutes of the meeting held on Wednesday, 27 March 2024**
**at 09:00 to 12:30 hours in the Boardroom, Alderson House, Hull Royal Infirmary**

**For the purpose of transacting the business set out below:**

**Present:**

**Core Members:**

| | |
|---|---|
| Mike Robson | Non-Executive Director (HUTH - Chair) |
| Gill Ponder | Non-Executive Director (NLaG) |
| Jane Hawkard | Non-Executive Director (HUTH) |
| Simon Parkes | Non-Executive Director (NLaG) |
| Shaun Stacey | Group Chief Delivery Officer |
| Lee Bond | Group Chief Financial Officer |

**In Attendance:**

| | |
|---|---|
| Annabelle Baron-Medlam | Acting Head of Compliance & Assurance (NLaG) |
| Andy Haywood | Group Chief Digital Information Officer |
| Alison Hurley | Assistant Trust Secretary (NLaG) |
| Linda Jackson | Vice-Chair (NLaG) |
| Jonathan Lofthouse | Group Chief Executive |
| Jackie Railton | Deputy Director, Performance and Planning |
| David Sharif | Group Director of Assurance |
| Brian Shipley | Operational Director of Finance (NLaG) |
| Simon Tighe | Interim Group Deputy Director of Estates, Compliance and Information (NLaG) |
| Sally-Ann Campbell | Personal Assistant (Minutes) |

**Observers**

| | |
|---|---|
| Ian Reekie | Lead Governor (NLaG) |

**KEY**
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

## 1. CORE BUSINESS ITEMS

### 1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Mike Robson, welcomed those present to the meeting. The following apologies for absence were noted:

Ivan McConnell, Group Chief Strategy and Partnership's Officer (represented by Jackie Railton), Dr Kate Wood, Group Chief Medical Officer (represented by Andy Haywood) and Stephen Evans, Operational Director of Finance (HUTH)

The Committees raised an issue about meetings being booked during the pre-planned CiC meetings, which meant Executive Directors needed to leave the meeting early and created quoracy issues.

*Ian Reekie joined the meeting at 09:05 hours.*

1.2 **Declarations of Interest**

No declarations of interests were received in respect of any of the agenda items.

1.3 **To approve the minutes of the meeting held on 28 February 2024**

The minutes of the meeting held on the 28 February 2024 were accepted as a true and accurate record with an amendment to move Dr Kate Wood to the Core Members section.

1.4 **Matters Arising**

No items were raised.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

7.1(HUTH) – Minutes – 27 November 2023 – it was confirmed that the Care Groups had been challenged to address the number of vacancies in their areas and review whether these posts were still needed. This had been discussed at the Executive Cabinet meeting the previous day where it was agreed that out of the 400 vacancies that many were not required. It was estimated that 200 vacancies would remain and a strong case would need to be made to retain these.

7.1 (NLaG) – Unplanned Care – 20 December 2023 – this action would be addressed at the April meeting of PEF CiC.

8.4.3 (NLaG) – Corporate Benchmarking – 20 December 2023 – Lee Bond and Brian Shipley presented a report which covered Human Resources, Payroll, Printers and Clinical Audit.

3.4.1(a) (NLaG) – CQC action report (NLaG) – 24 January 2024 – a report was presented to the Executive Cabinet meeting which highlighted a number of issues. Dr Wood would consider if there were any mitigating circumstances. It was confirmed that any Health and Safety actions identified would be brought back to the Committees as required. This action was closed.

4.3.1 (Group) – Update on Cancer Improvement Trajectories – 24 January 2024 – Shaun Stacey informed the Committees that the report had identified individual actions. These would be covered in future reports and there would be a second Cancer Deep Dive later in the year. This action was closed.

3.1 (Group) – Board Assurance Framework (BAF) – 28 February 2024 – the BAF had been under review and a revised Group BAF would be presented to the Committees in April. This action was closed.

4.3.1 (Group) – Deep Dive – Elective Care – 28 February 2024 – the

Committees raised concern about the clinical safety risk of approximately 37,000 unappointed patients who had not been risk stratified at present (as only patients with an appointment are risk stratified). These appointed slot issues (ASI) and it was hoped this was mitigated by patients returning to their GPs if required. This was a particular issue at HUTH and would be investigated further and be reported back to the Committees in April.

7.1 (Group) – Matters to be Referred to Other Board Committees – 28 February 2024 – the matter had been referred to Workforce, Education and Culture Committees in Common. This action was closed.

## 2. MATTERS REFERRED

### 2.1 Matters referred by the Trust Board(s) or other Board Committees

Mike Robson reported that no items had been referred for consideration at present to the PEF CiC.

## 3. RISK & ASSURANCE

### 3.1 Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) was still under review and was due to be revised as a Group version. This would be provided at the April PEF CiC meeting.

### 3.2 Risk Register Report

Mike Robson informed the Committees that an extract from the Risk Register Report, based on the Group model, had been submitted to the Audit, Risk and Assurance CiC and would be reported on at the next meeting of PEF CiC.

### 3.3 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

There were no external or internal audit reports & recommendations to note

### 3.4 Review of Relevant External Report(s), Recommendation(s) & Assurances(s)

There were no external reports, recommendations or assurances to note.

*Annabelle Baron-Medlam joined the meeting at 09:40 hours.*

#### 3.4.1 Care Quality Commission (CQC) Actions Report – Group

Mike Robson welcomed Annabelle Baron-Medlam to the meeting to present the CQC Action Report on behalf of NLaG.

Annabelle Baron-Medlam reported that there had been positive progress and the full assurance process had increased to 65%. All actions had been

reviewed with divisions and performance improvements were evident in several areas. Assurance papers were due to be submitted to the CQC.

Jane Hawkard queried what the implications would be for Maternity Services having not delivered on capacity and demand and referenced the report submitted to the Quality Improvement Group in December 2023. As no-one was available to comment on HUTH actions it was agreed to seek representatives from both HUTH and NLaG to present the CQC Actions Report at the next meeting.

***Action**: invite a HUTH representative to the April meeting of the Committees to jointly present the CQC Actions Report.*

Simon Parkes raised concerns regarding the ability of the organisation to deliver on the waiting times outlined for cancer patients, and queried whether NLaG was confident the end of June deadline would be achieved. Shaun Stacey confirmed the reason for limited assurance was that this would be dependent on the correct care pathway, accompanied by the planned change in practice and approach in order to be achievable.

Following a discussion, Mike Robson queried to what extent actions are externally verified to confirm the ratings were correct. Jonathan Lofthouse informed the Committees that the usual CQC engagement meeting was due on 9 April 2024 and would be followed by an on-site visit at HRI's emergency department (ED).

In response to a query from David Sharif, Annabelle Baron-Medlam advised that the move to the Care Group Structure would present some complexities to be addressed, which included the capture of evidence for monitoring and explaining changes to trajectories. Work was ongoing to progress a similar approach at HUTH to that utilised at NLaG to bring alignment across the Group.

*Annabelle Baron-Medlam left the meeting at 10:00 hours.*

**REVIEW** **ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?**

The Committees agreed to escalate the waiting list appointed slot (ASI) issues to the Trust Boards as noted in the action tracker item above.

**4. COMMITTEE SPECIFIC BUSINESS ITEMS**

**Joint Business Items**

4.1 **Annual Plan and Cost Improvement Plan**

Jackie Railton presented the paper and provided an overview for both HUTH and NLaG during what had been a particularly challenging time and noted national guidance was still not available. The report included details of planned activity volumes against the 2023/24 forecast outturn which had been submitted to the Integrated Care Board (ICB) as part of the first full draft submission and is subject to further refinement following feedback from the ICB and NHS England (NHSE) prior to final submission in April 2024.

Jackie Railton responded to a query from Lee Bond and confirmed due to the increase in referrals the planned activity levels had not been achieved. Sean Stacey added that the referring staff were being engaged through the connected health methodology, and review of follow up appointments were underway as they were not always required. A discussion ensued about the processes for referrals, conversion rates and follow up appointments.

Gill Ponder queried how the blockages identified would be addressed such as clinicians' reluctance to embrace patient initiated follow ups (PIFU). Jackie Railton provided an overview of the various approaches to address this including staff training, patient information and management through Delivery Groups. The use of virtual wards and remote monitoring was then discussed, together with the need to avoid unnecessary admissions.

4.2 **Financial Report – Month 11**

The report was taken as read and Lee Bond informed members that the Capital Plan was proving to be challenging and dependent upon developments with the ICB, the Group month 12 position could be impacted.

The Committees were reasonably assured on the financial position to date (in terms of the month 11 position of the financial year). It was noted that the agency spend was also progressing in relation to expectations. However, concerns remained regarding the Group underlying deficit of £107 million which had increased in month from £104.4 million, and the impact that this would have on the financial planning for 2024/25.

Following a discussion it was confirmed that the increased reliance on non-recurrent savings delivery is the main driver for the deterioration in month. Various queries were raised about how to drive efficiency savings alongside delivery of required activity levels and support the teams involved. Jonathan Lofthouse confirmed the Group were signed up to £85 million of Cost Improvement Programme (CIP) savings with increased activity and this needed to include improved patient care whilst reducing various waste elements. Achievement of the CIP savings was discussed, and Lee Bond stressed the need utilise and maximise existing Group assets. Gill Ponder concurred and added the need to address cultural changes with staff to support maximising efficiencies of the assets. Linda Jackson agreed and noted some long term issued required addressing through cultural changes and support of staff in those areas.

Mike Robson summarised the update and discussions and noted the potential issue with the year-end performance and the financial position of the ICB in month 12 which could impact the Group position.

4.3 **Group Integrated Performance Report (IPR)**

Shaun Stacey provided an overview of the IPR report and noted where performance was not in line with the set trajectories. It was noted that the Group model changes and the behavioural changes required to address the no criteria to reside (NCTR) patients (inpatients with no medical need for acute services), would continue to be embedded in 2024/25.

Simon Parkes queried how to determine whether targets were reasonable improvement targets or too stretching. A discussion followed and included the need for effective monitoring and the revised IPR due in May 2024.

Gill Ponder referred to feedback about difficulties encountered by staff following the Lorenzo patient administrative system (PAS) implementation. Jonathan Lofthouse confirmed there had been more issues than expected as discussed at the Executive Cabinet meeting the previous day, and assured Committees that Shaun Stacey was managing this process and supporting the staff concerned. Linda Jackson noted concerns had been raised about this adding to the timescales for effective implementation and utilisation of the system.

***Action**: Action plan to be developed for trajectories and submitted to the April meeting of the PEF CiC.*

*Simon Tighe joined the meeting at 11:17 hours.*

*Agenda item 4.4 was taken next.*

4.4 **Estates and Facilities – General Update**

Mike Robson welcomed Simon Tighe to the meeting to present the Estates and Facilities report. It was noted that the format of the report still required further development which would be undertaken by Jonathan Lofthouse, Lee Bond and Simon Tighe.

The report was taken as read and Simon Tighe highlighted items that were at risk which were as follows:

- Low Voltage Infrastructure (SGH);
- Water Systems (SGH);
- Primary Heating System (SGH);
- Two main water intake tanks (CHH).

The issue with the Low Voltage Infrastructure relates to the cables and boards which are between 30 to 40 years old and asbestos is present. This is compounded by the external fragile District Network 0perator which did not provide the required back up system. This had resulted in power outages to the site.

Regarding the water systems, investment had been made by the Health Service Executive (HSE) in 2015, and a HSE review was due to take place in mid-April. It was anticipated the review would highlight issues/problems which would require funding to be rectified.

The primary heating system at SGH was three steam boilers which were 34 years old. Grant funding had been applied for to replace them, and the application outcome should be known by the end of April. If not successful, then capital funding would be required.

The two main water intake tanks at CHH require attention. One had been

condemned and the other can only be half filled due to issues with the lining. If the second tank failed it would result in a loss of drinking water and if a failure happened bottle water would need to be sourced, which we had managed to achieve on other incidents from local supermarkets and our catering suppliers, A longer-term secondary plan had been agreed where an engineering temporary solution has been developed to bypass the tanks. A further plan had been developed to make both tanks operational should they fail completely.

The water intake tanks were due to be repaired by the end of quarter two.

These identified risks are being managed and Lee Bond and Simon Tighe would be meeting to review the risk register the following month.

Mike Robson thanked Simon for presenting his report and invited any questions. A discussion took place about when risks required highlighting at the Committees.

Gill Ponder suggested advertising on-site be explored as a financial income, and queried whether the fire alarm updates were on track for completion by the end of March at SGH. Simon Tighe confirmed there may be a slight slippage into early April but was otherwise this was on track.

Jane Hawkard and Stuart Hall referred to the report format and suggested it be summarised and risk based with details of the mitigations in place to manage the risks.

*Simon Tighe left the meeting at 11.35 hours.*

*The meeting continued as per the agenda.*

4.3.1 **Deep Dive – Length of Stay (LOS) and Beds**

Shaun Stacey presented the report and thanked Jackie Railton for producing it.
The pressures on general and acute beds was highlighted as this had grown significantly at HUTH whilst remaining static at NLaG. Overall occupancy of paediatrics beds was low on both Trusts, but there had been an increase at NLaG.

The number of patients with no criteria to reside (NCTR) had been increasing at HUTH and had caused issues with freeing up bed spaces for patients to be admitted from ED. This was not reflected at NLaG where there had been a decrease in numbers.

Shaun Stacey informed members of data collection and coding issues which had resulted in some inaccurate figures being recorded. Several staffing issues were also noted which had impacted on the ability to deliver and make progress. Jackie Railton provided an update on the model hospital and the data quality issues identified and Gill Ponder stated that this model was not always helpful as it did not compare like for like. Andy Haywood advised that some of the data issues identified would be addressed by the Lorenzo PAS system rollout.

The lack of day cases not being effectively utilised was noted, together with the opportunities the new same day emergency care (SDEC) and surgical SDEC offered. The type of patient stay and opportunities for improvement were then discussed by Mike Robson and Shaun Stacey. Linda Jackson made various suggestions to improve and support patient flow which included ring-fenced elective beds at HUTH. Lee Bond supported these discussions and confirmed that a lack of patient flow was a significant risk.

Mike Robson commented that with a change of models of working and practices, huge opportunities for moving forward presented themselves. An update on this deep dive was requested for the Committees in June with an action plan to address the issues raised.

***Action**: The deep dive topic be reconsidered for the June PEF CiC, with a Length of Stay and Bed Deep Dive update presented with an associated action plan.*

*Jonathan Lofthouse left the meeting at 11:48 hours.*

4.3.2 **Care Groups Transitional Arrangements**

The report was taken as read and Shaun Stacey provided an overview. Gill Ponder queried the impact of the staff vacancies in the new structure and plans to address this. Shaun Stacey stated that interim arrangements had been implemented and further interviews for the remaining substantive positions would be take place over the next few weeks. The difficulty in managing the changing position of staff vacancies during this transitional period was noted.

Mike Robson noted the report was very useful and informative but requested that a full update be given after three months of operating under the new structure, and that the Committees receive a brief update each month. Concerns were raised about the Committees not receiving the Care Group transition Readiness Assessment prior to implementation.

***Action**: Full report be submitted on the new Care Group after July 2024.*

4.5 **Contract Approvals**

4.5.1 **HUTH/20/291 Routine Radiology Reporting Services to Include Out of Hours**

The Committees were requested to approve the Routine Radiology Reporting Services contract extension of six months until June 2024. It was noted that this was a retrospective approval as it had expired at the end of January 2024 and would require consideration and approval again shortly. The Committee expressed concern that such contracts had not been brought for consideration in a timely fashion.

The contract extension was approved.

***Action**: Routine Radiology Reporting Services Contract to be added to the*

*PEF CiC agenda in May for consideration.*

*Lee Bond, Shaun Stacey, David Sharif and Andy Haywood left the meeting at 12:05 hours.*

4.6 **Emerging Issues**

None had been identified.

**REVIEW** **ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?**

The Committees were assured that the initial £55 million of CIP savings had a high confidence level of delivery out of the £85 million total. Concerns remained about the 2024/25 timeframe for achieving the remaining £30 million of CIP savings, and options continue to be explored.

The Committees raised concerns at the lack of oversight of the Readiness Assessment of the Care Group transition, prior to implementation on 1 April 2024.

The Committees were assured about the installation of the fire alarm systems at Scunthorpe General Hospital.

**5. ITEMS FOR INFORMATION**

5.1 **Work Plan for PEF CiC**

This item was carried forward to the next meeting of the PEF CiC.

5.2 **Performance Review Improvement Meetings HUTH & NLAG**

Shaun Stacey provided an update on the progress made with regards to these meetings during the transition to the new Care Groups across the Group model. Meetings dates were now planned from the end of May 2024. It was confirmed that Jonathan Lofthouse, the Group Chief Executive Officer would Chair these monthly meetings.

**6. ANY OTHER URGENT BUSINESS**

Mike Robson informed the Committees that Julie Beilby had been appointed as an Associate Non-Executive Director with effect from 9th April 2024 and would be attending future meetings of the PEF CiC.

**7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON**

7.1 **Matters to be Referred to other Board Committees**

There were no matters for referral to any of the other Board Committees-in-Common.

7.2 **Matters for Escalation to the Trust Boards**

It was agreed that the following matters required escalation to the Trust Boards-in-Common meeting in the PEF CiC highlight report:

- Finance position
- Annual Plan and Cost Improvement Plan
- CQC Action Report
- Performance
- Late contract approval
- Care Group transition
- Meeting Clashes

## 8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and time of the next PEF CiC meeting:**

Wednesday, 24th April 2024 at 09:00 hours, Main
Board Room, Diana, Princess of Wales Hospital, Grimsby

The meeting closed at 12:06 hours.

## Cumulative Record of Attendance at the PEF CiC 2024/2025

| Name | Title | 2024 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| **CORE MEMBERS** | | | | | | | | | | | | | |
| Gill Ponder | Chair / Non-Executive Director (NED – NLaG) | Y | Y | Y | | | | | | | | | |
| Mike Robson | Chair / Non-Executive Director (NED - HUTH) | Y | Y | Y | | | | | | | | | |
| Lee Bond | Group Chief Financial Officer | Y | D | Y | | | | | | | | | |
| Jane Hawkard | NED (HUTH) | Y | Y | Y | | | | | | | | | |
| Simon Parkes | NED (NLaG) | Y | Y | Y | | | | | | | | | |
| Shaun Stacey | Group Chief Delivery Officer | Y | Y | Y | | | | | | | | | |
| Dr Kate Wood | Group Chief Medical Officer | D | Y | D | | | | | | | | | |
| **REQUIRED ATTENDEES** | | | | | | | | | | | | | |
| VACANT | Group Director of Estates | D | D | N | | | | | | | | | |
| Andy Haywood | Group Digital Information Officer | N | N | Y | | | | | | | | | |
| David Sharif | Group Director of Assurance or deputy | D | D | Y | | | | | | | | | |
| Alison Drury | Deputy Director of Finance (HUTH) | Y | N | N | | | | | | | | | |
| Brian Shipley | Deputy Director of Finance (NLaG) | Y | Y | Y | | | | | | | | | |
| Stephen Evans | Operational Director of Finance (HUTH) | Y | Y | N | | | | | | | | | |
| Ian Reekie | Governor Observer (NLaG) | Y | Y | Y | | | | | | | | | |

***KEY**:* *Y = attended* *N = did not attend* *D = nominated deputy attended*

# PERFORMANCE ESTATES AND FINANCE COMMITTEES-IN-COMMON MEETING

**Minutes of the meeting held on Wednesday, 24 April 2024**
**at 09:00 to 12:30 hours in the Main Boardroom, Diana Princess of Wales Hospital, Grimsby**

**For the purpose of transacting the business set out below:**

**Present:**

**<u>Core Members</u>:**

| | |
|---|---|
| Gill Ponder | Non-Executive Director (NLaG) - Chair |
| Mike Robson | Non-Executive Director (HUTH) |
| Julie Beilby | Associate Non-Executive Director (NLaG) |
| Lee Bond | Group Chief Financial Officer |
| Jane Hawkard | Non-Executive Director (HUTH) |
| Simon Parkes | Non-Executive Director (NLaG) |
| Shaun Stacey | Group Chief Delivery Officer |
| Dr Kate Wood | Group Chief Medical Officer |

**<u>In Attendance</u>:**

| | |
|---|---|
| Annabelle Baron-Medlam | Acting Head of Compliance & Assurance (NLaG) |
| Leah Coneyworth | Head of Quality Compliance and Improvement (HUTH) |
| Adam Creeggan | Group Director of Performance |
| Jennifer Granger | Head of Compliance & Assurance (NLaG) |
| Alison Hurley | Deputy Director of Assurance (NLaG) |
| David Sharif | Group Director of Assurance |
| Simon Tighe | Interim Group Deputy Director of Estates, Compliance and Information (NLaG) |
| Sally-Ann Campbell | Personal Assistant (Minutes) |

**<u>Observers</u>**

| | |
|---|---|
| Linda Jackson | Vice-Chair (NLaG) |
| Ian Reekie | Lead Governor (NLaG) |

**KEY**
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

## 1. CORE BUSINESS ITEMS

### 1.1 Welcome and Apologies for Absence

The Performance, Estates and Finance (PEF) Committees-in-Common (CiC) Chair, Gill Ponder, welcomed those present to the meeting. Apologies for absence were noted for Ivan McConnell, Group Chief Strategy and Partnership Officer, who was represented by Adam Creeggan.

## 1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.3 **To approve the minutes of the meeting held on 27 March 2024**

The minutes of the meeting held on the 27 March 2024 were accepted as a true and accurate record with the following amendments:

Section 1.5 – item 4.3.1 - the 37,000 unappointed patients noted as not risk stratified be amended to reflect that they would have been triaged/risk stratified at their GP appointment prior to referral.

Section 4.2 – paragraph 3 – additional details to be added to clarify the high confidence levels in delivery of £55 million of the required £85 million CIP savings, and concerns around the unlikely ability to identify the remaining £30 million in the financial year.

Section 4.4, paragraph 4 – investments be amended to investigations, and paragraph 6 – a note to be added to clarify that the water intake tanks were due to be repaired in quarter one.

1.4 **Matters Arising**

No items were raised.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

7.1(HUTH) – Minutes – 27 November 2023 – it was confirmed that a process had been developed where vacant posts would be sub-divided by professional group and reviewed as part of ongoing management controls. This action was closed.

7.1 (NLaG) – Unplanned Care – 20 December 2023 – this action was a duplicate of 4.3 and was closed.

4.3.1 (Group) – Deep Dive – Elective Care – 28 February 2024 –Dr Wood informed the Committees that any new referrals from GPs were risk stratified as needing to be seen within 2 weeks, 6 weeks or in routine timescales. Patients are risk stratified when a referral letter is received from the GP based on the details provided and bookings are then made on clinical need. A robust system was now in place in line with national guidance where every 11 weeks patients are contacted to establish if the appointment is still required or there is any change in their symptoms etc., and clinicians can move patients up the waiting list if required. Some issues remained with follow up appointments which should be within 8 weeks, but realistically this took between 10-12 weeks. Steps were being taken to address this. This action was closed.

4.3 (Group) – Group Integrated Performance Report – 24 April 2024 – the matter would be considered on the agenda later in the meeting. This action was closed.

**2. MATTERS REFERRED**

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

Gill Ponder reported that no items had been referred for consideration at present to the PEF CiC.

## 3. RISK & ASSURANCE

### 3.1 Board Assurance Framework (BAF)

The report was taken as read and David Sharif provided an overview of the BAF elements which the PEF CiC had oversight of. This included a progress update regarding the harmonisation and rationalisation of the BAFs for HUTH and NLAG. Key points were then highlighted which included the Group finance end of 2023/24 year risk rating had been re-scoped and was now 8 (as detailed for both individual Trusts).

For 2024/25, the Group BAF finance strategic objective was noted as high level risk at 25 due to the risk that the Group would not achieve delivery of the in-year financial plan or manage the underlying position appropriately. A discussion ensued about the likelihood and consequence ratings for the risk scores and it was confirmed that Lee Bond and Rebecca Thompson were reviewing the risks in the BAF and different scores for different sites may result.

The Committees will further consider the Committee specific areas of the BAF upon receipt of the planned revised version once available for improved assurance and continue to receive the current version until this time.

The PEF CiC noted that the Capital and Major Projects (CaMP) CiC had requested a Digital Plan Delivery report be presented to the May 2024 meeting of the PEF CiC with an update on mitigations and timescales to address the requirement for timely and appropriate reporting, due to some concerns about the accuracy and availability of data since the migration to Lorenzo. This was also added to the May 2024 PEF CiC agenda.

***ACTION**: A Digital Plan Delivery update report be presented to the May 2024 meeting, to include an update on the accuracy and availability of reporting data, mitigations of any resultant risks and the timescales for resolution of outstanding data issues since the migration to Lorenzo*

### 3.2 Risk Register Report

David Sharif provided a verbal update on the Risk Register progress and explained that a process document was in development which would include the steps to be taken to refresh all risks. This would inform the Committees of the intermediate position and would be refreshed on an ongoing basis.

Gill Ponder advised members of the referral from the Capital and Major Projects CiC to the Audit, Risk and Governance (ARG) CiC relating to the lack of Committee oversight of the Risk Register. It was requested that the ARG CiC review and establish whether there is a gap in controls on behalf of all CiCs and, if so, if that gap had been sufficiently mitigated. The PEF CiC also agreed to refer this matter to the ARG CiC to establish a level of assurance.

***ACTION** – refer the lack of oversight of the Risk Register to the Audit, Risk*

*and Governance (ARG) CiC for review*

3.3 **Review of Relevant External & Internal Audit Report(s) & Recommendation(s)**

There were no external or internal audit reports & recommendations to note.

3.4 **Review of Relevant External Report(s), Recommendation(s) & Assurances(s)**

There were no external reports, recommendations or assurances to note.

*Agenda 4.1 was taken next.*

**4. COMMITTEE SPECIFIC BUSINESS ITEMS**

**Joint Business Items**

4.1 **Annual Plan Update (Operational & Financial) including CIP**

Adam Creeggan presented the report and provided an update which was captured in a second updated report following receipt of the national guidance on 27 March 2024. It was agreed to circulate the updated report to members.

The report outlined the national guidance with regards to Cancer, Accident and Emergency (A&E), Outpatients, Elective and Non-Elective Spells and Same Day Emergency Care (SDEC) trajectories. Some of the targets had been met and work was still required to address a number of areas, particularly with regards to Outpatients. Modest changes to the Emergency Departments (ED) performance was noted since the Urgent Treatment Centres (UTC) had opened but not had the significant impact as expected yet.

In response to a query from Jane Hawkard, Adam Creeggan confirmed that the impact of changes made would be included in the next Board report. He clarified to Gill Ponder that this would be available for the next PEF CiC meeting. A discussion ensued about the upcoming Board Development session and how finances and operational elements could be considered together.

The Committees noted the Annual Plan and Cost Improvement Plan did not yet include aligned activity, finances and workforce plans and the Committees were unable to endorse the plan for Board approval until the plans were aligned and it was noted that a supporting presentation/report on the updated Operational Plans referred to within the meeting would be circulated after the meeting to provide additional assurance.

***ACTION*** *– Adam Creeggan to circulate the revised Annual Plan Update / presentation to members*

*Annabelle Baron-Medlam, Jennifer Granger and Leah Coneyworth joined the meeting at 09:40 hours.*

*Item 3.4.1 was taken next*

3.4.1 **Care Quality Commission (CQC) Actions Report – Group**

Gill Ponder welcomed Annabelle Baron-Medlam and Jennifer Granger to the meeting to present the CQC Action Report on behalf of NLaG and Leah Coneyworth to present the CQC Action Report on behalf of HUTH.

Annabelle Baron-Medlam informed the Committees that for all future meetings of PEF CiC Jennifer Granger would be presenting on behalf of NLaG.

Annabelle Baron-Medlam reported that following the move to the Group structure all closed actions had been removed from the report. The report had evolved to take into account the different Care Groups and action leads and four new actions had been added to the report. Cancer waiting times were still an issue and close working with Shaun Stacey was ongoing to address these.

Mike Robson questioned the status of the relationship with the CQC. Dr Kate Wood confirmed the relationship was very positive and meetings were held with the CQC on a monthly basis. This would shortly be handed over to the new Group Chief Nurse, Amanda Stanford, as planned.

Linda Jackson queried why only 72 actions were noted in the report and Annabelle Baron-Medlam advised they were CiC specific and not the complete set of actions. Dr Kate Wood concurred. Gill Ponder noted the thorough process and significant work undertaken to address and close many of the actions.

Leah Coneyworth then presented the CQC Action Report on behalf of HUTH and informed members that following the 2022 CQC inspection, HUTH had developed action plans to address the concerns and regulation breaches raised by the CQC. This had resulted in action plans for ED, Surgery, Medicine and Trust Wide.

The national CQC Maternity team inspected Maternity in March 2023 and, as a result, a Section 31 notice was issued following a revisit in April 2023. Mike Wright, an external consultant, was brought in to support the service and introduced Reverse RAG rating. As a result of this, maternity have completed 26 actions with evidence and assurance, 11 actions were on track and there were no overdue actions at that time. Dr Kate Wood confirmed the piece of work that Mike Wright had undertaken was very labour intensive but had achieved the desired outcome.

**REVIEW** **ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?**

Gill Ponder thanked the speakers for their presentations and confirmed assurance on work being undertaken on the CQC actions.

*Annabelle Baron-Medlam, Jennifer Granger and Leah Coneyworth left the meeting at 10:01 hours.*

*The meeting continued as per the planned agenda.*

4.2 **Financial Report – Month 12**

The report was taken as read and Lee Bond informed members that the planned break-even position had been achieved across the Group and noted a slight surplus of £0.1 million. There has been a significant increase in the amount of spend on agency staff both clinical and non-clinical and this was under investigation.

With regards to the Cost Improvement Programme (CIP), HUTH had delivered 93% and NLaG had delivered 72% which equated to £75 million of the £90 million target, but a significant proportion of those savings had been non-recurrent. The Groups estimated underlying deficit remained at £105.3 million and this was largely due to the pay rise and the cost of inflation which was around £100 million. The Group's cash balance at the end of the year was £78.8 million, with the Group forecast requiring external cash support during quarter three of 2024-25.

The Group costs of using bank and agency staff was £90.5 million with the majority of these costs in Medical Staffing and the increase was as a result of industrial action.

Overall, the end of year results were noted as a reasonable outcome position and it was noted that the accounts had been submitted.

Gill Ponder thanked Lee Bond for presenting the report.

Linda Jackson questioned whether the 3.2% cap on agency staff would be included in the Integrated Performance Report. Lee Bond could not confirm this but advised it would be included in the financial plan.

In response to Linda Jackson advising of the discussion at the Council of Governors' meeting for NLaG on this topic and the option to offer existing staff various alternatives for working extra hours and shifts, Lee Bond advised alternatives to bank and agency staffing had been explored on the North Bank but not the South Bank yet.

Gill Ponder questioned whether using non-clinical agency staff was more expensive than directly employing staff. Lee Bond confirmed that it was but there were difficulties in recruiting staff. A plan had been agreed to develop existing staff which would help reduce some of these costs in the long term. It was acknowledged that recruiting in the public sector was an ongoing issue. Simon Parkes concurred.

Gill Ponder confirmed that the Committees felt assured by the Financial Report.

4.3 **Group Integrated Performance Report (IPR)**

Shaun Stacey informed the meeting that the IPR included both Elective and Non-Elective performance but as the topic for the Deep Dive was Urgent Care he would not specifically address the Non-Elective elements under this agenda item. The report was taken as read and key issues were highlighted.

The overall referrals to treatment (RTT) waiting times had increased to over 52

weeks and the national requirement to clear all 65-week waits had been moved from March 2024 to the end of September 2024. There was confidence that this target would be met by both HUTH and NLaG. HUTH had been removed from the tiering system which meant that improvement in waiting times had been recognised but further work was still required to maintain this going forward.

Cancer performance figures demonstrated that HUTH was at 58.9%, which was an improvement compared to the January figure of 52%. The operational plan delivery target was 70%. NLaG had shown significant improvement at 71.1% against the February figure which had been 52.45%.

The Faster Diagnosis Standard (combined) 75% target was achieved for HUTH with performance of 81.7% against the plan of 78%. There had been a deterioration at NLaG on the previous month's position of 78.8% which could be attributed in part to machinery failures during the working week. NLaG was now receiving Tiering support.

The Operational and Performance teams had been working together to improve the trajectories. Three main areas had been focussed on: referral management, the concept of a one stop shop with diagnostics being undertaken before the first appointment and a push for increased percentage outcomes with less follow ups.

Mike Robson questioned whether the No Criteria To Reside (NCTR) figures had improved, whether a joint Care Group would improve the cancer trajectory figures but also informed the Committees that a Get It Right First Time (GIRFT) audit report was expected at the ARG CiC meetings the following day which was a very positive and glowing report and may require greater visibility. Shaun Stacey explained the overall figures for NCTR had improved but that a large piece of work needed to be undertaken by engaging with partners to help reduce this figure even further. This work had commenced but it was noted that working practices at HUTH needed to change and would not be a quick fix. On the South Bank elderly frail patients have an assessment undertaken in their own homes and therefore NCTR was not an issue. This was not currently undertaken on the North Bank and had become an issue.

Shaun Stacey acknowledged that the GIRFT report was very positive and felt that it should be brought to these CiCs.

***Action**: Get It Right First Time (GIRFT) report to be added to the May agenda*

Julie Beilby informed the Committees that, in a previous role, a hospital discharge scheme had been developed which had involved a number of different sectors working together to ensure that plans were established to safely discharge patients back into the community. Specialist officers had been recruited to work with NHS staff and it had proved to be very successful and a budget had been set aside to manage minor adaptations in residences to allow patients to be discharged in a timely manner. Shaun Stacey found this information very useful and suggested that they set up a meeting to discuss further.

***Action**: Shaun Stacey to meet with Julie Beilby to discuss a hospital*

*discharge scheme*

Gill Ponder raised concerns regarding the Lorenzo data utilised to produce reports and statistical information and queried whether recognised temporary loss and corruption of data had been resolved, as the Committees had previously been informed that the transition had happened with no issues. Adam Creeggan confirmed there had been a technical issue with a warehousing build which had happened overnight and had now been resolved. However, this had resulted in a backlog which would be addressed.

Gill Ponder queried the flash report in regards to theatre productivity which seemed to be showing that not all allocated slots had been utilised. Shaun Stacey agreed to take this issue away and report back either before or at the next meeting.

***Action**: Shaun Stacey to review theatre utilisation figures in the weekly Flash Report and report back to the May meeting*

Gill Ponder noted that whilst many of the constitutional standards were not yet being met, the updated IPR provided the Committees with assurance that effective improvement plans were in place to address cancer performance, diagnostics and referrals to treatment (RTTs).

4.3.1 **Deep Dive – Urgent Care**

Adam Creeggan presented the report which provided benchmarking information for A&E which illustrated that both Trusts were in the lower quartile for compliance of the four hour standard. Time spent in A&E was one area which required improvement. Overall HUTH was performing better than NLaG but there were breaches (60%) on the non-admitted pathway at HUTH. Out of 134 people who attended A&E, 38 were leaving without being seen. Between the hours of 11.00pm to 4.00am one in five people leave without being seen. Lee Bond asked whether there was any information available to show if the patients had returned the next day or at a later date. Adam Creeggan confirmed that currently this information was not available but that it was a piece of work that needed to be undertaken.

Figures showed that there was an age profile relating to admittance/non admittance. People aged over 65 years of age were more likely to be admitted than the 65 and under age group. It was noted that a similar age profiling exercise could be conducted for younger patients.

Gill Ponder thanked Adam Creeggan for his presentation.

Shaun Stacey highlighted an exercise that had been undertaken by Michael Kaiser on pathways at HUTH, which would result in some dramatic changes and would address some of the problems. This would require some rota changes and revised working practices. It was noted that the changes would result in changes to the ground floor space so that it was used more effectively and would also include the acute assessment ward and short stay wards. Care Groups would be informed to monitor weekly progress and the benefits would be evidenced over the next few months.

Lee Bond commented that this was very encouraging to hear and stated that the frailty model would be reinvigorated and reintroduced to greater effect and there would be a separate plan for emergency care.

A discussion took place and Shaun Stacey informed the Committees that there would be a change in how patients were streamed when they arrived at the front door. A senior Clinician would make the initial assessment and then patients would be streamed following their advice. It was also noted that a dedicated discharge lounge would need to be created.

Gill Ponder thanked Shaun Stacey for his report and acknowledged that a huge amount of work had been undertaken regarding urgent care. A very good discussion was noted and the Committees were assured of the positive actions being undertaken and the initial improvements evidenced, particularly the progress with rota changes to align demand and capacity, however assurance of the outcomes required was not yet established.

*Simon Tighe arrived at the meeting at 11.25*

*Agenda item 4.4 was taken next.*

4.4 **Estates and Facilities – General Update**

Simon Tighe took the report as read and referred to the changes made following requests at the last PEF CiC meeting and work is ongoing to further revise the report. A monthly risk review had been undertaken and three high risks had been identified on the North Bank as follows:

- Loss of mains water at the Castle Hill Hospital (CHH) site
- IT system failure due to the server room overheating at CHH
- Reliability of the seven lifts in the Tower Block at Hull Royal Infirmary (HRI).

All these risks were in the planned work for 2024-25 and in the meantime control measures had been put in place to manage the risks.

There were eleven high risks on the South Bank and were mainly due to the age of the infrastructure:

- Water Safety
- Electrical: Age and resilience of the Trust Uninterrupted Power Supply (UPS)
- Fire Compliance at Scunthorpe General Hospital (SGH)
- Electrical: Age and resilience of Low Voltage Electrical Infrastructure
- Replacement of Primary Heat Source
- Replacement of Flat Roofs
- Poor condition of Fuel Oil Storage Tanks
- Ageing Diesel-Powered Generator Sets
- Equality Act 2010 compliance – access around the sites
- Heating, Ventilation and Air Conditioning (HVAC)
- Medical Piped Gas System

Ongoing and planned works would be undertaken to manage and minimise

these risks.

A discussion took place around various risks including the lifts at HRI and fire compliance completion at SGH and the issues this causes. Although the Committees had previously been advised that the installation of the fire alarm systems at SGH was complete and that the risk score would reduce accordingly, it was reported that the risk score cannot be reduced until testing of the newly installed system had been carried out which was due for completion by August 2024.

A positive update was provided on the number of schemes which had been completed under the umbrella of Developing the Future Estate in Quarter 4 of the 2023-2024 financial year and further schemes were planned for Quarter 1 of the 2024-2025 financial year.

Proposals to align the North and South Commercial Group Contracts to realise cost savings were noted which could take two to three years to achieve.

Gill Ponder thanked Simon Tighe for his presentation and felt assured that risks were being managed. There was a degree of underfunding and concerns remained around the fire compliance and water tanks at SGH and additional assurance was requested to evidence that sufficient work had been undertaken on the replacement of the water tanks at SGH to enable the improvement notice to be lifted. However, the Committees recognised the achievement in securing funding for the installation of LED lighting and were assured by the ongoing plans to align North and South Bank contract end dates to enable future tendering of Group-wide contracts.

***Action**: Additional evidence to be presented to the next meeting of the Committee on progress with the replacement of the water tanks at SGH and the status of the improvement notice.*

*Jane Hawkard left the meeting at 11:57*
*Simon Tighe left the meeting at 12:02*

*The meeting continued as per the agenda.*

4.3.2 **Care Groups Transitional Arrangements**

The report was taken as read and Shaun Stacey thanked everyone for their support. The corporate areas had been redesigned and it had been a great achievement in a very short space of time. Thanks were particularly extended to Simon Nearney for support with union colleagues etc. It was agreed to provide an update to the Committees after July.

Mike Robson congratulated Shaun Stacey on this very positive area of work. Gill Ponder agreed and added that the Group had progressed the restructuring very quickly which provided assurance to the Committees.

***Action**: Full report be submitted on the new Care Group structure and progress made after the planned review in July 2024 had been completed.*

4.5 **Contract Approvals**

There were no contracts for approval.

4.6 **Emerging Issues**

None had been identified.

**REVIEW** **ASSURED, ESCALATE OR ADDITIONAL INFORMATION REQUESTED?**

These details were captured in the agenda items above.

**5. ITEMS FOR INFORMATION**

5.1 **Work Plan for PEF CiC**

Linda Jackson questioned whether the PEF CiC should receive updates/highlights from sub-groups and this be captured in the work plan. Lee Bond responded that any outputs will be included in the Finance Report. A discussion then took place and it was agreed that the Committees would receive the following minutes/reports for information at future meetings:

- Consolidated North Bank Site Report;
- Consolidated South Bank Site Report;
- Planned Care Board Meeting Minutes;
- Unplanned Care Board Meeting Minutes.

5.2 **Performance Review Improvement Meetings HUTH & NLAG**

Shaun Stacey provided an update on the progress made with regards to these meetings during the transition to the new Care Groups across the Group model. The meetings were scheduled on a monthly basis and the first meetings had been arranged for the end of May 2024.

**6. ANY OTHER URGENT BUSINESS**

No items of any other business were raised.

**7. MATTERS TO BE REFERRED BY THE COMMITTEES-IN-COMMON**

7.1 **Matters to be Referred to other Board Committees**

Gill Ponder advised that the Capital and Major Projects Committee had referred the lack of Committee oversight of the Risk Register to the ARG CiC with a request to review and establish whether there is a gap in controls on behalf of all CiCs and, if so, if that gap had been sufficiently mitigated.

7.2 **Matters for Escalation to the Trust Boards**

It was agreed that the following matters required escalation to the Trust Boards-in-Common meeting in the PEF CiC highlight report:

- Financial Position
- Annual Plan and Cost Improvement Plan

- Performance

## 8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and time of the next PEF CiC meeting:**

Wednesday, 29th May 2024 at 09:00 hours, Nightingale Room, Education Centre, Scunthorpe General Hospital

The meeting closed at 12:18 hours.

## Cumulative Record of Attendance at the PEF CiC 2024/2025

| Name | Title | 2024 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| **CORE MEMBERS** | | | | | | | | | | | | | |
| Gill Ponder | Chair / Non-Executive Director (NED – NLaG) | Y | Y | Y | Y | | | | | | | | |
| Mike Robson | Chair / Non-Executive Director (NED - HUTH) | Y | Y | Y | Y | | | | | | | | |
| Lee Bond | Group Chief Financial Officer | Y | D | Y | Y | | | | | | | | |
| Jane Hawkard | NED (HUTH) | Y | Y | Y | Y | | | | | | | | |
| Simon Parkes | NED (NLaG) | Y | Y | Y | Y | | | | | | | | |
| Shaun Stacey | Group Chief Delivery Officer | Y | Y | Y | Y | | | | | | | | |
| Dr Kate Wood | Group Chief Medical Officer | D | Y | D | Y | | | | | | | | |
| **REQUIRED ATTENDEES** | | | | | | | | | | | | | |
| VACANT | Group Director of Estates | D | D | D | D | | | | | | | | |
| Andy Haywood | Group Digital Information Officer | N | N | Y | N | | | | | | | | |
| David Sharif | Group Director of Assurance or deputy | D | D | Y | Y | | | | | | | | |
| Alison Drury | Deputy Director of Finance (HUTH) | Y | N | N | N | | | | | | | | |
| Brian Shipley | Deputy Director of Finance (NLaG) | Y | Y | Y | N | | | | | | | | |
| Stephen Evans | Operational Director of Finance (HUTH) | Y | Y | N | N | | | | | | | | |
| Ian Reekie | Governor Observer (NLaG) | Y | Y | Y | Y | | | | | | | | |

***KEY**: Y = attended N = did not attend D = nominated deputy attended*

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)117**

| **Name of the Meeting** | **Trust Boards-in-Common** |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Kate Truscott & Tony Curry, Non-Executive Directors / Chairs of Workforce, Education & Culture Committees-in-Common |
| **Contact Officer/Author** | Amy Slaughter, Personal Assistant |
| **Title of the Report** | Minutes of the Workforce, Education & Culture Committees-in-Common – March & April 2024 |
| **Executive Summary** | The minutes attached are the formal account of the meeting. The minutes include any actions and resolutions made. |
| **Background Information and/or Supporting Document(s)** (if applicable) | The minutes attached are for review. |
| **Prior Approval Process** | Workforce, Education & Culture Committees-in-Common on 30th April and 23rd May 2024 |
| **Financial implication(s)** (if applicable) | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/A |
| **Recommended action(s) required** | ☐ Approval ✓ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

# WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

**Minutes of the meeting held on Thursday 28th March 2024 at 13:30 to 17:00 at Boardroom, Diana Princess of Wales Hospital, Grimsby**

**For the purpose of transacting the business set out below:**

**Present:**

**Core Members:**

| | |
|---|---|
| Tony Curry | Non-Executive Director (HUTH) (Chair) |
| Kate Truscott | Non-Executive Director (NLaG) |
| Sue Liburd | Non-Executive Director (NLaG) |
| Una Macleod | Non-Executive Director (HUTH) |
| David Sulch | Non-Executive Director (HUTH) |
| Dr Kate Wood | Group Chief Medical Officer |
| David Sharif | Group Director of Assurance |
| Simon Nearney | Group Chief People Officer |

**In Attendance:**

| | |
|---|---|
| Jonathan Lofthouse | Group Chief Executive (until item 4.3.2) |
| Linda Jackson | Vice Chair (NLaG) |
| Rebecca Thompson | Deputy Director of Assurance (HUTH) |
| Amy Slaughter | Quality Governance Officer (HUTH) (Minute Taker) |
| Ashok Pathak | Associate Non-Executive Director (HUTH) |
| Robert Pickersgill | Deputy Lead Governor (NLaG) (Observer) |
| Annabelle Baron-Medlam | Acting Head of Compliance and Assurance (NLaG) (item 3.3.1*)* |
| Wendy Page | Interim Deputy Chief Nurse (HUTH) |
| Melanie Sharp | Deputy Chief Nurse (NLaG) |
| Lucy Vere | Group Director of Learning and Organisational Development |

**KEY**
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

## 1. CORE BUSINESS ITEMS

### 1.1 Welcome and Apologies for Absence

The committee chair welcomed those present to the meeting. The following apologies for absence were noted:

Jo Ledger, Interim Chief Nurse (HUTH)
Paul Bunyan, Group Director of Planning, Recruitment, Wellbeing, and Improvement

### 1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.3 **To approve the minutes of the meetings held on 29th February 2024**

The minutes of the meetings held on the 29th February 2024 were accepted as a true and accurate record subject to the following amendments:

Linda Jackson noted that the attendance list required the following changes: Linda Jackson was not a core member and Robert Pickergill would need to be recorded as an observer. Linda Jackson requested that the discussion on page 8 regarding the lack of movement in respect to consultant recruitment required more detail including the development of a medical workforce strategy and the risk of the age profile of the consultant workforce. Dr Kate Wood commented that she had recruited a member into her team to work on the medical strategy with the People directorate, which would be presented at the June 2024 committee.

1.4 **Matters Arising**

The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. The following matters arising were discussed:

Kate Truscott asked for an update on the plans to improve the NLaG non-registered nursing vacancy position, Melanie Sharp updated that the deep dive into the non-registered nursing vacancy nursing position had commenced and would be presented at the May 2024 meeting.

1.5 **Committees-in-Common Action Tracker**

The following updates to the Action Tracker were noted:

Action 4.3.1 regarding concerns about the timeline for the Care Group's implementation was raised at Cabinet and a risk assessment was undertaken by David Sharif. The risk assessment identified that the preparation by the finance and HR teams was good, however, there were some issues regarding engagement and communication. The risk assessment concluded that patient harm was more likely by delaying the implementation of the Care Groups.

Action 4.3.2 regarding concerns about the pace of change and the impact on staff for the Care Group implementation was raised at the Group Board Development session.

Action 4.5.3 regarding an update on the Portfolio Pathway Programme and Training Fellowships was included on the agenda. Lucy Vere updated that the undercroft at the new day surgery unit at CHH had been confirmed as the new training centre. The centre was under development and would be operational in Q1. Ashok Pathak asked if the training centre would have an impact on theatre working, Lucy Vere advised that the spaces were separate and highlighted the benefits of being in close proximity for training for theatre staff.

**2. MATTERS REFERRED**

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

The committee chair reported that the following matter had been referred by the Performance, Estates and Finance Committees-in-Common for consideration by the committees:

The potential impact on productivity due to delays in signing off consultant job plans and the potential impact on finances from loss of oversight of PAs.

Simon Nearney advised that although job plans may not have been reviewed, medical staff would still have an out-of-date job plan. The issue of up-to-date job plans had been made a priority for the site medical directors. Dr Kate Wood noted that the job planning system was not sophisticated enough to determine the impact on productivity as the system only states the number of hours worked not the number of procedures or patients seen. A report would be provided next month on job planning within the new Care Groups by Dr Kate Wood.

**Action: Dr Kate Wood to provide a report on Group Job Planning to the April 2024 committee.**

Jonathan Lofthouse advised that at a previous Trust, targets were set for each specialty for the percentage of PAs in job plans that were used for Direct Clinical Care (DCC) time as a measure for productivity. Dr Kate Wood agreed to investigate how to implement this measure within the Group.

**Action: Dr Kate Wood to investigate implementing targets for the percentage of PAs in job plans that are used for Direct Clinical Care (DCC) time as a measure for productivity across the Group.**

Jonathan Lofthouse advised that new productivity metrics for all NHS organisations were expected to be released shortly. Ashok Pathak asked about consultants in NLaG who work more DCC than the national working time directive and if this was being revisited, Dr Kate Wood advised that a review was being undertaken of medical staff working over 12 PAs and what those PAs were being used for i.e. clinical or non-clinical.

## 3. RISK & ASSURANCE

### 3.1 Board Assurance Framework (BAF)

Rebecca Thompson communicated that the BAF formats were now aligned across the two Trusts. Throughout April and May 2024, a full review of all risks, controls and gaps in controls would be undertaken to ensure they are relevant and appropriate. Once the review was complete, actions would be assigned to any gaps in controls. It was confirmed that there were no changes in risks for either of the Trusts. The assurance for the BAF update was agreed as reasonable.

### 3.2 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

There were no external or internal audit report and recommendations to note.

### 3.3 Review of Relevant External Report, Recommendations & Assurances

The committee received and considered the following external reports, recommendations, and assurances.

#### 3.3.1 NLAG and HUTH: CQC Actions Progress Report for March 2024

Annabelle Baron-Medlam presented the NLaG CQC progress report. The inspection of the Goole Midwifery Led Unit retained the rating of Good: Safe was rated as Requires Improvement and Well-Led was rated as Good. The inspection produced 3 must do actions and 1 should do action. One of the must do actions was in relation to safeguarding training. An action plan was under development,

which must be returned to the CQC within 28 days of the publication of the report. It was noted that Safeguarding Level 3 training was the issue predominantly, previous inspections only included Level 2 training, but these had now been updated to include Level 3.

65% actions on the NLaG CQC plan were now rated as full or significant. Themes for improvement included training within the nursing and medical staff. Christine Ramsden had produced a survey for the medical staff to understand the concerns or barriers in respect to training.

Dr Kate Wood acknowledged that performance meetings were due to restart in April 2024 and mandatory training would be addressed at these meetings. The issues raised by the medical staff in respect to mandatory training compliance included the time required to complete training, support required for staff to be able to attend training, the lack of flexibility of the delivery model and cancellation of sessions. Lucy Vere advised that the training and development team were undertaking an alignment exercise and full review of required learning across the Group including how the training delivery models could be adapted.

**Action: Lucy Vere to provide a full review of required learning and delivery models across the Group to the July 2024 meeting.**

Sue Liburd asked if the review could consider sanctions for staff who had not completing their mandatory training. Lucy Vere described the issues regarding the training rooms and also sessions being cancelled in respect to operational pressures.

Linda Jackson asked for a HUTH representative at future meetings to present the HUTH CQC action plan. Dr Kate Wood commented that discussions would be taken forward regarding ownership of the HUTH CQC action plan at the next Cabinet meeting. Dr Kate Wood would discuss with Rob Chidlow outside of the meeting to ensure accurate representation for the committee going forwards.

**Action: A HUTH representative for the CQC Action Plan to be identified to attend future meetings.**

Melanie Sharp highlighted feedback received from the face-to-face safeguarding training sessions regarding staff staying behind to talk to the safeguarding team about different issues, this echoed the need for a variety of training delivery methods to meet the needs of staff.

Jonathan Lofthouse disclosed that new NHS planning guidance had been released, which included specific HR metrics and a cap on agency spend.

4.1 **Group Consultant Engagement**

Dr Kate Wood provided a verbal update on Group medical engagement. A medical engagement and leadership strategy was currently under development, an update on progress would be shared at the July 2024 committee. The strategy would include visibility of the senior medical leadership team with forums, communication channels and newsletters. It was noted that NLaG already had in place forums for medical staff to meet with the medical leadership team however, at HUTH all communication with the medical staff went through the LNC.

The plan for professional development was to continue with the current programme for 2024/25 and develop a Groupwide programme for 2025/26. Recognition and appreciation for medical staff would also form part of the strategy with nominations for the Golden Stars Awards. Team building sessions would also be included to encourage multi-disciplinary working. A new Responsible Officer for appraisal and revalidation across the group had been appointed, Anantha Ananthasayanam.

Jonathan Lofthouse queried if it was the HUTH LNC's view or the consultant's view regarding communication and stated that HUTH consultants need to be directly asked about their preference. Linda Jackson noted that HUTH consultants had previously expressed an interest in direct communication. Dr Kate Wood commented that a medical engagement scale could be an option for investment, David Sulch advised that he had used Faculty of Medical Leadership and Management at a previous Trust to measure medical engagement.

**Action: Dr Kate Wood to provide a monthly verbal update on Group medical engagement with an update on progress of the medical engagement and leadership strategy at the July 2024 meeting.**

The assurance for the Group Consultant Engagement update was agreed as limited.

4.2 **Registered Nurse & Midwifery Staffing**

4.2.1 **Registered Nurse & Midwifery Staffing (HUTH)**

Wendy Page presented the HUTH Registered Nurse and Midwifery Staffing report. The number of Care Hours Per Patient Day (CHPPD) had reduced slightly to 7.46 for February 2024. Initial analysis indicated that this was due to the creation of additional capacity to support operational pressures and a further ward by ward analysis would be completed.

HUTH were currently over-established by 89.18 WTE registered nurses, which was reflected in the anticipated working plan. The non-registered nursing vacancy position was 47.34 WTE. The senior nursing team continued to meet five times a day to assess staffing correctly and ensure patient safety.

The apprenticeship team held a recruitment week in February 2024, which attracted over 500 applicants, the team were working closely with partners to ensure applicants were on the right programs. Ofsted had assessed the apprenticeship programme with the University of Hull, initial feedback was positive. The recruitment for midwifery students was ongoing with 23 students appointed from a cohort of 30. The mass recruitment for nursing assistants had ceased, however, the "new to care" initiative continues to be supported. Recruitment of international nurses had ceased. Nine international nurses were still awaiting their NMC PIN numbers with two international nurses due to take their fourth and final attempt at OSCE.

The Trust had completed the bi-annual Nursing and Midwifery establishment review, which would be presented to the Board.

Jonathan Lofthouse queried the over-establishment position, Simon Nearney informed that 40 of the nurses were to offset maternity leave, winter wards and additional capacity with the remaining used to cover any gaps. Jonathan Lofthouse

stated that assurance and control over vacancy requests was mandatory, and no post was to go out to advert without prior approval from Cabinet.

Sue Liburd asked what would happen if the two international nurses were not successful at their final OCSE assessment, Wendy Page assured that conversations would take place with the two staff members to identify if they would want to be redeployed.

Kate Truscott highlighted the non-registered vacancy rate and asked if the two Trusts were working together, Wendy Page advised that the HUTH and NLaG nursing teams were in the initial stages of working together.

Linda Jackson queried the risk attached to the over-establishment if the amount of maternity leave and sickness absence reduced, Simon Nearney replied that HUTH lose an average of 14 registered nurses a month which would be covered by the over-establishment. The assurance for the HUTH Registered Nurse and Midwifery Staffing report was agreed as substantial, with a focus on vacancy control.

4.2.2 **Registered Nurse & Midwifery Staffing (NLaG)**

Melanie Sharp presented the NLaG Registered Nurse & Midwifery Staffing report. The turnover and vacancy rates had improved within nursing and midwifery. Recruitment was underway for newly qualified nurses. A target had been set to appoint 90 international nurses for 2024/25. In January 2024, there were 2 wards with a CHPPD below 6 due to an increase in non-registered sickness absence and both areas were supported with no concerns raised. The nursing establishment review had been completed and would be presented to the Board.

Due to the change to the national job profiles for Band 2 Health Care Assistants, an options paper would be produced for the April 2024 meeting regarding next steps. A key focus for the next six months would be to scope the potential for a Group nursing strategy.

**Action: An options paper relating to the Band 2/3 national profile change to be presented at the April 2024 meeting for NLaG.**

Ashok Pathak asked what the positives were from the nursing retention strategy, Melanie Sharp informed that there had been investment in communication with new starters before they join the Trust and further support for new starters once they were in place on the wards. Career clinics had also been successful and had been adapted to meet the needs of staff.

Simon Nearney highlighted that the registered nursing vacancy rate had beat the target of 8% for February 2024 and was at 6.57%. The plan was for the vacancy rate to be at 0 by September 2024. Simon Nearney briefed that further action was being taken to significantly reduce agency spend with controls in place.

Linda Jackson questioned the difference between the number of CHPPD between HUTH and NLaG, it was agreed that an analysis would be undertaken to understand the difference.

**Action: An analysis of the difference between the number of CHPPD between HUTH and NLaG to be undertaken by Jo Ledger and Melanie Sharp.**

Kate Truscott queried the midwifery vacancy position, Melanie Sharp informed that vacancies in community and outpatients continued to be a concern however, a rolling recruitment program was in place with retention initiatives.

The assurance for the NLaG Nursing and Midwifery staffing report was agreed as reasonable.

4.3 **Performance Reports**

4.3.1 **People Strategy Progress Report (HUTH)**

Simon Nearney presented the HUTH People Strategy Progress Report. The overall vacancy position was 2.4%. The turnover rate was 9.8% against the target of 9.3% however, HUTH had reached the ICB target of 12.2%. The number of staff who leave within the first year of employment in the Trust remained an issue with high turnover in Administrative and Clerical staff and Additional Clinical Services. Job planning was 66%, sickness absence met the Trust target 3.9%. The appraisal rate for Agenda for Change staff had reduced to 81% against the target of 85%, consultant appraisals were at 89.7%. Mandatory training rate was above target of 85% at 88%.

Jonathan Lofthouse raised concerns regarding the number of first year leavers in the Administrative and Clerical staff and asked for a breakdown by grade of staff and services. Ashok Pathak queried how the Trust compared nationally with leavers within their first year of employment, Simon Nearney advised that there was no national requirement to measure first year leavers therefore there was no benchmarking. Linda Jackson noted that staff leaving within their first year was a Groupwide issue.

**Action: A breakdown to be produced for the number of first year leavers at HUTH in the Administrative and Clerical staff by grade of staff and services.**

An error was noted regarding vacancies by staff group as Operating Department Practitioners (ODPs) were incorrectly assigned to Additional Professional Scientific and Technical staff and should be under Additional Clinical Services. It was also raised that ODPs were not included in the glossary. It was also noted that as of 1st April 2024, Band 2 staff were only £0.01 above national minimum wage.

Dr Kate Wood communicated that a piece of work was underway with Helen Knowles to improve job planning and medical appraisals.

The assurance for the HUTH People Strategy Progress Report was agreed as reasonable.

4.3.2 **Workforce Integrated Performance Report (NLaG)**

Simon Nearney presented the NLaG Workforce Integrated Performance Report. The overall vacancy position had reduced further to 7.66% against the target of 8%. The turnover rate was 10.7%. The sickness absence continued to be a concern at 5.6% against the target of 4.1%. The combined PDR rate remained above target at 85.7% with the medical and dental staff PDR rate at 96.5%. The core mandatory training rate was at 90% however, the role specific mandatory training was at 79% below the target of 85%. A group report was under development to align reporting.

Kate Truscott asked about the hotspot areas for sickness absence and asked for assurance that support had been provided to these areas, Simon Nearney assured that HR Business Partners discuss sickness absence reports monthly with their specialties and investigate further into the detail and concerns. Kate Truscott asked if workforce issues would be included in the reinstated performance meetings, which was confirmed by Simon Nearney.

Kate Truscott highlighted that the NLaG IPR contained information regarding suspensions and disciplinaries however, this information was not included in the HUTH report. Kate Truscott asked for this to be addressed in relation to the guidance included in the 2019 letter from Dido Harding. It was noted that Jonathan Lofthouse and Simon Nearney received fortnightly reports regarding timelines for cases and cases that involved the police. The EDI networks also received reports on relevant cases and a workforce committee would be aligned across the Group, which would discuss these issues. Kate Truscott noted that the HUTH report was only on the workplan for once a year and asked for this to be brought to the committee more frequently, this issue would be raised at the 3-monthly review meeting.

**Action: The frequency of the HUTH Suspension and Discipline report to be reviewed at the 3-monthly review meeting.**

The assurance for the NLaG Workforce Integrated Performance Report was agreed as limited.

4.4 **Recruitment / Time to Hire KPI**

Simon Nearney presented the Recruitment / Time to Hire KPI reports. Simon Nearney apologised for the lack of detail in the reports and commented that further narrative would be included in future reports. In February 2024 at NLaG, the number of active vacancies was 165, the number of applications received was 4268, the number of conditional offers issued was 199 and the number of new starters was 171.

The Time to Hire KPI, which was from conditional offer to checks completed, target was 20 days however NLaG did not meet the target in January or February 2024. One of the main reasons for delays was due to Occupational Health clearance timescales. Simon Nearney noted that he had asked for an immediate change to the NLAG Occupational Health clearance process to resemble the process HUTH Occupational Health used, which would help to reduce the delays. It was noted that the information in this report could be benchmarked across other Trusts and would be included in the report going forwards. Sue Liburd asked what had changed in Occupational Health for the delays to still be in place after previous changes had been implemented. Simon Nearney advised that the overall waiting times for Occupational Health referrals had reduced however, the timescale for recruitment clearances had not.

The assurance for the NLaG Recruitment / Time to Hire KPI was agreed as limited.

In February 2024 at HUTH, the number of active vacancies was 128, the number of applications received was 4284, the number of conditional offers issued was 93 and the number of new starters was 147. The HUTH Time to Hire KPI improved from January to February 2024 and was just below target. Ashok Pathak asked about the discrepancies between medical and general staffing, Simon Nearney

acknowledged differences in the process for medical staff including the number of international staff. Kate Wood asked for the report to include further metrics relating to the management of the recruitment process i.e. operational, medical, nursing etc.

Simon Nearney highlighted that the People Directorate was undergoing organisational change and recruitment process would be harmonised across the Group in the future. The assurance for the HUTH Recruitment / Time to Hire KPI was agreed as reasonable.

4.5 **Group Values Update**

Lucy Vere provided an update on the Group values. 48 face-to-face sessions had taken place across the Group alongside virtual sessions with over 800 attendees in total. Mentimeter was used for staff to provide their personal values, current values of the Group and desired values for the Group. The Barrett Values online survey tool received 1416 responses; the results were similar to those in the face-to-face sessions. The values had been put into families, which had been discussed in focus groups with circa 100 staff. Simon Nearney highlighted the importance of staff providing their views regarding the future of the Group. It was also crucial how the Executive Team communicated and portrayed the values to drive the culture of the organisations.

The confirmed values would be presented at the next Board meeting on 11th April 2024 following discussions at Cabinet. The plan was to launch the values and staff charter at the top 100 leadership event on 16th April 2024. It was discussed that an update on how staff were feeling following the implementation of the staff values would be beneficial, which was tabled for the June 2024 meeting.

The assurance for the Group Values update was agreed as good.

**Action: Lucy Vere to provide an update on how staff were feeling following the implementation of the staff values at the June 2024 meeting.**

4.6 **Group Staff Survey Update**

Simon Nearney presented an update on the Group Staff Survey results. The response rate for both HUTH and NLaG had improved. The staff engagement levels had improved better than the national average. The launch of the Care Groups and values would support improvements to the results. Conversations between the HR Business Partners and their aligned care groups regarding the results of the staff survey would commence from 1st April 2024 and action plans would be produced. These action plans would be discussed at the Group Workforce Transformation Committee. A quarterly report regarding the action plan for the group would be brought to this committee as per the work plan.

David Sulch mentioned the upcoming communications regarding the financial reduction required for the Group and the impact this would have on staff. It was noted that a communication strategy regarding the financial plans was under development.

The assurance for the Group Staff Survey Update was agreed as limited, although it was noted that good progress had been made on last year's results.

4.7 **Plan for Care Group Support and Development**

Lucy Vere provided a verbal update on the plan for Care Group Support and Development. Lucy Vere and Nami Sajja, Organisational Development Manager, worked with Shaun Stacey to decide the most effective way to support the Care Groups. They had attended the Operational Management Group meeting and asked managers what they needed. A guide was under development, which included managing yourself, leading by example, how to get to know staff within the Care Groups, visibility, cross-site working, early improvements and staff support. The overarching plan was split into 3, 6, 9 and 12-month stages. Staff would be able to complete their Insights or Print profiles and access 1:1 executive coaching sessions.

The next stage of the plan was for Organisational Development (OD) to speak to every Care Group and understand what they needed as a team, what the teams within the Care Group needed and any urgent cultural differences highlighted. Monthly meetings with Shaun Stacey regarding the plan had been scheduled. The full plan had not been approved by Shaun Stacey and would be presented at the next meeting.

Lucy Vere briefed that there was limited capacity within OD and discussions were needed regarding urgent support requirements. A request had been made to the Cabinet for additional resources for this support and development, however this request had been declined. Linda Jackson highlighted concerns regarding the lack of investment into organisational development to support the implementation of the Care Groups. It was noted that the implementation of the Care Groups was crucial for the success of the Group and not investing in the support and development could be highly detrimental, therefore, it was agreed that this issue would be escalated to the Board. Tony Curry suggested seconding in the relevant skills and expertise required to support organisational development.

David Sharif asked if it was the Care Group triumvirates and Site Team triumvirates that were a priority, Lucy Vere confirmed and acknowledged that several corporate teams also required support. Lucy Vere also raised that a conversation was needed about the business as usual work for the OD team whilst this support was in place. The committee noted that they were happy with the plan in principle but there were major concerns regarding the resource.

The committee were not assured about the plan for Care Group Support and Development.

**NLaG Specific Business Items**

4.8 **Update on Portfolio Pathway Programme and Training Fellowships**

Simon Nearney provided an update regarding the Portfolio Pathway Programme and Training Fellowships. Paul Bunyan had met with the HUTH and NLaG postgraduate medical education directors to work through the programme. The medical education programme would be developed for May 2024 and would require clinical input from the Chiefs of Service.

A Groupwide Certificate of Eligibility for Specialist Registration (CESR) programme was being developed. An assessment was currently underway to identify who was currently completing their CESR, who was not and who should be. This assessment would identify where the resource needed to be targeted. The CESR program would be ready for June 2024.

Ashok Pathok asked about the Group using the MTI training programme, Dr Kate Wood advised that the programme only allows international doctors to come to the UK for 2 years and the programme follows Royal College guidance. The fellowship programme had different visa requirements and had been developed by the Trust.

The assurance for the update on Portfolio Pathway Programme and Training Fellowships was agreed as limited.

**HUTH Specific Business Items**

4.9 **Briefing on the OCS issues within HUTH raised by the GMB**
This item was not accepted by the committee due to the paper being received after the deadline. Committee members were reminded that all papers must be submitted before the deadline. It was agreed that the paper would be tabled at the April 2024 committee.

**5. ITEMS FOR INFORMATION / TO NOTE**

5.1 The Workplan for the Workforce, Education and Culture Committees-in-Common was noted and would be updated to remove the Staff Survey Q4 update. Linda Jackson advised that the workplan would be scrutinised at the Workforce, Education and Culture CiC review meeting.

**6. ANY OTHER URGENT BUSINESS**
The following items were raised:

Linda Jackson mentioned the Lorenzo rollout at NLaG and how staff were feeling in response to this change. Tony Curry asked if there was a feedback mechanism and how this feedback was collected. Simon Nearney advised that the trade unions had raised a formal concern to Jonathan Lofthouse regarding the rollout. The floorwalkers from HUTH who provided support had ceased and an extension of formal support would be discussed by the Cabinet. The committee requested a verbal update on the Lorenzo rollout from Jackie France in relation to the impact on staff at the next meeting.

**Action: Jackie France to be invited to provide a verbal update on the Lorenzo rollout and the impact on staff at the April 2024 meeting.**

Lucy Vere informed that a business case was presented for a permanent HUTH Health and Wellbeing Manager to the Cabinet, which was declined. The 1-year secondment had not been extended and the current person in post would return to their role on 1st April 2024. The NLAG Health and Wellbeing Manager had been seconded to the People Promise Manager role, therefore this role was also vacant. The HUTH People Promise Manager role was currently out to advert.

**7. MATTERS TO BE REFERRED BY THE COMMITTEES**

7.1 **Matters to be Referred to other Board Committees**

There were no matters for referral to any of the other board committees.

7.2 **Matters for Escalation to the Trust Boards**

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- The HUTH Training Suite underneath the Day Surgery Unit was being developed and would be operational in Q1.
- NLAG Maternity Services at Goole retained a 'Good' CQC rating.
- Concern was raised across both Trusts regarding the need for additional investment in OD resource to support the implementation of the new Care Group structure.

## 8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Tuesday 30th April 2024, at 09:00, in the Boardroom, Alderson House, Hull Royal Infirmary.

The committee chair closed the meeting at 16:45 hours.

**Cumulative Record of Core Membership Attendance 2024**

| Name | Possible | Actual |
|---|---|---|
| Sue Liburd | 3 | 3 |
| Kate Truscott | 3 | 3 |
| Simon Nearney | 3 | 2 |
| Tony Curry | 3 | 2 |
| Una Macleod | 3 | 3 |
| Kate Wood | 3 | 2 |
| David Sharif | 1 | 1 |
| David Sulch | 1 | 1 |
| Amanda Stanford | 0 | 0 |

# WORKFORCE, EDUCATION AND CULTURE COMMITTEES-IN-COMMON MEETING

**Minutes of the meeting held on Tuesday 30th April 2024 at 09:00 to 12:30 at Boardroom, Alderson House, Hull Royal Infirmary**

**For the purpose of transacting the business set out below:**

**Present:**

**Core Members:**

| | |
|---|---|
| Kate Truscott | Non-Executive Director (NLaG) (Chair) |
| Sue Liburd | Non-Executive Director (NLaG) |
| David Sulch | Non-Executive Director (HUTH) |
| Dr Kate Wood | Group Chief Medical Officer |
| David Sharif | Group Director of Assurance |
| Simon Nearney | Group Chief People Officer |

**In Attendance:**

| | |
|---|---|
| Rebecca Thompson | Deputy Director of Assurance (HUTH) |
| Amy Slaughter | Personal Assistant (HUTH) (Minute Taker) |
| Ashok Pathak | Associate Non-Executive Director (HUTH) |
| Lucy Vere | Group Director of Learning and Organisational Development (OD) |
| Helen Knowles | Group Director of People Services |
| Paul Bunyan | Group Director of Planning, Recruitment, Wellbeing, and Improvement |
| Jo Ledger | Deputy Chief Nurse (HUTH) |
| Annabelle Baron-Medlam | Acting Head of Compliance and Assurance (NLaG) (item 3.3.1) |
| Jennifer Grainger | Head of Compliance and Assurance (NLaG) (item 3.3.1) |
| Leah Coneyworth | Head of Quality Compliance and Patient Experience (HUTH) (item 3.3.1) |
| Fran Moverley | Freedom to Speak Up Guardian (HUTH) (item 4.3.1) |
| Elizabeth Houchin | Freedom to Speak Up Guardian (NLaG) (item 4.3.1) |
| Jackie France | Operations Director, Patient Services (item 4.8) |
| Jenny Hinchliffe | Director of Nursing, Site South (item 4.9) |
| Craig Hodgson | Interim Group Deputy Director of Commercial and Facilities Services (item 4.10) |

**KEY**
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

## 1. CORE BUSINESS ITEMS

**1.1 Welcome and Apologies for Absence**
The committee chair welcomed those present to the meeting. The following apologies for absence were noted:

Tony Curry, Non-Executive Director (HUTH)
Amanda Stanford, Group Chief Nurse
Linda Jackson, Vice Chair (NLaG)
Melanie Sharpe, Deputy Chief Nurse (NLaG)

1.2 **Declarations of Interest**
The following declarations were noted:

Ashok Pathak declared that his son and daughter in law were surgeons at Leeds Teaching Hospitals NHS Trust.

1.3 **To approve the minutes of the meetings held on 28th March 2024**
The minutes of the meetings held on the 28th March 2024 were accepted as a true and accurate record subject to the following amendments:

Dr Kate Wood requested for the date for the medical workforce strategy to be presented to the committee to be amended to August 2024.

1.4 **Matters Arising**
The committee chair invited committee members to raise any matters requiring discussion not captured on the agenda. The following matters arising were discussed:

Kate Truscott mentioned that she had agreed for the nursing band 2/3 options paper to be deferred to the May 2024 meeting with a verbal update provided later at this meeting.

1.5 **Committees-in-Common Action Tracker**
The following updates to the Action Tracker were noted:

The analysis of the difference between the number of CHPPD between HUTH and NLaG would be included in the registered nursing and midwifery paper for the May 2024 meeting.

Simon Nearney updated that admin teams within HUTH were broken down into hubs and the HR team had been tasked with investigating if staff that had been recorded as leavers had left the organisation or moved between hubs or to another role within the Trust. An update would be provided to the May 2024 committee.

It was agreed that the suspension and disciplinary report would come to the committee twice a year.

Simon Nearney communicated that a report would be presented at the June 2024 meeting to provide an update on medical workforce recruitment including a progress update on pipelines and measures that were in place.

**Action: A Medical Recruitment Progress Update Report to be presented at the June 2024 meeting.**

## 2. MATTERS REFERRED

2.1 **Matters referred by the Trust Board(s) or other Board Committees**

The committee chair reported that the following matter(s) had been referred by the Audit, Risk and Governance Committees-in-Common for consideration by the committees:

An internal audit report highlighted concerns with sickness absence and return to work documentation, an escalation report from the Chair of the Audit, Risk and Governance CiC detailing actions for this CiC would be received shortly.

A briefing regarding the challenges of implementing eRostering was received at the Audit, Risk and Governance CiC, it was noted that medical rosters were the concern. Helen Knowles advised that due to the change of portfolios within the People Senior Leadership team, both HUTH and NLaG eRostering teams were within her portfolio. The current rosters need to be mapped into the new Care Group structure. Helen Knowles acknowledged the challenges of this piece of work and provided an example of one roster, which included 18 doctors and was split between 5 Care Groups. This piece of work would be led by Helen Knowles and Dr Kate Wood and the site triumvirates. It was agreed that an update would be provided at the July 2024 meeting.

**Action: Helen Knowles to provide an update on eRostering at the July 2024 meeting.**

The committee chair reported that the following matter(s) had been referred by the Capital and Major Projects Committees-in-Common for consideration by the committees:

The risk to the CDC model due to recruitment concerns. Paul Bunyan updated that he had met with the Care Group to review the CDC model. The medical model would have a consultant level built into the establishment and it was being considered what portion of the model could be transferred to specialists. To enable this model, the Chief of Service was due to travel to India in June 2024 to speak to medical leads about the criteria for the roles and to gain assurance regarding the level of candidates. Inreach and outreach was under review as the CDCs were a separate entity. Further detail would be included in the Medical Recruitment Progress Update Report.

The sonography model remained a risk as there was an international issue with recruitment of sonographers. The Group currently use private models within the UK, the mitigation to this risk was to continue using the outsource model whilst developing internal candidates. There was a 2-year programme to develop radiographers into sonographers. A workforce plan was in place for all other areas to deliver in time for the CDC development.

Ashok Pathak asked about the level required for medical specialist roles in CDC, Paul Bunyan advised that the department was exploring a fully established consultant model, and the aim was to develop medical staff through the CESR model. Paul Bunyan noted that training programmes would be built in to support individuals through their CESR registration. Dr Kate Wood stated that the specialist role was not a training role, and the Group could not commit to providing individuals, who had converted from a specialist role, with a consultant role. Simon Nearney noted that this point needed to be discussed further outside of the

meeting. The CiC agreed that clarity regarding the role must be given to candidates.

The committee chair reported that the following matter(s) had been referred by the Quality and Safety Committees-in-Common for consideration by the committees:

Pharmacy recruitment had been added to the NLaG risk register. An update was requested for the May 2024 meeting.

**Action: Paul Bunyan to provide an update on NLaG pharmacy recruitment at the May 2024 meeting.**

## 3. RISK & ASSURANCE

### 3.1 Board Assurance Framework (BAF)

Rebecca Thompson presented the report to the Committees in Common for information. She advised that work was being carried out to merge the workforce and leadership risks for both organisations into a Group position. At the June 2024 Boards-in-Common meeting, the Q4 BAFs would be officially closed down and the updated Board Assurance Framework presented.

### 3.2 Review of Relevant External & Internal Audit Report(s) & Recommendation(s)

There were no external or internal audit report and recommendations to note.

### 3.3 Review of Relevant External Report, Recommendations & Assurances

The committee received and considered the following external reports, recommendations, and assurances.

#### 3.3.1 NLAG and HUTH: CQC Actions Progress Report for April 2024

Annabelle Baron-Medlam updated that all closed actions from the NLaG CQC action plan had been transferred to a Quality Monitoring Assurance Process. A new action had been added for Level 3 Safeguarding Adults training following the Goole Midwifery Led Unit inspection. The provision of safeguarding training was being reviewed with bespoke training offered to areas with low compliance and the safeguarding team were looking at delivering a joint Level 3 Adult and Children Safeguarding training session.

Simon Nearney asked if the NLaG action plan was on track or intervention was required, Annabelle Baron-Medlam advised that the plan depended on the Care Groups and the priority for the compliance team was to engage with the Care Groups regarding the actions. Lucy Vere highlighted the difference in training between who was accountable for the subject and who was responsible for the delivery. A full review would be completed across the Group of which staff were required to complete what training and what training was required, this would be included in the review of the delivery methods of training. Sue Liburd asked if this work could be aligned to the Care Group work, Lucy Vere advised that was included as part of the People metrics.

Leah Coneyworth informed that the overall training compliance for HUTH was above target, however medical staff training remained below target. Within Surgery, there were four members of staff identified to complete Safeguarding Level 4 training. Issues with resuscitation training continued to be raised by the CQC, performance levels were static. The process for using local induction

checklists and sending them to HR for auditing had been implemented and was being monitored. Training within maternity continued to improve, 16 out of 20 competencies were compliant. Jo Ledger acknowledged that a cleanse of the training data was required as Advanced Life Support training was not included when data was pulled for resus training. The assurance of the NLAG and HUTH CQC Actions Progress Report was agreed as reasonable.

## 4. COMMITTEE SPECIFIC BUSINESS ITEMS

**Joint Business Items**

4.1 **Group Workforce Integrated Performance Report**

Paul Bunyan shared that the report was the first iteration of a Group level workforce performance report. This report enabled sight of both HUTH and NLAG performance reporting with aligned KPI's and reporting parameters. Future reports would include trend data in relation to the newly formed operational care groups as well as more focused narrative in relation to specific workforce interventions and actions.

The overall turnover rate had reduced to within target range but had plateaued, attention would be concentrated in specific areas including Additional Clinical Services. The sickness rate was stable and within target range. The Care Groups would be held to account for appraisal rates and had been given time to concentrate on areas of concern. More staff groups were within target for core mandatory training however, role specific training remains a concern. Work had begun within the Care Groups regarding validation of role specific training. Initial feedback indicated that some of the role specific training was not applicable so further work and realignment would be undertaken.

Two People Promise Managers had been recruited on 12-month fixed term contracts, which were funded by NHSE. The focus of the roles was improvement within the domains of the People Promise.

An integrated team across the group had been comprised to reduce agency spend. A 10-point action plan had been developed and implemented for reducing nursing agency spend including authorisation levels and a review of future bookings. Week commencing 25th March 2024, nursing agency spend in NLaG was circa 4000 hours per week whereas week commencing 22nd April 2024, nursing agency spend was circa 1,400 hours per week and continued to decrease. Simon Nearney commented that NLaG were working to reduce the number of nursing vacancies and the plan was to be fully established by November 2024. The approval process for medical agency spend had also been changed and similar work was being undertaken to reduce medical agency spend. David Sulch asked if the reduction in agency spend meant there were unfulfilled shifts, Simon Nearney advised that no safety issues had been raised due to unfulfilled shifts and were monitored by the rota managers. Jo Ledger highlighted the number of staff who had joined the Bank who had previously worked at the hospitals through an agency and the number of agency staff who were applying for permanent positions at the Trust. Kate Truscott advocated for ensuring these applications do not face delays.

Jo Ledger responded to previous concerns regarding over-establishment of the nursing workforce at HUTH. 80 nursing students had been recruited from Hull University, the initiatives for the over-establishment would require investment. The

over-establishment was in place to allow for additional capacity during winter and maternity leave as well as any other shortfalls within the workforce planning.. A report would go to Cabinet for sign off for the nursing over-establishment. Kate Truscott thanked members for their contribution to the nursing establishment and recruitment.

Sue Liburd noted a previous focus on long term sickness absence at NLaG and asked for an update. Paul Bunyan responded that the amount of long-term sickness absence had vastly reduced. Psychological sickness remained the highest concern. NLaG were discussing the possibility of an inhouse psychological service with Navigo similar to HUTH as the wait time for an external service was circa six months. Long Covid had re-emerged as a concern with 25-30 cases across the Group and the main service provision had reduced.

Sue Liburd asked if there were any patterns to the differences in turnover by Care Groups, Paul Bunyan replied that the data for the new Care Group model needed to be reviewed and was one of the priorities for the HR Business Partners. Simon Nearney briefed that resilience hubs that were provided by mental health partners and paid for by NHS England had lost their funding, which would affect sickness absence management for the Group. Lucy Vere acknowledged the significant reduction in capacity for health and wellbeing due to the lack of funding for the Health and Wellbeing manager roles. The OD team would continue to deliver psychological de-briefing sessions and Schwartz briefings; however, these would be limited and reactive. Staff who were accessing mental health services through the resilience hubs would have access to the Trust counselling and Occupational Health services however, this was not the advanced support that was required. It was likely that the HUTH Psychology team would get more referrals following these changes and would have longer waiting lists. It was agreed to escalate this concern to the board.

Dr Kate Wood highlighted the differences between the data in the Workforce Integrated Performance Report and the Job Planning report. There were two different metrics within the reports for job planning and a note of caution was given to the CiC regarding the data. Work was being undertaken to align data reporting. The assurance of the Group Workforce Integrated Performance Report was agreed as limited.

4.2 **Recruitment / Time to Hire KPI**

Paul Bunyan shared that the Group were in a vacancy control management process and all vacancies had to be approved by the cabinet. The vacancy levels were comparable between HUTH and NLaG. The recruitment pipeline pathway data at group level was not yet available.

At NLaG, there had been an increase in interest in registered nursing roles making the process more competitive. International programmes were reducing, the ICB international hub would continue to provide support. The unregistered nursing vacancy position was 106.81 WTE. The budget was being utilised in different ways to enable bank service provision and the team were working with ward managers to understand the recruitable position required. 33.15 WTE unregistered nurses were in the pipeline. 20 new Health Care Assistants were planned to start per month. The response to adverts for these roles was high, which would enable a pool of candidates.

The site medical directors had started a piece of work with the Care Groups to understand the medical vacancy position and the workforce planning required over the next three months. Work had begun on restructuring medical leadership roles within the care groups.

It was noted that HUTH and NLaG report recruitment statistics differently. The recruitment teams were being restructured to bring the teams together as one recruitment team for the group. It was acknowledged that the issue with occupational health performance at NLaG had been resolved and delays were no longer expected.

David Sulch questioned if the vacancy control process would cause delays for posts within the new care groups, Simon Nearney advised that the Cabinet meeting where the vacancies were discussed takes place on a weekly basis and should not cause any delays. The vacancy control process would be amended to ensure all information from the finance team was included and recommendations from the site managing directors were received. Dr Kate Wood added that there needed to be a clear understanding of why these roles were required.

Ashok Pathak asked if the financial challenge would have an impact on the roles that were currently being advertised, Paul Bunyan advised that roles that were approved prior to the introduction of the vacancy control process would not be affected. It was acknowledged that any posts that were not approved would contribute to the financial savings programme. Simon Nearney updated that the Group was still awaiting approval for a MARS scheme however, no MARS schemes had yet been approved nationally.

Kae Truscott communicated that Tony Curry had asked for a focus in areas that were difficult to recruit to be included in future reports. Simon Nearney responded that the medical workforce report would provide assurance and include information regarding areas of concern. The assurance for the Recruitment / Time to Hire KPI report was agreed as reasonable with caveat that it was a work in progress.

4.3 **Freedom to Speak Up Quarterly Reports**

4.3.1 **Freedom to Speak Up Quarterly Report (HUTH)**

The HUTH Freedom to Speak Up Guardian (FTSUG) shared that in Q4, there had been a further significant increase in the number of concerns, 89 in total. There was a significant increase in the number of concerns from nursing and midwifery staff. Several groups of staff spoke to the Guardian and raised multiple concerns. The themes of concerns received were general concerns, concerns about roles and patient safety.

Annually, the total number of concerns was 201, which was a significant increase from 100 in 2022/23. The increase in the number of concerns was likely due to more promotion of the FTSUG and the implementation of drop-in sessions and walkarounds with the Deputy Chief Nurse. The themes of concerns annually were also general concerns, concerns about roles and patient safety. The FTSUG continued to work with staff members to agree how to escalate the concerns raised. The number of concerns raised about unacceptable behaviour was the same as 2022/23. The number of anonymous concerns remained low with only one raised in Q4, which was also sent to the Group CEO who had instigated an investigation into the allegations.

The HUTH and NLaG FTSUGs cannot share specific concerns and details of concerns with each other, however themes of concerns could be discussed. The FTSUGs had worked together to ensure consistent reporting across both Trusts. The FTSUGs had been invited to a national roundtable focus group to share practices. The data included in the report would be split by Care Groups from Q1 2024/25 onwards.

Ashok Pathak asked if there was a particular Health Group which had a high number of concerns, Fran Moverley responded that in Q4, Family and Women's had a number of concerns however, there were no surprises in the concerns as the issues raised were already being managed. Sue Liburd queried if there were concerns about culture and leadership as there was an increase in groups of staff raising concerns together, Fran Moverley advised that it was mainly due to staff feeling safety in numbers.

Jo Ledger and Lucy Vere had undertaken lots of improvement work in maternity including the introduction of the incivility tool. Lucy Vere highlighted the cultural issue regarding empowering managers to feel they could take action and the OD team were working with leaders within maternity about taking responsibility and having challenging conversations. Kate Truscott wanted to understand the outcomes of the interventions by the FTSUG, and lessons learnt from the concerns raised. Kate Truscott asked for more information on what general support convers. Fran Moverley advised that a common theme under general support was improvement ideas and suggested that the Trust needed a system to allow for virtual suggestions for improvements.

David Sulch asked about the proportion of concerns where staff had tried to raise the issue through line management first versus those who had gone straight to the FTSUG. Fran Moverley advised that she would share this information with the committee following the meeting. Kate Truscott enquired if there were groups of staff or individuals who were using the FTSUG more than appropriate, Fran Moverley responded that some staff had raised multiple concerns but not more than appropriate. The assurance for the HUTH Freedom to Speak Up Quarterly Report was agreed as reasonable.

4.3.2 **Freedom to Speak Up Quarterly Report (NLaG)**

The NLaG FTSUG shared that 73 concerns were raised in Q4, and a record number of 321 concerns were raised annually. Annually, 20 concerns were raised anonymously, which was below the national average. The main themes were process, behaviours, and patient safety. 50% of concerns raised annually were related to inappropriate behaviour, which was higher than the national average. The diversity of different professions across all divisions contacting the FTSUG continued to demonstrate the increased awareness of the FTSUG role amongst staff in the Trust.

15 Freedom to Speak Up champions had been recruited. The staff survey showed an improvement in staff feeling that they could raise concerns. The HUTH and NLaG FTSUGs were working together on a Group Freedom to Speak Up strategy. Elizabeth Houchin responded to the earlier question regarding staff who had spoken to their line manager first before raising concerns with the FTSUG was a 50/50 split and there were some members of staff who had raised concerns repeatedly. It was noted that morale was low amongst staff, which was linked to

the changes with the new structure. Kate Truscott noted that the indicators of success included in the report were helpful and asked the HUTH FTSUG to include in their report going forwards.

Dr Kate Wood asked if the FTSUGs had enough resources. Fran Moverley advised she would have more capacity going forwards as she was moving from the Governance team to the Communications team. Elizabeth Houchin shared that she was employed as designated FTSUG for three days a week and hoped the introduction of the Freedom to Speak Up champions would cause a reduction in number of direct concerns as 15-20% of concerns relate to signposting which could be done by the champions.

Sue Liburd noted that Medicine in NLaG had a high number of concerns and also had issues with mandatory training rates and asked if the committee should be concerned with respect to Medicine. Dr Kate Wood noted that patients within Medicine were predominantly acute, it was a high intensity specialty and the management team needed to continue being vigilant about supporting the workforce and empowering colleagues to deliver change. The change to Care Groups would give a better idea of where some of the issues were. The assurance for the NLaG Freedom to Speak Up Quarterly Report was agreed as reasonable.

4.4 **Care Group Support Programme Presentation**

Lucy Vere briefed that the programme had been co-created by the OD team and Shaun Stacey and the Care Groups. The programme defined the deliverables and outcomes that were crucial for the success of the Care Groups. The programme would support the Director teams to implement changes, engage with staff and embed new ways of working to drive Care Group performance. The programme had three layers of support: formation of Care Group teams, personal and team coaching support, which would be a combination of expert led and peer led and identifying priority services that required intervention.

The timeline was split into getting started, getting going and getting on. In May-June 2024, the OD team would meet with each Care Group team to identify and address the needs of their Care Groups. In July-September 2024, the focus would be further team coaching, culture and staff engagement. The Operational Management Development Programme (OMDG) meetings would be held once a month as peer learning sessions and an open space for colleagues to discuss concerns. The relationship with the OD team and the Care Groups would develop into a support and challenge relationship.

David Sulch advocated that development sessions should not be cancelled due to operational pressures and a record should be made of staff who do not attend. Lucy Vere assured the committee that Shaun Stacey was leading the programme, and his perspective was that the ODMG were essential. Other elements of the programme would be monitored through an organisational diary. Lucy Vere would attend the Operations Senior Leadership Team meeting on a monthly basis to provide an update on the programme and address any escalations. Davd Sulch noted that it was an internal priority and could be included on the BAF.

Simon Nearney praised the programme and guide, which was echoed by the committee. It was highlighted that Nami Sajja had led the project and done outstanding work. Lucy Vere advised there was £150k in recurrent funding for NLaG OD, which would allow recruitment for two OD practitioners who would

support this programme. Two internal Heads of OD had been appointed. It was agreed that an update on the progress of programme would be provided to the September 2024 meeting.

**Action: Lucy Vere to provide an update on the progress of the Care Group support programme at the September 2024 meeting.**

Sue Liburd asked about the ambition of the care group management team, Lucy Vere advised that there was mix of feelings from colleagues however, the overall position was positive. The assurance for the Care Group Support Programme was agreed as reasonable.

The agenda was taken out of order at this point.

**<u>NLaG Specific Business Items</u>**

4.8 **Lorenzo Update – Impact on Staff**

Jackie France shared that the migration to Lorenzo affected 1700 staff at NLaG. The training for the Lorenzo started several months before the migration however, there were budget limitations for the project and a variation in the quality of the training and floorwalking provided. Adapting to a new system and the requirement for an increased level of data compared to the previous system has had a significant impact on workload.

To support the migration, virtual training, extensive training guides, a 24/7 support helpdesk and floorwalkers were provided. Visibility of managers was increased and a number of staff from HUTH provided exceptional support. Connections with staff from HUTH continued to be built on. Daily briefing sessions were held where staff could raise concerns. The data warehouse replacement has had an impact on reporting, the Lorenzo data and the reported data was currently being consistency checked. A business case was submitted about the predicted impact of the workload on current staff however, this was not approved. 10 WTE staff were recruited on a temporary basis to support staff for a year.

The helpdesk was still in place to support staff but was not receiving any further calls. A number of project staff had been extended until end of June 2024 to support staff and provide training. Optimisation work had started to further align the system and staff had also suggested improvements. Some staff chose to leave the Trust after they struggled to cope with the new system, and some chose to retire. There had also been an impact on the senior team with some members affected by workplace related stress. Additional support had been provided to ward clerks and receptionists.

Recent feedback from staff indicated that they prefer Lorenzo, the extra work involved was highlighted but staff could see the benefits of more information available on the system. The projects had been successful, which was attributed to the dedication and perseverance of operational and digital staff.

Dr Kate Wood shared that the NLAG risk management process for waiting lists did not translate into Lorenzo, this issue was being worked through however, it was an additional stress for clinicians and admin teams. Mitigations were in place which meet the national standards. The assurance for the impact on staff due to the Lorenzo update was agreed as reasonable.

4.9 **Nursing Band 2/3 Options Paper**

Jenny Hinchliffe shared that work was being undertaken to re-evaluate job descriptions for band 2 and band 3 staff at NLaG. As part of the work national profiles were reviewed and clinical amendments were made in July 2021, which had been brought to attention by unions nationally and locally. Re-grading claims had already been submitted by maternity and ophthalmology Health Care Assistants (HCA), job descriptions were reviewed, and staff were upgraded to band 3. A grievance had been submitted about backdated pay.

Skills and competencies were being reviewed alongside training and establishment reviews. The majority of wards had band 2 staff who undertake tasks that were attributed to band 3. Jenny Hinchliffe advised that stopping band 2 staff from doing band 3 would have a negative effect on timely patient care and recruitment and retention. HR colleagues were undertaking a piece of work to benchmark against other Trusts and their position on the split between band 2 and band 3 staff. HUTH had conducted a similar piece of work and found that band 2 staff do not generally undertake any band 3 work. Jenny Hinchliffe was working with the new Group Chief Nurse to understand what was needed from the different bands of staff for service provisions.

Kate Truscott noted that Linda Jackson had raised the issue of band 2 staff salaries being £0.01 above national minimum wage and the effect this had on car parking and staff lottery. Simon Nearney noted that action was taken to ensure staff were not paid below the national minimum wage. The ideal solution was to pay a 2% increase to Band 2 staff to bring them above the limit in advance of the national pay award. As a foundation trust, NLaG could make the increase however, HUTH did not have approval to make the increase therefore as a Group the increase was not an option. The Group had written to NHS England to request an uplift for all band 2 staff. Sue Liburd asked if communications had been sent to staff that this issue was being investigated at the highest level, Simon Nearney advised that communications had been sent to staff. A residual piece of work was being undertaken to review any deductions from pay and to look at different options for payments for car parking etc. The Nursing Band 2/3 options paper would be presented at the May 2024 committee.

**HUTH Specific Business Items**

4.10 **Briefing on the OCS issues within HUTH raised by the GMB**

Craig Hodgson briefed the committee that action had been taken by GMB for OCS staff outside the front of HRI on 13th February 2024 with no prior notification to the Trust. The concerns that were raised regarding rest facilities access were not replicated or substantiated throughout the workforce. A suggestion box had been implemented for OCS staff and regular meetings were planned between OCS management and staff.

Sue Liburd asked if the media interest had reduced, Craig Hodgson confirmed it was non-existent. Kate Truscott noted that Tony Curry had enquired about contract management with OCS, Criag Hodgson advised that the facilities team meet monthly with OCS for an operational meeting, 6 monthly for a contract review meeting and hold an annual review meeting. Kate Truscott raised concerns about the length of time that there was no OCS site management in post and the impact this had on the contract. Craig Hodgson provided assurance that there was now an

increased HR management presence and the Trust had challenged OCS to improve their sickness position, which had now improved. Sue Liburd asked if GMB had raised any further issues, Craig Hodgson advised that the situation was resolved. The assurance for the OCS issues raised by the GMB was agreed as reasonable.

The agenda returned to order at this point.

4.5 **Job Planning**

Dr Kate Wood acknowledged that the report was the first attempt at bringing together job planning across the Group. The alignment of the care groups was a work in progress. The year-end position for signed off job plans appeared to be 64% for HUTH and 93% for NLaG however, the committee could not be assured on the validation of the data. The job planning framework had national terms and conditions however, there was different locally negotiated terms and conditions with management teams across the two Trusts.

At HUTH, medical staff were not paid for more than 12 PAs however, some job plans were above 12 PAs. At NLaG, medical staff were paid for more than 12 PAs. Allocate software was used across both Trusts for job planning. Consistency was required across the Care Groups. The job planning framework would be negotiated with both JLNCs to implement a Group job planning framework. Within NLAG, there was a successful Job Planning Committee, which would need to be replicated at HUTH. A plan was needed to reduce all consultant PAs across the Group to 12 PAs, it was crucial that this was done in a planned, risk-based, staged approach.

Ashok Pathak raised concern regarding job planning appeals, Dr Kate Wood advised that job plans were a signed agreement between a clinician and their clinical lead and that the Group was under no obligation to provide clinicians with a job plan more than 10 PAs. Job plans could be changed at 3 months' notice unilaterally.

Simon Nearney asked what level discussions had taken place regarding parity for consultants across the Group, Dr Kate Wood advised that discussions were currently at Chief of Service level. Dr Kate Wood noted some additional PAs were about service needs and others were leadership requirements and further investigation was being undertaken to provide clarity. David Sulch agreed with the process to gradually reduce PAs in a controlled way.

The committee agreed that time needed to be given to Dr Kate Wood and the Care Groups to enable a clear and robust approach to the development of Group job planning. Dr Kate Wood updated that she had a meeting planned with the BMA regarding job planning framework. A draft group job planning framework would be socialised and negotiated with both JLNCs. Within the alignment of Care Group staff, a cleanse would be undertaken of clinical leads. Clinical leads would continue to be responsible for signing off job plans. It was agreed that a written update report would be provided in October 2024. The assurance for the Group Job Planning report was agreed as limited.

**Action: Dr Kate Wood to provide a written update report on Group Job Planning to the October 2024 meeting.**

4.6 **Monthly Group Medical Engagement Update**
Dr Kate Wood updated that development of the medical engagement strategy was underway. The leadership programmes that were in place for HUTH and NLaG would continue for 2024/2025, a Group based programme would be launched for 2025/26. It was agreed to change the date for the medical engagement strategy to August 2024 in line with the medical workforce strategy. It was agreed that Dr Kate Wood would continue to provide a verbal update each month on medical engagement in advance of the strategy.

4.7 **Equality Delivery Standards 2022 Updated Report**
Lucy Vere noted that the updated report showed the action plans for both HUTH and NLaG. In future, the report would become outcome focused with clear assurance of what could and could not be done. It was highlighted that a Group Equality, Diversity and Inclusion programme was being developed. The Equality Delivery Standards 2022 report was approved by the committee.

## 5. ITEMS FOR INFORMATION / TO NOTE

5.1 The workplan would be updated with amendments discussed in the meeting.

## 6. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

## 7. MATTERS TO BE REFERRED BY THE COMMITTEES

7.1 **Matters to be Referred to other Board Committees**

There were no matters for referral to any of the other board committees.

7.2 **Matters for Escalation to the Trust Boards**

It was agreed that the following matters required escalation to the Trust Board(s) in the committees' highlight report:

- Removal of the funding for Resilience Hubs from NHS England.
- The issue of the action taken by GMB on behalf OCS staff at HUTH was resolved.
- The feedback from staff regarding the support provided during the transition to Lorenzo was positive.

## 8. DATE AND TIME OF THE NEXT MEETING

8.1 **Date and Time of the next Workforce, Education and Culture CiC meeting:**

Tuesday 23rd May 2024, at 13:30, in the Boardroom, Alderson House, Hull Royal Infirmary.

The committee chair closed the meeting at 12:35 hours.

**Cumulative Record of Core Membership Attendance 2024**

| Name | Possible | Actual |
|---|---|---|

| Sue Liburd | 4 | 4 |
|---|---|---|
| Kate Truscott | 4 | 4 |
| Simon Nearney | 4 | 3 |
| Tony Curry | 4 | 2 |
| Una Macleod | 3 | 3 |
| Kate Wood | 4 | 3 |
| David Sharif | 2 | 2 |
| David Sulch | 2 | 2 |
| Amanda Stanford | 1 | 0 |

**Trust Boards-in-Common Front Sheet**

**Agenda Item No: BIC(24)118**

<table>
<tr><td>Name of the Meeting</td><td>Trust Boards-in-Common – Public Meeting</td></tr>
<tr><td>Date of the Meeting</td><td>Thursday, 13 June 2024</td></tr>
<tr><td>Director Lead</td><td>Dr Kate Wood, Group Chief Medical Officer</td></tr>
<tr><td>Contact Officer/Author</td><td>Dr Wajiha Arshad, Guardian of Safe Working, HUTH<br>Dr Elizabeth Evans, Guardian of Safe Working, NLaG</td></tr>
<tr><td>Title of the Report</td><td>Guardian of Safe Working Hours Report for Quarter Four – 01 January 2024 to 31 March 2024 - HUTH and NLaG</td></tr>
<tr><td>Executive Summary</td><td><u>HUTH</u>:<br><br><u>Exception Reports:</u><br>A total of 122 exception reports were submitted across the quarter.<br>General Medicine (56), Medical Oncology (14), and General Surgery (12) were the three departments with the highest number of exception reports submitted. The majority of exception reports were due to hours worked and missed educational opportunities.<br><br><u>Fines:</u><br>4 fines were issued in total. 1 for General Surgery, Paediatric Surgery, Plastic Surgery, and Oncology & Haematology.<br><br>Three of the fines issued within the quarter relate to non-resident on call shifts and trainees remaining on site or returning to site due to a variety of reasons, resulting in breaches of maximum shift length and required rest.<br><br><u>eRoster Rollout:</u><br>The Guardian of Safe Working continues to work with Medical Staffing on the roll out of e-roster across all rotas within the organisation. The standard of rota is determined by the below categories.<br><br>Gold Fully Operational<br>(Fully on eRoster and e-Roster main point of truth)<br>Green Fully functional<br>Blue Partially Functional<br>Red Not functional<br><br>The table below summarises by Health Group current utilisation of e-Roster as at end March 2024, this table shows that 89% of HUTH rotas are now live on eRoster. Although this number remains the same since the last quarter, there have been a number of rotas that have moved up the categories (ie. Blue to</td></tr>
</table>

| | |
|---|---|
| | Green, Green to Gold) and the Medical Staffing team are working with those departments not currently using he system to implement. |

| | Red | Blue | Green | Gold |
|---|---|---|---|---|
| Surgery | 2 | 2 | 8 | 7 |
| Clinical Support | 0 | 2 | 5 | 2 |
| Family and Women's | 3 | 5 | 4 | 0 |
| Medicine | 2 | 7 | 10 | 0 |
| Emergency Medicine | 0 | 0 | 5 | 0 |
| **Total** | **7 (11%)** | **16 (25%)** | **32 (50%)** | **9 (14%)** |

Trainee Doctor Fill Rate:
Over the quarter, 90.2% of trainee doctor posts were filled and increase from 89.3% last quarter.

Oral & Maxillofacial Surgery department has highest number of Trainee vacancies with 27.3% Fill Rate.

Emergency Medicine had highest number of locums requests with their trainee fill rate being 76.3%.

**NLaG:**

The report includes exception reporting and reasons for any immediate safety concerns.

There has been an increase in the number of reports received compared to last quarter. This is not an unexpected finding at this time of year, and the small number of immediate4 safety concerns is reassuring.

The majority of reports concerned working hours breeches, with a small number due to service support available during clinical commitments.

| | |
|---|---|
| **Background Information and/or Supporting Document(s)** (if applicable) | **HUTH:**<br>Whilst the report provides an overview of the last quarter, the data and can be found in the appendices linked at the bottom of the report.<br><br>**NLaG:**<br>Junior Doctors TCS (Version 11) – https://www.nhsemployers.org/system/files/2023-02/NHS-Doctors-and-Dentists-in-Training-England-TCS-2016-VERSION-11.pdf |

| Prior Approval Process | Workforce, Education and Culture Committees-in-Common meeting held on Thursday, 23 May 2024. | |
|---|---|---|
| **Financial implication(s)** (if applicable) | **HUTH:**<br>This report contains information on Guardian of Safe Working fines. £4,936.54 fines have been issued over the quarter. Paediatric Surgery and Plastic Surgery have continued to have a number of fines issued over several consecutive quarters.<br>**NLaG:**<br>Not applicable | |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | None identified | |
| **Recommended action(s) required** | ☐ Approval<br>☐ Discussion<br>☐ Assurance | ✓ Information<br>☐ Review<br>☐ Other – please detail below: |

**Hull University Teaching Hospitals NHS Trust**

**Quarterly Report on Safe Working Hours**
**Doctors and Dentists in Training**
**1st January – 31st March 2024**

## 1. Purpose of this Report

Under the 2016 Terms and Conditions of Service, the Guardian of Safe Working Hours must report to the Board at least once per quarter. This report sets out data from January – March 2024.

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

## 2. High Level Data

| | |
|---|---|
| Number of doctors / dentists in training (total): | 628.9 |
| (establishment) | 697.0 |
| Number of doctors / dentists in training on 2016 TCS (total FTE's): | 628.9 |
| Amount of time available in job plan for guardian to do the role: | 1 PA (4 hours per week) |
| Admin support provided to the guardian (if any): | 1 WTE |
| Amount of job-planned time for educational supervisors: | 1 WTE<br>0.25 PAs per trainee (max; varies between health groups) |

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

Doctors and dentists in training terms and conditions (England) 2016 | NHS Employers

## 3. Exception Reports

There was a total of 122 exception reports (122 episodes) reported by doctors in training and locally employed doctors for this quarter. There was a wide range of themes highlighted from exception reports this quarter, further details are provided in this report.

**Appendix A:**
**Exception reports (episodes) by department 1st January – 31st March 2024**

General Medicine, Medical Oncology, and General Surgery had the highest number of exception reports submitted over the quarter.

Within General Medicine, out of the 56 exception reports submitted, 38 were due to hours (overtime), 10 were for educational reasons, 3 were due to pattern, and 5 for service support.

Medical Oncology and General Surgery had significantly less exception reports submitted. Out of the 14 exception reports submitted within medical oncology, 13 were due to hours (overtime) and only 1 exception report was submitted due to pattern.

Out of 12 exception reports submitted for general surgery, 7 were due to hours (overtime), 2 due to pattern, 2 due to service support and 1 for educational reasons.

**Appendix B:**
**Exception reports (episodes) by grade 1st January – 31st March 2024**

The highest number of exception reports were submitted by FY1 trainees.
61 exception reports were submitted by FY1 trainees in the quarter, and of those, 45 were for hours (overtime), 10 were for missed educational opportunities, 4 for service support and 2 due to pattern.

**Appendix C:**
**Exception reports (episodes) by rota 1st January – 31st March 2024**

Rota 4 (FY1 Medicine), Rota 8 (Oncology and Haematology), and Rota 18b (Critical Care/Medicine) had the highest number of exception reports within the quarter.

Rota 4 had 19 exception reports due to hours (overtime), 6 due to missed educational opportunities, and 1 due to pattern.

Rota 8 had 13 exception reports submitted, all for hours (overtime).

Rota 18b had 11 exception reports submitted, 10 of which for hours (overtime) and 1 for service support.

**Appendix D:**
**Exception reports (episodes) - response time 1st January – 31st March 2024**

The 2016 TCS require that the trainer meets with the doctor in training to discuss an exception report within seven days.
It has continually been identified that meting within seven days is often difficult for trainees and supervisors. Guardian of Safe Working continues to educate both junior doctors and supervisors on the importance of exception reporting and meeting in a timely manner.

## 4. Work Schedule Reviews

The following rotas were under review between January and March 2024; all relevant health groups are aware.

- Acute/Elective Surgery – Rota 27
- Urology – Rota 42
- Oral & Maxillofacial Surgery – Rota 37
- ENT – Rota 34
- Infectious Diseases – Rota 16

It is anticipated that work schedule reviews may increase as we move over to the Care Group structure and there are expected requests for amended rotas covering the hospitals in the Group.

## 5. Locum bookings 1st January – 31st March

**Appendix E – G:**
**Bank 1st January – 31st March**

The Trust has a number of avenues to fill rota gaps with post gaps filled by doctors working within the Trust initially either as overtime or via our Medical Bank. The bank data details bookings made with doctors working through the Trust's 'Remarkable Bank' and does not include data on any rotational doctors working additional hours/overtime above their base working hours.
The information covers shifts that have been booked by the Medical Staffing Team, Emergency Department and Anesthetics. There are a number of departments in the Trust that manage their own rotas and book their own bank cover for staffing gaps.

**Appendix H – J:**
**Agency 1st October – 31st December 2023**

The Trust also uses limited amount of agency staff. All agency bookings are managed by the Medical Staffing team but are only used when internal and bank routes are exhausted.

**Appendix K:**
**Locum work carried out by doctors in training 1st October – 31st December**

This data is collected to help assess whether individual doctors in training are in breach of the WTR and the 2016 TCS, or at significant risk of breaching.

The table represents the top 10 doctors in training that have worked the most extra hours and whether they have opted out of the WTD.

6. **Vacancies:** The below table details the Doctors and Dentists in training establishment and current doctors in training in post as appointed by NHS England (formerly Health Education England) for the quarter covered by this report.

Hull University Teaching Hospitals NHS Trust - Junior Doctor Trainee Establishment January to March 2024

| | Trainee Establishment | | | | | | Trainee In Post | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Department | F1 | F2 | CT/ST1-2 | GPSTR | ST | **Total** | F1 | F2 | CT/ST1-2 | GPSTR | ST | **Total** | **% Filled March 2024** | % Filled Dec 2023 |
| Academic, GP, Psych & Community | 9 | 29 | 0 | 105 | 0 | 143 | 9 | 28.4 | 0 | 96.9 | 0 | 134.3 | **93.9%** | 91.5% |
| Acute Medicine | 5 | 7 | 8 | 0 | 9 | 29 | 4 | 7 | 6.9 | 0 | 7.4 | 25.3 | **87.2%** | 90.3% |
| Anaesthetics | 5 | 4 | 25 | 0 | 30 | 64 | 5 | 4 | 20.5 | 0 | 32.8 | 62.3 | **97.3%** | 92.3% |
| Breast Surgery | 2 | 0 | 1 | 0 | 2 | 5 | 2 | 0 | 1 | 0 | 1 | 4 | **80.0%** | 60.0% |
| Cardiology | 3 | 1 | 3 | 1 | 10 | 18 | 3 | 1 | 3 | 1 | 10 | 18 | **100.0%** | 94.7% |
| Cardiothroacic Surgery | 0 | 3 | 0 | 0 | 4 | 7 | 0 | 3 | 0 | 0 | 3 | 6 | **85.7%** | 85.7% |
| Chemical Pathology | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | **100.0%** | 100.0% |
| Colorectal Surgery | 8 | 0 | 2 | 0 | 3 | 13 | 8 | 0 | 2 | 0 | 3 | 13 | **100.0%** | 100.0% |
| Dermatology | 1 | 0 | 0 | 1 | 0 | 2 | 1 | 0 | 0 | 1 | 0 | 2 | **100.0%** | 100.0% |
| Elderly Medicine | 6 | 3 | 5 | 7 | 6 | 27 | 6 | 3 | 6 | 7 | 4.2 | 26.2 | **97.0%** | 97.0% |
| Emergency Medicine | 0 | 12 | 12 | 6 | 18 | 48 | 0 | 11.5 | 8.4 | 5 | 11.7 | 36.6 | **76.3%** | 83.8% |
| Endocrinology | 3 | 0 | 2 | 0 | 4 | 9 | 3 | 0 | 1.8 | 0 | 4 | 8.8 | **97.8%** | 97.8% |
| ENT | 2 | 1 | 2 | 3 | 5 | 13 | 2 | 1 | 2 | 3 | 3.6 | 11.6 | **89.2%** | 88.3% |
| Gastroenterology | 3 | 0 | 2 | 0 | 5 | 10 | 3 | 0 | 2 | 0 | 4.5 | 9.5 | **95.0%** | 92.7% |
| General Surgery | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | **0.0%** | 0.0% |
| Haematology | 2 | 2 | 2 | 0 | 4 | 10 | 1 | 2 | 2 | 0 | 3 | 8 | **80.0%** | 92.0% |
| Histopathology | 0 | 0 | 0 | 0 | 7 | 7 | 0 | 0 | 0 | 0 | 6.6 | 6.6 | **94.3%** | 100.0% |
| Immunology | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | **100.0%** | 100.0% |
| Infectious Diseases/Neuro-Rehab | 2 | 1 | 1 | 4 | 6 | 14 | 2 | 1 | 1 | 4 | 6.3 | 14.3 | **102.1%** | 102.1% |
| Neurology | 4 | 3 | 3 | 0 | 5 | 15 | 4 | 3 | 2 | 0 | 3.5 | 12.5 | **83.3%** | 83.3% |
| Neurosurgery | 1 | 1 | 2 | 0 | 4 | 8 | 1 | 0 | 2 | 0 | 4 | 7 | **87.5%** | 75.0% |
| Obstetrics & Gynaecology | 0 | 3 | 7 | 5 | 13 | 28 | 0 | 3 | 7 | 4.6 | 12.4 | 27 | **96.4%** | 87.4% |
| Oncology | 3 | 0 | 2 | 4 | 12 | 21 | 2 | 0 | 1 | 4 | 12 | 19 | **90.5%** | 85.7% |
| Ophthalmology | 1 | 1 | 0 | 0 | 6 | 8 | 1 | 1 | 0 | 0 | 5.8 | 7.8 | **97.5%** | 97.5% |
| Oral & Maxillofacial Surgery | 0 | 0 | 10 | 0 | 1 | 11 | 0 | 0 | 2 | 0 | 1 | 3 | **27.3%** | 27.3% |
| Paediatric Neonatal Medicine | 0 | 0 | 9 | 0 | 7 | 16 | 0 | 0 | 8.8 | 0 | 5.4 | 14.2 | **88.8%** | 87.9% |
| Paediatric Surgery | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 0 | 2 | **100.0%** | 90.0% |
| Palliative Care | 0 | 0 | 0 | 2 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 2 | **100.0%** | 120.0% |
| Plastic Surgery | 0 | 0 | 3 | 0 | 6 | 9 | 0 | 0 | 3 | 0 | 5 | 8 | **88.9%** | 88.9% |
| Paediatrics | 3 | 4 | 4 | 4 | 9 | 24 | 3 | 3 | 3.8 | 3.2 | 8.6 | 21.6 | **90.0%** | 77.0% |
| Radiology | 0 | 1 | 0 | 0 | 37 | 38 | 0 | 0 | 0 | 0 | 31.4 | 31.4 | **82.6%** | 94.2% |
| Renal Medicine | 2 | 1 | 2 | 0 | 6 | 11 | 2 | 0 | 1 | 0 | 5 | 8 | **72.7%** | 72.7% |
| Respiratory Medicine | 6 | 2 | 2 | 2 | 8 | 20 | 5 | 2 | 2 | 2 | 8.3 | 19.3 | **96.5%** | 96.5% |
| Rheumatology | 0 | 0 | 1 | 2 | 3 | 6 | 0 | 0 | 1 | 2 | 2.8 | 5.8 | **96.7%** | 93.3% |
| Stroke Medicine | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | **100.0%** | 100.0% |
| Trauma & Orthopaedics | 0 | 5 | 3 | 1 | 9 | 18 | 0 | 5 | 2 | 1 | 9 | 17 | **94.4%** | 94.4% |
| Upper GI | 9 | 0 | 2 | 0 | 4 | 15 | 9 | 0 | 1 | 0 | 4 | 14 | **93.3%** | 86.7% |
| Urology | 1 | 3 | 2 | 0 | 3 | 9 | 1 | 3 | 2 | 0 | 3 | 9 | **100.0%** | 100.0% |
| Vascular Surgery | 7 | 0 | 1 | 0 | 5 | 13 | 6 | 0 | 0.8 | 0 | 4 | 10.8 | **83.1%** | 84.6% |
| **TOTAL** | **88** | **88** | **120** | **147** | **254** | **697** | **83** | **81.9** | **98** | **136.7** | **229.3** | **628.9** | **90.2%** | 89.3% |

## 7. Fines

The 2016 Medical and Dental T&C's contract states fines should be issued for the following breaches:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule);
- A breach of the maximum 13-hour shift
- A breach of the maximum of 72 hours worked across any consecutive 168-hour period.
- Where 11 hours' rest within a 24-hour period has not been achieved (excluding on-call shifts);
- Where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved;
- Where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved
- Where a concern is raised that breaks have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct, the Guardian of Safe Working hours will levy a fine.

Standard rates are outlined in the Terms and Conditions.

**Summary of fines issued 1st January – 31st March 2024**
**Appendix L:**

4 fines were issued in total. 1 for General Surgery, 1 for Paediatric Surgery, 1 for Plastic Surgery, and 1 for Oncology and Haematology.

3 of the fines issued within the quarter relate to non-resident on call shifts and trainees remaining on site or returning to site due to a variety of reasons, resulting in breaches of maximum shift length and required rest.

The fine within General Surgery was in relation to a non-resident on call shift covering junior doctor's strikes which breached 8 hours rest within a 24-hour period due to the department being short staffed due to industrial action.

The fines relating to Paediatric Surgery and Plastic Surgery were in relation to non-resident on call shifts where the trainees remained on site for emergency theatre cases, resulting in breaches of 8 hours rest in a 24-hour period, and 5 hours continuous rest.

The fine for the Medical Oncology department was due to a breach of 13-hour maximum shift length due to the trainee remaining on shift to attend to a crash call for arrest.

Steps taken to resolve issues:
The circumstances resulting in these fines are deemed to be exceptional circumstances due to external factors, and trainees staying on site to maintain patient safety.
The trainees have then followed up appropriately by submitting exception reports and escalating the breaches.

The clinical lead in Paediatric Surgery has also produced several business cases to combat rota issues which have resulted in breaches, and the most recent case is still pending financial approval.

## 8. GOSW Funds Expenditure

No purchases were made using GOSW Funds in the quarter January – March 2024.
All expenditure from the GOSW Funds is agreed at the Junior Doctors' Forum.

## 9. Appendices

Please see attached appendices containing data referred to above.
Appendix A – L.

| Specialty (Where exception occurred) | No. exeptions carried over | No. exceptions raised (episodes) | No. exceptions closed | No exceptions outstsanding |
|---|---|---|---|---|
| Cardiology | 0 | 1 | 1 | 0 |
| Cardio-thoracic surgery | 2 | 8 | 8 | 0 |
| General medicine | 62 | 56 | 41 | 15 |
| General surgery | 26 | 12 | 8 | 4 |
| Geriatric medicine | 0 | 1 | 1 | 0 |
| Medical oncology | 20 | 14 | 8 | 6 |
| Paediatric surgery | 0 | 2 | 2 | 0 |
| Plastic surgery | 8 | 5 | 1 | 4 |
| Psychiatry | 9 | 8 | 0 | 8 |
| Surgical specialties | 10 | 8 | 4 | 4 |
| Trauma & Orthopaedic Surgery | 5 | 1 | 1 | 0 |
| Vascular Surgery | 14 | 6 | 4 | 2 |
| **Total** | **156** | **122** | **79** | **43** |

| Grade | No. exeptions carried over | No. exceptions raised (episodes) | No. exceptions closed | No exceptions outstsanding |
|---|---|---|---|---|
| CT1 | 15 | 21 | 19 | 2 |
| CT2 | 9 | 1 | 0 | 1 |
| FY1 | 87 | 61 | 47 | 14 |
| FY2 | 27 | 13 | 8 | 5 |
| ST1 | 20 | 13 | 1 | 12 |
| ST2 | 0 | 3 | 0 | 3 |
| ST3 | 6 | 7 | 3 | 4 |
| ST4 | 14 | 2 | 1 | 1 |
| ST5 | 2 | 1 | 0 | 1 |
| **Total** | **180** | **122** | **79** | **43** |

| Rota | No. exceptions raised (episodes) | No. exceptions closed | No exceptions outstsanding |
| --- | --- | --- | --- |
| Rota 12 Medical Oncology SpR | 1 | 0 | 1 |
| Rota 121 Cardiology & CT Surgery F2/CT | 9 | 9 | 0 |
| Rota 124a Acute Elective CT | 4 | 4 | 0 |
| Rota 124b General Surgery | 4 | 0 | 4 |
| Rota 13 Acute & General Medicine | 4 | 1 | 3 |
| Rota 130 NCTR & Gen Medicine (F2+) | 2 | 0 | 2 |
| Rota 131 NCTR & Gen Medicine (F1) | 1 | 1 | 1 |
| Rota 134 Orthopaedic/Orthogeriatric | 1 | 1 | 0 |
| Rota 135 Orthopaedic & Plastic Surgery CT | 2 | 0 | 2 |
| Rota 137 Psychiatry SHO | 8 | 0 | 8 |
| Rota 14 Medicine SHO | 5 | 4 | 1 |
| Rota 15 Gastro/Endo/Renal/ID | 3 | 2 | 1 |
| Rota 18 F1 Oncology | 1 | 1 | 0 |
| Rota 18b Crit Care/Medicine | 11 | 8 | 3 |
| Rota 23 Vascular/ENT/Neurology/Urology | 6 | 4 | 2 |
| Rota 25 Acute/Elective F1 | 11 | 7 | 4 |
| Rota 27 Acute & Elective Surgery SPR | 1 | 1 | 0 |
| Rota 4 Medicine FY1 | 26 | 21 | 4 |
| Rota 40 Plastic Surgery SpR | 3 | 1 | 2 |
| Rota 5 Neuro/DME/Derm | 2 | 2 | 0 |
| Rota 66 Paediatric Surgery | 2 | 2 | 0 |
| Rota 8 Oncology & Haematology | 13 | 8 | 5 |
| Rota 9 Chest/Renal | 2 | 2 | 0 |
| **Total** | **122** | **79** | **43** |

| Grade | Adressed within 48hrs | Addressed within 7 days | Addressed in 7+ days | Outstanding |
|---|---|---|---|---|
| CT1 | 1 | 3 | 15 | 2 |
| CT2 | 0 | 0 | 0 | 1 |
| FY1 | 6 | 10 | 31 | 14 |
| FY2 | 3 | 0 | 5 | 5 |
| ST1 | 1 | 0 | 0 | 12 |
| ST2 | 0 | 0 | 0 | 3 |
| ST3 | 2 | 1 | 0 | 4 |
| ST4 | 0 | 1 | 0 | 1 |
| ST5 | 0 | 0 | 0 | 1 |
| **Total** | **13** | **15** | **51** | **43** |

| Locum Bookings (Bank) by Grade | | | | |
|---|---|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| F1 | 156 | 0 | 163 | 0 |
| F2 | 1882 | 562 | 15355.26 | 5399.41 |
| CT/GPSTR/ST1-2 | 571 | 100 | 2008.25 | 1026.67 |
| ST3+ | 910 | 191 | 4641.75 | 1774.75 |
| **Total** | **3519** | **853** | **22168.26** | **8200.83** |

| Locum Bookings (Bank) by Department | | | | |
|---|---|---|---|---|
| **Specialty** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| Acute Medicine | 821 | 379 | 6227.25 | 3720.33 |
| Anaesthetics | 39 | 0 | 309 | 0 |
| Breast Surgery | 13 | 0 | 113 | 0 |
| Cardiology | 70 | 5 | 281.5 | 37.5 |
| Chest Medicine | 34 | 0 | 239 | 0 |
| Clinical Oncology | 19 | 0 | 99.25 | 0 |
| Colorectal Surgery | 57 | 0 | 394.5 | 0 |
| CT Surgery | 12 | 0 | 130.75 | 0 |
| Elderly Medicine | 128 | 40 | 803 | 309.75 |
| Emergency Medicine | 884 | 159 | 819.25 | 1531.25 |
| Endocrinology | 10 | 0 | 114.25 | 0 |
| ENT | 113 | 20 | 1240 | 269 |
| Gastroenterology | 75 | 2 | 608.5 | 19.5 |
| General Medicine | 19 | 4 | 102.5 | 19.25 |
| General Surgery | 118 | 73 | 1231.5 | 723 |
| Haematology | 44 | 14 | 418 | 115.08 |
| Infectious Diseases | 86 | 13 | 712 | 131 |
| NCTR/Winter Wards | 121 | 0 | 960.5 | 0 |
| Neonatology | 11 | 4 | 113 | 42 |
| Neurology | 66 | 15 | 546 | 103.75 |
| Neurosurgery | 239 | 12 | 2153.25 | 141.92 |
| Obs & Gynae | 33 | 1 | 391.75 | 10.5 |
| Oncology | 23 | 0 | 278.5 | 8 |
| Oral and Maxillofacial Surgery | 60 | 43 | 500.75 | 360.5 |
| Paediatric Surgery | 59 | 28 | 460 | 231 |
| Plastic Surgery | 11 | 1 | 111 | 9 |
| Radiology | 7 | 0 | 62 | 0 |
| Renal Medicine | 4 | 1 | 38.5 | 8 |
| Respiratory Medicine | 15 | 2 | 186 | 25 |
| Rheumatology | 60 | 15 | 496 | 117.5 |
| Stroke | 46 | 0 | 369 | 0 |
| Trauma & Orthopaedics | 160 | 15 | 1178.76 | 177.5 |

| | | | | |
|---|---|---|---|---|
| Upper GI Surgery | 21 | 0 | 173.5 | 0 |
| Urology | 28 | 7 | 238 | 90.5 |
| Vascular Surgery | 13 | 0 | 68.5 | 0 |
| **Total** | **3519** | **853** | **22168.26** | **8200.83** |

| Locum Bookings (Bank) by Reason | | | | |
|---|---|---|---|---|
| **Reason** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| Additional Resource | 571 | 46 | 1301.25 | 386.5 |
| Annual leave | 43 | 0 | 336 | 0 |
| Compassionate Leave and Special Leave | 13 | 2 | 87.5 | 25 |
| Sickness | 505 | 97 | 2829.5 | 995 |
| Maternity/Paternity Leave | 23 | 0 | 75.5 | 0 |
| Study Leave | 0 | 0 | 0 | 0 |
| Vacancy, Covid-19 Pressures and Strike Action | 2363 | 706 | 17536.51 | 6792.33 |
| Crem Fees | 1 | 2 | 2 | 2 |
| **Total** | **3519** | **853** | **22168.26** | **8200.83** |

| Locum Bookings (Agency) by Grade | | | | |
|---|---|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| F1 | 156 | 0 | 163 | 0 |
| F2 | 1878 | 550 | 15355.26 | 4900.34 |
| CT/GPSTR/ST1-2 | 575 | 17 | 2008.25 | 200.5 |
| ST3+ | 910 | 51 | 4641.75 | 659 |
| **Total** | **3519** | **618** | **22168.26** | **5759.84** |

| Locum Bookings (Agency) by Department | | | | |
|---|---|---|---|---|
| **Specialty** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| Acute Medicine | 821 | 5 | 6227.25 | 59.5 |
| Anaesthetics | 39 | 0 | 309 | 0 |
| Breast Surgery | 13 | 0 | 113 | 0 |
| Cardiology | 70 | 7 | 281.5 | 72 |
| Chest Medicine | 34 | 0 | 239 | 0 |
| Clinical Oncology | 19 | 0 | 99.25 | 0 |
| Colorectal Surgery | 57 | 0 | 394.5 | 0 |
| CT Surgery | 12 | 0 | 130.75 | 0 |
| Elderly Medicine | 128 | 0 | 803 | 0 |
| Emergency Medicine | 884 | 400 | 819.25 | 3432.34 |
| Endocrinology | 10 | 2 | 114.25 | 23 |
| ENT | 113 | 43 | 1240 | 632 |
| Gastroenterology | 75 | 45 | 608.5 | 338 |
| General Medicine | 19 | 0 | 102.5 | 0 |
| General Surgery | 118 | 23 | 1231.5 | 263 |
| Haematology | 44 | 2 | 418 | 15 |
| Infectious Diseases | 86 | 0 | 712 | 0 |
| NCTR/Winter Wards | 121 | 0 | 960.5 | 0 |
| Neonatology | 11 | 3 | 113 | 27 |
| Neurology | 66 | 2 | 546 | 23 |
| Neurosurgery | 239 | 49 | 2153.25 | 511.5 |
| Obs & Gynae | 33 | 0 | 391.75 | 0 |
| Oncology | 23 | 8 | 278.5 | 92.5 |
| Oral and Maxillofacial Surgery | 60 | 0 | 500.75 | 0 |
| Paediatric Surgery | 59 | 0 | 460 | 0 |
| Plastic Surgery | 11 | 0 | 111 | 0 |
| Radiology | 7 | 0 | 62 | 0 |
| Renal Medicine | 4 | 0 | 38.5 | 0 |
| Respiratory Medicine | 15 | 8 | 186 | 85.5 |
| Rheumatology | 60 | 0 | 496 | 0 |
| Stroke | 46 | 14 | 369 | 104.5 |
| Trauma & Orthopaedics | 160 | 6 | 1178.76 | 69 |

| | | | | |
|---|---|---|---|---|
| Upper GI Surgery | 21 | 0 | 173.5 | 0 |
| Urology | 28 | 1 | 238 | 12 |
| Vascular Surgery | 13 | 0 | 68.5 | 0 |
| **Total** | **3519** | **618** | **22168.26** | **5759.84** |

| Locum Bookings (Agency) by Reason | | | | |
|---|---|---|---|---|
| **Reason** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| Additional Resource | 571 | 6 | 1301.25 | 63 |
| Annual leave | 43 | 34 | 336 | 262 |
| Compassionate Leave and Special Leave | 13 | 2 | 87.5 | 23 |
| Sickness | 505 | 30 | 2829.5 | 344 |
| Maternity/Paternity Leave | 23 | 3 | 75.5 | 33 |
| Study Leave | 0 | 0 | 0 | 0 |
| Vacancy | 2363 | 543 | 17536.51 | 5034.84 |
| Crem Fees | 1 | 0 | 2 | 0 |
| **Total** | **3519** | **618** | **22168.26** | **5759.84** |

| Base Specialty | Grade | Number of hours worked | Number of hours rostered per week | Opted out of WTD |
|---|---|---|---|---|
| Anaesthetics | F2 | 191 | 44:15 | Yes |
| Anaesthetics | F2 | 168 | 46:30 | No |
| Anaesthetics | ST3 | 131.5 | 46:30 | Yes |
| General Practice | ST3 | 129.5 | 40:00 | Yes |
| Haematology | ST3+ | 128 | 42:45 | Yes |
| Trauma and Orthopaedics | ST3+ | 126 | 47:45 | Yes |
| Haematology | ST3+ | 112 | 34:45 | Yes |
| Elderly Medicine | F1 | 111.5 | 46:00 | No |
| Neurosurgery | ST3+ | 104.5 | 46:45 | Yes |
| Acute Medicine | ST3+ | 101.5 | 44:00 | No |

| Dr Awarded | GoSW Awarded | Total Fine | Date Fine Issued | Grade | Specialty | Breach |
|---|---|---|---|---|---|---|
| £614.44 | £1,023.82 | £1,638.26 | 19/03/2024 | ST4 | General Surgery (Upper GI) | 8 hours rest in 24 hour period |
| £614.44 | £1,023.82 | £1,638.26 | 19/03/2024 | ST3 | Paediatric Surgery | 8 hours rest in 24 hour period<br>5 hours continuous rest |
| £614.44 | £1,023.82 | £1,638.26 | 19/03/2024 | ST3 | Plastic Surgery | 8 hours rest in 24 hour period<br>5 hours continuous rest |
| £8.16 | £13.60 | £21.76 | 19/03/2024 | CT1 | Medical Oncology | 13 hour shift length |

# Guardian of Safe Working Quarterly Report

**Dr Liz Evans**
**Guardian of Safe Working**
**1st April 2024**



Kindness · Courage · Respect

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## 1. Executive Summary

Exception reports for the quarter 1st January 2024 to 31st March 2024 saw an increase from 40 to 81 exception reports. The majority of the exception reports submitted were in connection with working hours, with a smaller number submitted around service support, educational opportunities and work patterns, which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant divisions/directorates.

There is still work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared.

Once refresher training has been carried out for the Educational Supervisors, the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce.

Current numbers of Doctors in Training within NLaG is as follows:

| | |
|---|---|
| Number of Training Posts (WTE) | 317.98 |
| Number of Doctors/Dentists in Training (WTE) | 315.44 |
| Number of Less than full time (LTFT) Trainees (Headcount) | 52 |
| Number of Training post vacancies (WTE) | 2.52 |

Source Finance data

During the period of this quarterly report (1st January 2024 to 31st March 2024) there have been a total of 87 exception reports submitted through the allocate exception reporting system.

This showed an increase of 47 reports from the last quarter (1st October 2023 to 31st December 2023).

Of the 87 exception reports submitted, 61 were linked to hours. This showed an increase of 33 reports from the previous quarter.

The exception reports for this quarter relating to hours have been compensated by the Guardian of Safe Working (GoSW) for either payment or time off in lieu (TOIL). They

have mostly been closed successfully. The amount of TOIL granted has increased as a proportion- this is in line with our policy of providing TOIL rather than payment to try to reduce burnout and fatigue.

The below table is a breakdown of the exception reports over the last quarter (January -March 2024)

| Exception Reports Open (ER) between 1st January 2024 – 31st March 2024 | |
|---|---|
| Total number of exception reports received | 87 |
| Number relating to hours of work | 61 |
| Number relating to pattern of work | 2 |
| Number relating to educational opportunities | 7 |
| Number relating to service support available to the Doctor | 17 |
| Number initially relating to immediate patient safety concerns | 1 |

*Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support have the option of specifying whether the report constitutes an immediate safety concerns (ISC). ISC is not an exception by itself.

| Exception Report Outcomes (ER) between 1st January 2024 and 31st March 2024 | |
|---|---|
| Total number of exception reports resolved as at 31/03/24* | 69 |
| Total number of exception reports unresolved as at 31/03/24** | 23 |
| Total number of exception reports where TOIL was granted | 37 |
| Total number of exception reports where overtime was paid | 17 |
| Total number of exception reports resulting in a work schedule review | 1 |
| Total number of exception reports resulting in no further action | 14 |
| Total number of exception reports resulting in fines | 0 |

"Note:

* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.

* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.

* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded. This may also be because a work schedule review is pending.

**2. Immediate Safety Concerns**

During this quarter there was 1 exception report submitted where a Doctor raised an immediate safety concern in addition to a concern around working hours and clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

This quarter there was only one Immediate Safety Concern, however it turned out to have been created in error so no further action was taken.

**Work Schedule Reviews**

During this quarter there were three work schedule reviews required. One of these has been closed following review, with some support structures put in place. The other two remain open at the time of writing.

## 3. Trend in Exception Reporting

There has been a significant increase in exception reporting this quarter. This is partially to be expected, as there is usually a significant increase in the number of reports at this time of year. It is reassuring to see that despite the number or reports the ratio of Immediate Safety Concerns to exception reports remains low. This Provides evidence that they system is embedded correctly and is being used appropriately. The number of reports for excess hours outstrips the other reasons for exception reporting, which is a consistent finding throughout the year. Improved engagement with the doctors during induction has embedded a culture of exception reporting among the doctors in training, particularly at a foundation level..

## 4. Fines Levied against Departments this quarter

There have been no fines this quarter.

## 5. Communication and Engagement

Work continues regarding communication and engagement with our Doctors in Training.

The Junior Doctors Forum has been up and running now for several years, has formal terms of reference, agenda and notes. Work to improve engagement and attendance at the forum is ongoing. The time of the JDF is re-discussed at the first JDF of the new academic year to confirm that this time is convenient for the Doctors in Training, and a survey sent out to the doctors to ensure that the time is appropriate.

The Guardian of Safe Working runs a drop-in session to allow for face to face contact with the Doctors in Training. This is usually run by the guardian of safe working, but several times a year is a joint session with PGME or the Freedom to Speak Up Guardian. There is also a joint drop in session in the canteen run by both the Guardian of Safe Working and the Freedom to Speak up Guardian to raise awareness of the role and to promote the culture of open reporting, the most recent of which took place in Grimsby on the 5th of December. A range of information including the fatigue charter and information on the junior doctors contract is available at this session, which is run in both Scunthorpe and Grimsby.

In addition there is a regular quarterly newsletter which is circulated via e-mail. Information pertaining to the guardians office is available on the HUB, and there is a leaflet which is provided to all doctors in training on joining the trust containing details of the support available. There is also now a regular meeting between the Guardian of Safe Working, the Freedom to Speak up Guardian, and a representative of PGME. This enables the support mechanism for Doctors in Training to establish any common themes and co-ordinate an approach to finding solutions. An exit survey for doctors leaving the

trust has been circulated, with good response. Finally a screen saver has been implemented across the trust to remind the Doctors in Training of the exception reporting system. A project to put up posters clarifying the procedure for reporting has been started in conjunction with one of the BMA reps.

## 6. Support for the Guardian Role

There is a dedicated administrative resource for the Guardian of Safe Working which sits within the Chief Medical Officers Directorate.

The Trust's Guardian of Safe Working, Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW, commenced in this role in June 2021.

## 7. Key Issues and Summary

Exception reporting during this quarter demonstrated an increase compared with the previous quarter. This is what we would expect for this time of year, although the numbers involved are quite high. There have been no appropriate immediate safety concerns, which is reassuring. Concerns raised have been escalated appropriately and actions taken to prevent recurrence where appropriate.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise. We will ensure that we continue with this work, as it provides real-time information about the situation on the wards, in addition to being a contractual obligation.

Engagement of the Educational Supervisors still remains an issue which needs improvement- this will ensure a timely response to exception reports, in addition to providing improved support to the doctors in training, and contributing to our efforts to make the training experience at NLaG a positive one.

**Dr Liz Evans -** Guardian of Safe Working

Date: 1st April 2024

**Trust Boards-in-Common Front Sheet**

**Agenda Item No: BIC(24)121**

| **Name of the Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | Ivan McConnell, Group Chief Strategy & Partnerships Officer |
| **Contact Officer/Author** | Adam Creegan, Group Director of Performance |
| **Title of the Report** | Integrated Performance Report |
| **Executive Summary** | This report provides details of performance achieved against key national performance, quality and governance indicators defined in the NHSE Single Oversight Framework (SOF) |
| **Background Information and/or Supporting Document(s)** (if applicable) | |
| **Prior Approval Process** | Presented to the Performance, Estates and Finance Committees-in-Common, Workforce, Education & Culture Committees-in-Common and Quality & Safety Committees-in-Common May 2024 |
| **Financial implication(s)** (if applicable) | The report covers a number of metrics that relate to financial performance inclusive of Elective Recovery Fund activity versus published plan |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | |
| **Recommended action(s) required** | ☐ Approval ✓ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below:<br><br>The Trust Board are asked to note the report |

**Group Performance Report**
**April 2024 Month 1 Position**

## 1. Purpose of Report

This report provides an overview of the Group's performance across a range of metrics with specific detail in relation to each individual Trust.

## 2. Performance Comparison

A comparison of key areas of note is provided below (March 2024 position unless otherwise stated).

| Domain | HUTH Performance | NLaG Performance | Commentary |
|---|---|---|---|
| ED 4 hour threshold (76% March 2024) | 64.1% | 66.4% | HUTH data now includes Type 1 HRI and Type 3 UTC activity. The Bransholme and ERCH Type 3 activity is excluded. |
| Ambulance Handover delays (60+ mins) | 975 | 628 | HUTH - There were 975 waits over 60 minutes reported in March 2024, which equated to 26.6% - a slightly improved position.<br>NLaG – Improved position compared to February 2024. 45 minute ambulance handover zero tolerance protocol/pathway in place. |
| Long waits<br>- 104 weeks<br>- 78 weeks<br>- 65 weeks<br>- 52 weeks | <br>0<br>8<br>69<br>2009 | <br>0<br>0<br>28<br>839 | HUTH - 8 x breaches of the 78-week target, against a forecast position 9, with the majority of the breaches (7) in gynaecology and 1 in Rheumatology. The Trust is consistently under the +52-week trajectory of 5,101 patients.<br><br>NLaG - 15 patients above the Operating Plan Trajectory of 13. Number of patients exceeding 52 weeks treatment time continues to increase.<br><br>National requirement to clear all 65 week waits moved from March 2024 to end of September 2024. |
| Cancer<br>- 62 day referral (85%) | Feb 2024<br>58.9% | Mar 2024<br>71.1% | HUTH - February 2024 performance is 58.9%, an improvement when compared to January 2024 at 52%; the operational plan delivery target is 70%. Issues for the decline include Breast Surgeon illness, thoracic capacity, radiotherapy backlog, late IPT's and industrial action. With the investment provided, HUTH has committed to achieving 65% by 31 March 2024.<br><br>NLaG - Significant improvement with indicative performance (unvalidated) in March showing achievement of the revised standard at 71.1%, against the published figure for February of 52.45%. |

| Domain | HUTH Performance | NLaG Performance | Commentary |
|---|---|---|---|
| Cancer<br>- 63+ days | Mar 2024<br>180 | | HUTH - At the end of March 2024 the number of patients +63 days was 180, compared to 228 at the end of February 2024, an improving position against the trajectory of 148 for the end of March 2024. The Trust under-achieved the target by 32 patients, however this represents a reduction of 200 patients from September 2023. |
| Cancer<br>- Faster Diagnosis (28 days) standard | Feb 2024<br>81.7% | Mar 2024<br>72.5% | HUTH - The Faster Diagnosis Standard (combined) February 2024 achieved the 75% target (HUTH plan 78%) with performance of 81.7%. The planning guidance required delivery of the 75% standard by March 2024, with HUTH committing to a stretch target of 80% with additional financial support; provisional performance is currently 82.8%.<br><br>NLaG – Deterioration on previous month's performance of 78.8%. NLaG now placed in Tiering system, predominantly as a result of FDS performance. |

### 3. Recommendation

The Performance, Estates and Finance Committee in Common is asked to note the contents of this report, including the detailed summaries for each Trust attached as appendices.

Shaun Stacey
Group Chief Delivery Officer

Ivan McConnell
Group Chief Strategy and Partnerships Officer

May 2024

# Integrated Performance Report

## MONTH 1: April 2024 Performance

March 2024 for Cancer data
Produced May 2024

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# 1. Executive Summary

This report provides an overview of the Group's performance across a range of metrics with specific detail in relation to each individual Trust.

<table>
<tr><th>Domain</th><th>HUTH Performance</th><th>NLAG Performance</th><th>Commentary</th></tr>
<tr><td>ED: 4 hour standard<br>(Type 1 & 3)<br>78% by March 2025</td><td>59.7%<br><br>Footprint (incl. Bransholme & ERCH)<br>77.5%</td><td>73.8%<br><br>Footprint (incl. Goole UTC)<br><br>76.9%</td><td>• Type 1 performance continues to deteriorate over the quarter at HUTH despite a reduction in attendances in attendance volumes in April. National ranking is 137 of 142 in April, a decline from 128 of 142 in March.<br>• NLaG moved from the lower quartile nationally into the interquartile range and national ranking increased from 113 in March to 66 of 142 in April. Attendances remain static and within the expected range.<br>• Progress to align workforce to intraday demand profile is underway.</td></tr>
<tr><td>RTT Long Waits<br>• 104 weeks<br>• 78 weeks<br>• 65 weeks<br>• 52 weeks</td><td><br>0<br>10<br>45<br>1,850</td><td><br>0<br>0<br>29<br>778</td><td>• Continued progress in reducing the long waits on both Trust's PTLs.<br>• Increased oversight and scrutiny of reported breaches across both Trusts via revised Group governance</td></tr>
<tr><td>Diagnostic 6w Performance</td><td>23.4%</td><td>14.9%</td><td>• Revised governance in place – Group level RTT Delivery Group (tactical) with Exec oversight via Planned Care Board<br>• Both HUTH and NLaG benchmark positively with NLAG being close to the lower quartile (low being better). Both Trust have shown significant improvements since September 2023; HUTH has improved from 40% (currently 23.4%) and NLAG improved from 37% (currently 14.9%).</td></tr>
<tr><td>Cancer 62 day Performance</td><td>March 2024<br>63.2%</td><td>March 2024<br>70.5%</td><td>• Revised governance in place – Group level RTT Delivery Group (tactical) with Exec oversight via Planned Care Board providing support & challenge to Care Groups with tumour sites to develop and deliver robust Faster Diagnosis Standard sustainability plans to be presented 23/05/24<br>• Revised Cancer Improvement Programme in development; priorities & resources to be confirmed by 31 May 2024 – focus on diagnostic access and turnaround, time the decision to treat and histology delays.<br>• +63 day backlog reviews implemented across the Group</td></tr>
</table>

# 2. Pathway Summary – Benchmark Report – Elective Care

## HUTH

| Indicator | Period | Target | | SPC | Last 12 Months | Centile |
|---|---|---|---|---|---|---|
| RTT 52 Week Breach | Mar 24 | 0 | 1,972 | | | 36 |
| RTT 65 Week Breach | Mar 24 | - | 69 | | | 53 |
| RTT 78 Week Breach | Mar 24 | 0 | 8 | | | 40 |
| RTT 95th Percentile Admitted Waiting Time | Mar 24 | 18.0 | 67.6 | | | 55 |
| RTT 95th Percentile Non-Admitted Waiting Time | Mar 24 | 18.0 | 50.5 | | | 58 |
| RTT Admitted Treatment Within 18 Weeks | Mar 24 | 90.0% | 54.4% | | | 52 |
| RTT Average (Median) Admitted Waiting Time | Mar 24 | 9.0 | 14.0 | | | 62 |
| RTT Average (Median) Non-Admitted Waiting Time | Mar 24 | 5.0 | 6.2 | | | 83 |
| RTT Average Wait for Incomplete | Mar 24 | 7.00 | 14.0 | | | 56 |
| RTT Incomplete 18 Week Standard | Mar 24 | 92.00% | 59.3% | | | 53 |
| RTT Incomplete 92nd Percentile | Mar 24 | - | 42.1 | | | 54 |
| RTT Incomplete Pathways With a DTA | Mar 24 | 25.0% | 17.8% | | | 33 |
| RTT Non-Admitted Treatment Within 18 Weeks | Mar 24 | 95.0% | 71.7% | | | 69 |
| RTT Total Clock Starts | Mar 24 | - | 18,853 | | | 90 |
| RTT Total Clock Stops | Mar 24 | - | 16,953 | | | 91 |
| RTT Total Incompletes | Mar 24 | - | 73,820 | | | 18 |

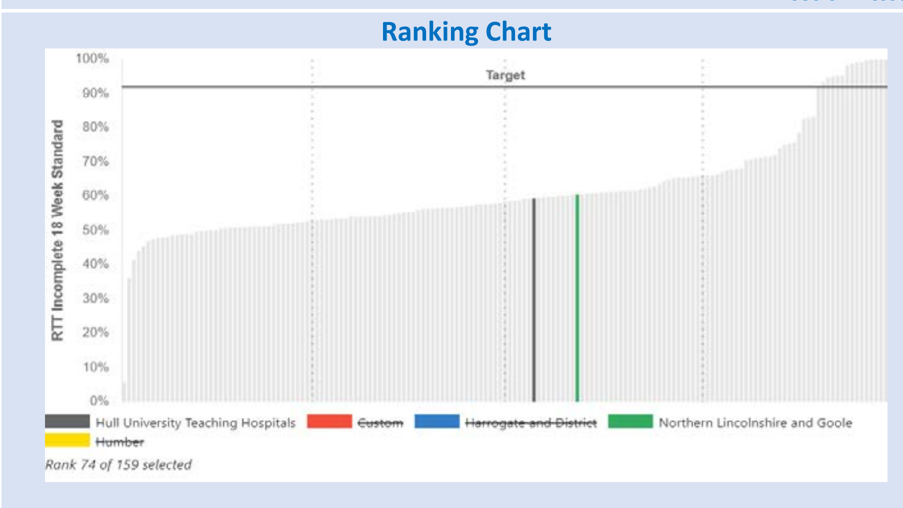
## NLAG

| Indicator | Period | Target | | SPC | Last 12 Months | Centile |
|---|---|---|---|---|---|---|
| RTT 52 Week Breach | Mar 24 | 0 | 783 | | | 57 |
| RTT 65 Week Breach | Mar 24 | - | 29 | | | 61 |
| RTT 78 Week Breach | Mar 24 | 0 | 3 | | | 52 |
| RTT 95th Percentile Admitted Waiting Time | Mar 24 | 18.0 | 62.6 | | | 67 |
| RTT 95th Percentile Non-Admitted Waiting Time | Mar 24 | 18.0 | 51.1 | | | 54 |
| RTT Admitted Treatment Within 18 Weeks | Mar 24 | 90.0% | 54.9% | | | 54 |
| RTT Average (Median) Admitted Waiting Time | Mar 24 | 9.0 | 14.3 | | | 59 |
| RTT Average (Median) Non-Admitted Waiting Time | Mar 24 | 5.0 | 8.1 | | | 57 |
| RTT Average Wait for Incomplete | Mar 24 | 7.00 | 13.3 | | | 59 |
| RTT Incomplete 18 Week Standard | Mar 24 | 92.00% | 60.4% | | | 59 |
| RTT Incomplete 92nd Percentile | Mar 24 | - | 39.8 | | | 70 |
| RTT Incomplete Pathways With a DTA | Mar 24 | 25.0% | 14.0% | | | 53 |
| RTT Non-Admitted Treatment Within 18 Weeks | Mar 24 | 95.0% | 67.5% | | | 57 |
| RTT Total Clock Starts | Mar 24 | - | 9,960 | | | 58 |
| RTT Total Clock Stops | Mar 24 | - | 6,848 | | | 49 |
| RTT Total Incompletes | Mar 24 | - | 44,270 | | | 41 |

## 3. Pathway Trending – Elective Care

### RTT – Incomplete Standard

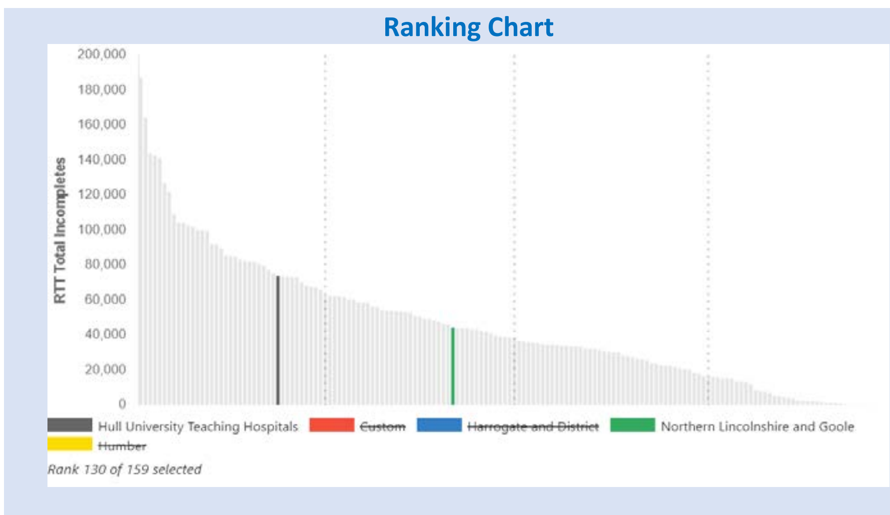
**Ranking Chart**



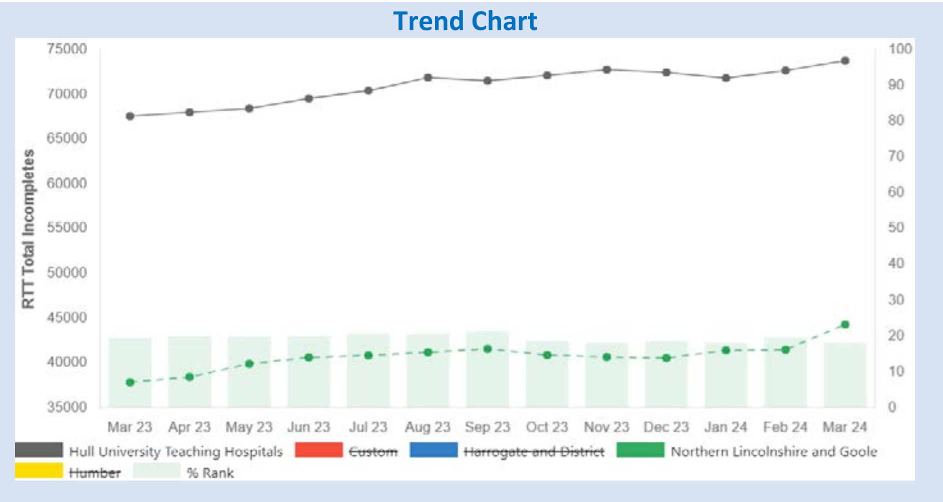

**Trend Chart**

### RTT – Total Waiting List Volume

**Ranking Chart**

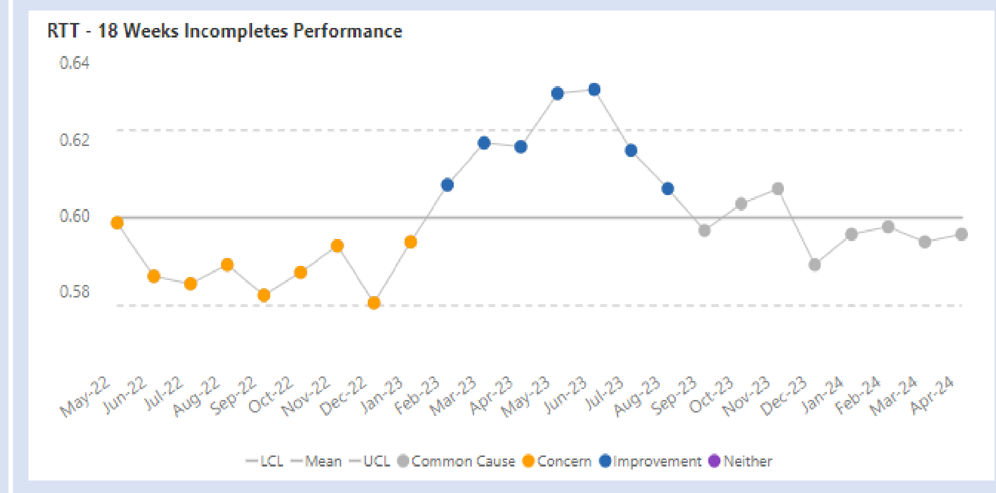



**Trend Chart**



## 4. Referral to Treatment - HUTH

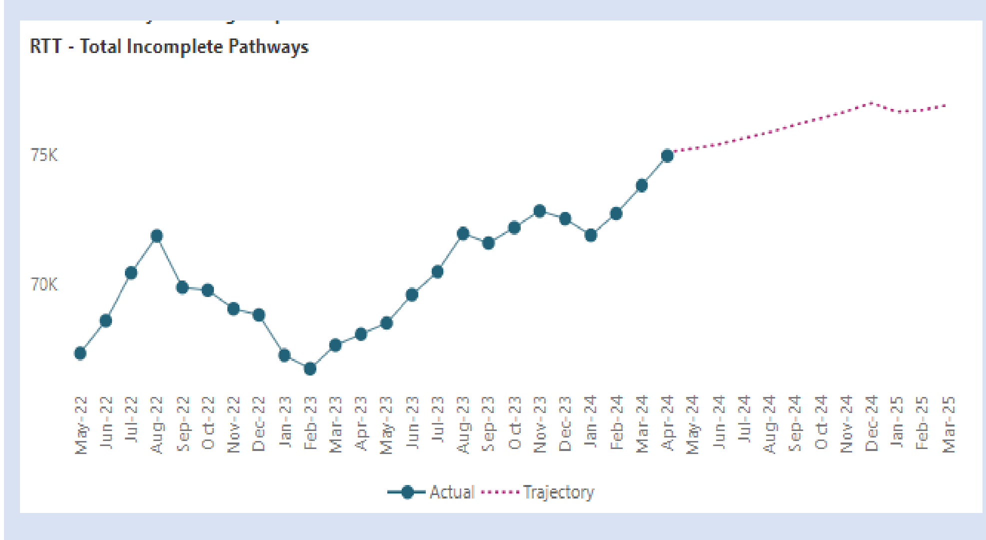
**Compliance**




**Key Themes**

- April performance of 59.5% is a marginal improvement on March.
- 61% of patients on the PTL are awaiting a first seen appointment with large volumes in ENT, Ophthalmology, Dermatology, Cardiology and Neurology
- Average wait for incomplete pathway is 14 weeks against a standard of 7 and is currently rising.
- Increasing waiting list volume with a current increase of 7.4% in referral rate.
- Operational plan has been updated to include no further increase in waiting list volume.

**Critical Enabler**



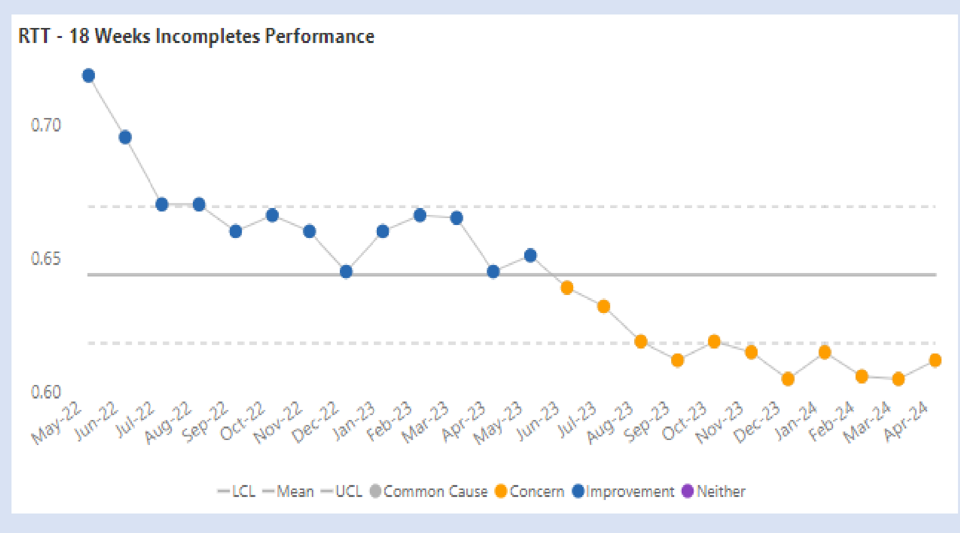

**Actions**

Critical actions being progressed through RTT Delivery Group:

- Ensure all patients who will be a 65weeks by the end of September have a first seen appointment by end of June 2024:
  - 364 x undated – 213 of which in Rheumatology with capacity to date all
- Increase first outpatient activity to restore 19/20 baseline. Where 19/20 baseline is being achieve Care Groups have identified additional activity schemes over and above the 24/25 operational plan to achieve additional Elective Recovery Funds income
- Decrease waits for first outpatient activity >13 weeks.
- Reallocate follow up outpatient activity without a procedure.
- Working with ICB to implement a Single Point of Access Referral Management Service to reduce referral demand

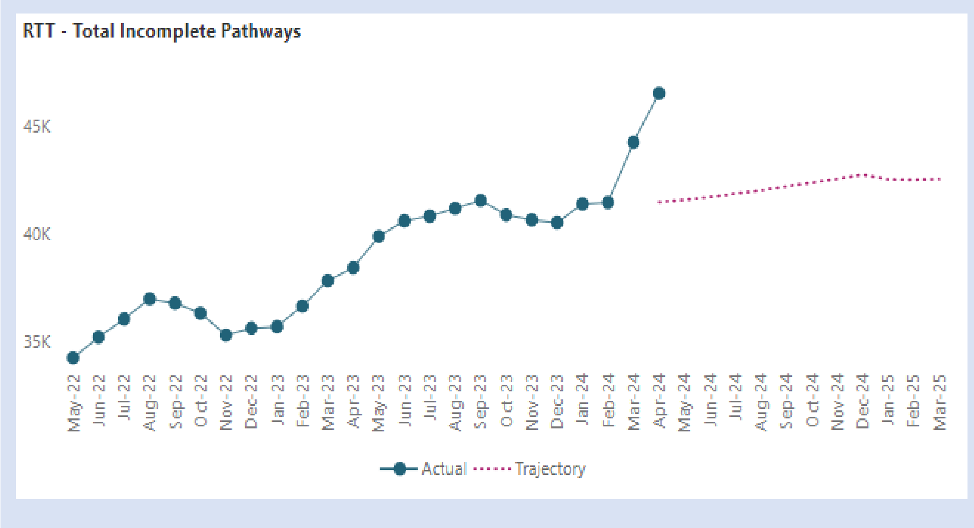
## 5. Referral to Treatment - NLAG

Compliance




### Key Themes

- April performance is 61.2% which is a marginal improvement on March. This is set against a deteriorating trend for the last 11 months.
- Data recording and validation backlogs post Lorenzo have driven increase in Patient Tracking List (PTL) from Feb.
- This is a predicted post deployment impact and resource plans are in place to transact all outstanding pathway events.
- Detailed review of all outstanding pathway events requiring admin transaction confirm that baseline PTL size will be restored by June data publication. The most significant cohort of outstanding validation/pathway transaction relates to patients attending having attended an outpatient clinic who require the clinic outcome to be updated.



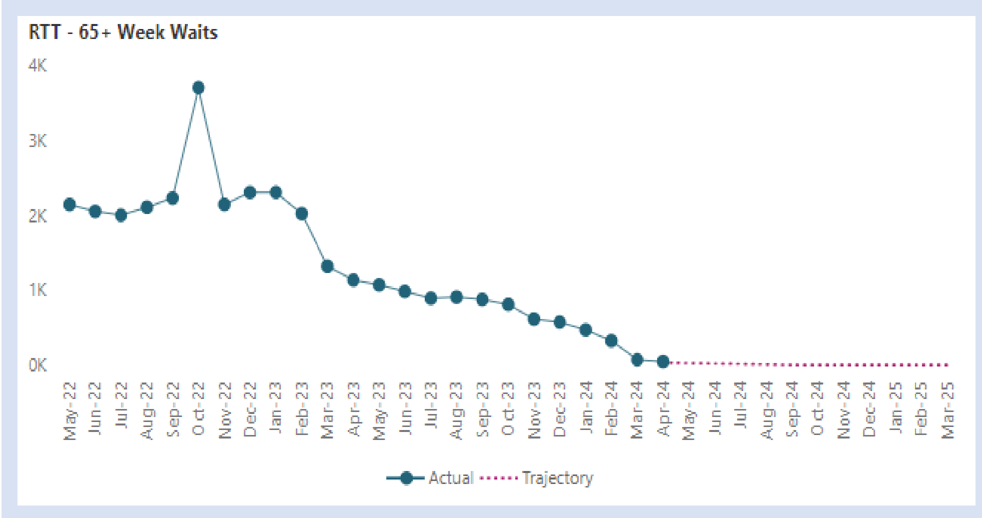

### Actions

Critical actions being progressed through RTT Delivery Group

- Ensure all patients who will be a 65w risk for end of September have a first appointment by end of June 2024
  - 55 x undated
- Increase first outpatient activity and decreased waits for first outpatient activity >13 weeks.
- Decrease follow up outpatient activity without a procedure.
- Care Groups to identify additional activity over and above the 24/25 operational plan to achieve additional Elective Recovery Funds
- Working with ICB to implement a Referral Management Service to reduce referral demand.
- Recruitment to 10 x validators underway to restore and stabilise the PTL. Further admin resourcing sourced via HUTH RTT team, medical records, etc.

## 6. Referral to Treatment – 65w Waits - HUTH

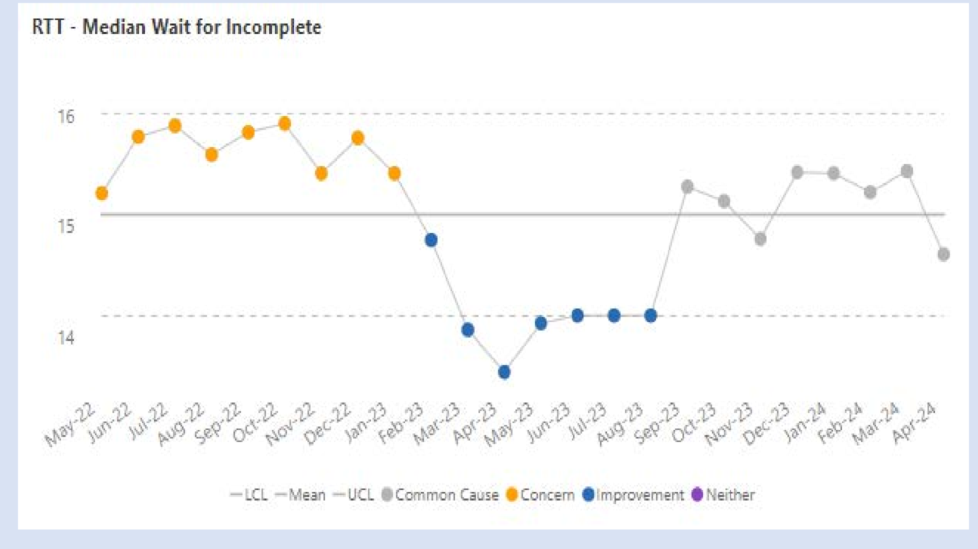
**Compliance**




**Key Themes**

- On plan position with 69 reported at the end of March (forecast of 70).
- Improved position end of April with 45 reported (forecast of 50).
- Forecast position for end of May of 30 (predominately Gynaecology).
- Specialty concerns
  - Gynaecology complex endometriosis
  - Plastic surgery complex hand.

**Critical Enabler**




**Actions**

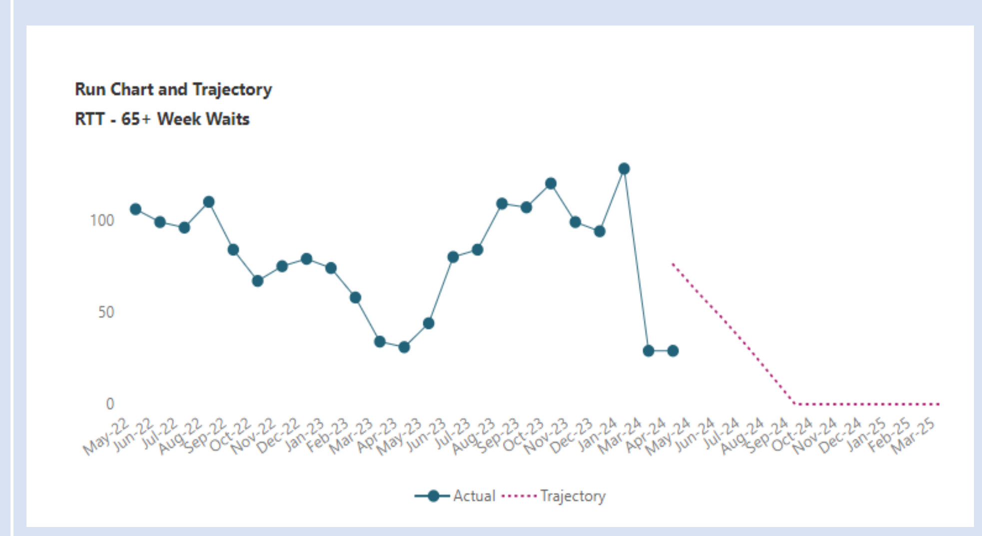
1. Elimination of 78w waits by end of June 2024
2. Elimination 65w waits by end of September 2024
3. Reduce 52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Continued focus at speciality level of patients dated and/or risks now focussed to eliminate the number of +65-week waits by the end of September 2024
- Weekly performance meetings in place with specialties
- Gynaecology mutual aid in place with NLAG to transfer complex endometriosis
- Additional weekend waiting list initiatives to create capacity in Plastic surgery
- Detailed plan to stabilise Ophthalmology given increase in PTL and future risk to 65 week delivery.

# 7. Referral to Treatment – 65w Waits - NLAG

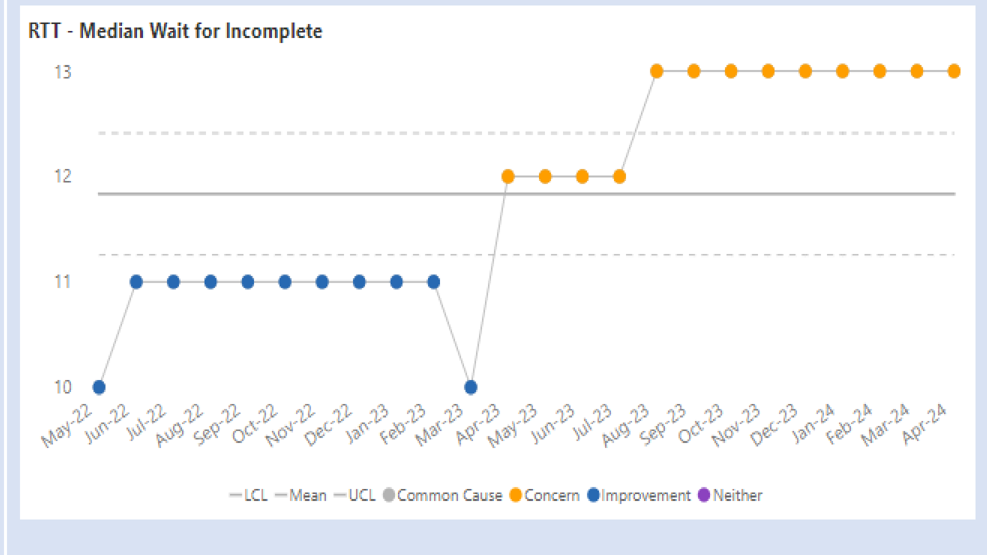
**Compliance**




## Key Themes

- Improvement in 65w waits with a reduction from 107 in February to 29 at the end of March.
- Static position at the end of April with 29 breaches reported.
- Deterioration in median waits from 10 weeks to 13 weeks (national standard 7 weeks) since March 2022 – noting this will reflect the admin backlog currently inflating the PTL
- April breaches were 47 cases ahead of the operational plan trajectory

**Critical Enabler**



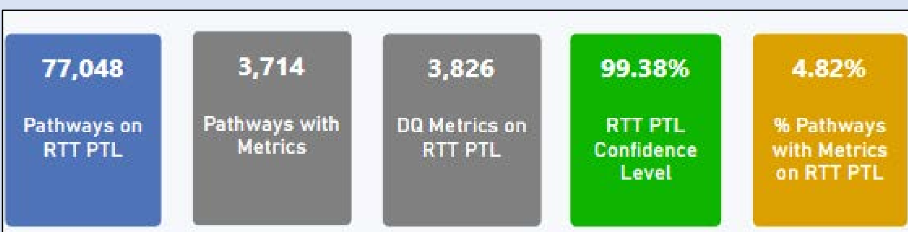

## Actions

Critical actions being delivered through the RTT Delivery Group

1. Clear 78w waits by end of June 2024
2. Clear 65w waits by end of September 2024
3. Reduce 52w waits by end of March 2025
   - Focus on those patients that will breach 65w by end of September to have a first seen appointment by end of June
   - Review of weekly meeting structure to provide increased oversight and scrutiny
   - RTT Insights Model to be implemented which will greatly assist operational teams in management and scrutiny of their PTL

# 8. Referral to Treatment – Data Quality - HUTH

**Compliance**



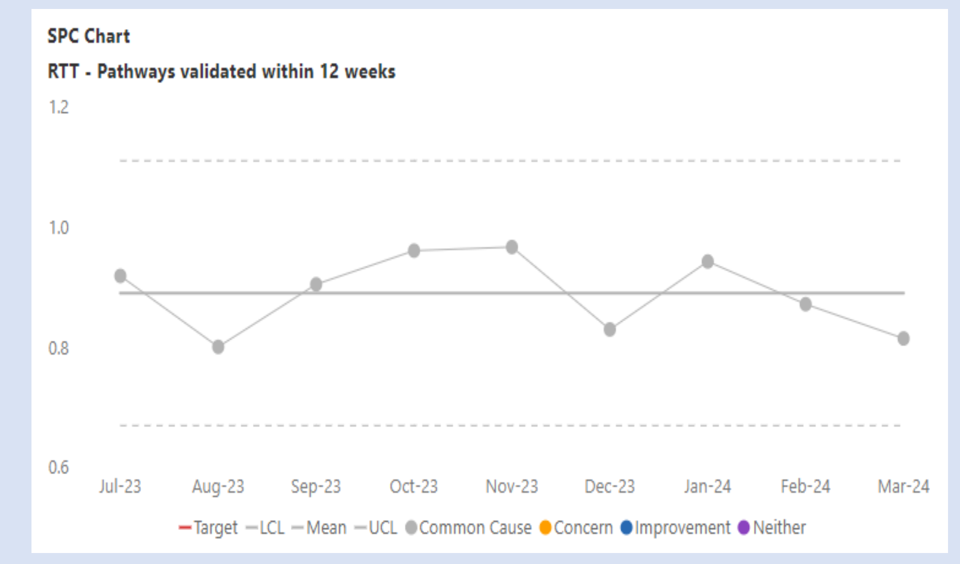

**Key Themes**

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

The Trust has oversight with systems and process in place to support timely validation, these are monitored by RTT BI data quality reports in conjunction with the LUNA system, with established escalation processes in place. LUNA is currently reporting that the Trust has a 99.38% confidence level for RTT PTL data quality.

For those pathways validated every 12 weeks there has been a slight drop in to 85% against a 90% standard.

**Critical Enabler**



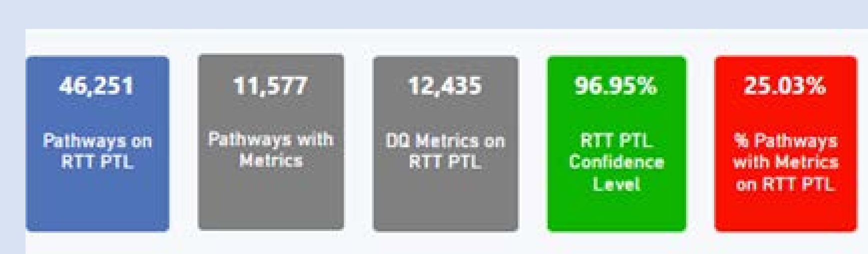

**Actions**

Critical actions to be taken:

- Business as usual process in place between the Performance and CAS teams
- BI data quality reports are used to monitor weekly and escalation processes are in place.
- Focus by CAS on ensuring the pathways over 12 weeks have an up-to-date validation comment

# 9. Referral to Treatment – Data Quality - NLAG

Compliance




**Key Themes**

- The internal 12week report reports validation at just under 50%.
- LUNA data quality is showing a 96.9% confidence rate but a significant number of pathways flagging as data quality issues – the majority in a status of 99 (RTT Status Unknown).
- This links to the admin delay in transacting pathway event post Lorenzo deployment

Critical Enabler

SPC Chart

RTT - Pathways validated within 12 weeks

0.52
0.50
0.48
Feb-24
Mar-24
Target LCL Mean UCL Common Cause Concern Improvement Neither

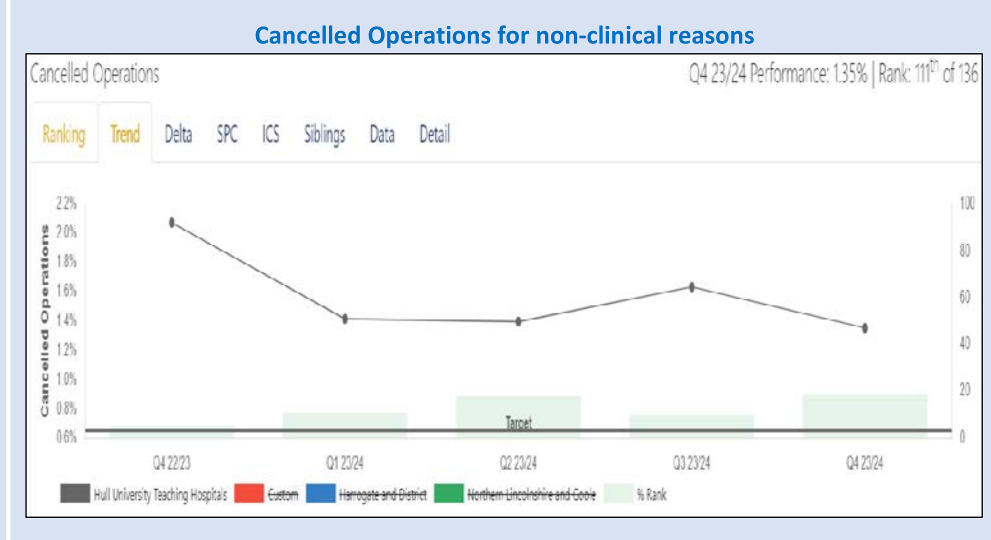
**Actions**

- Focus on improving up-to-date validation / tracking comments to ensure patients are being managed proactively on the Incomplete pathway.
- Information Team to check the Waiting List MDS submission to NHSE for the reporting anomaly externally.
- Information Team to review the mapping of status 99 (RTT Status Unknown).

## 10. Cancelled Operations - HUTH

Compliance

**Cancelled Operations for non-clinical reasons**

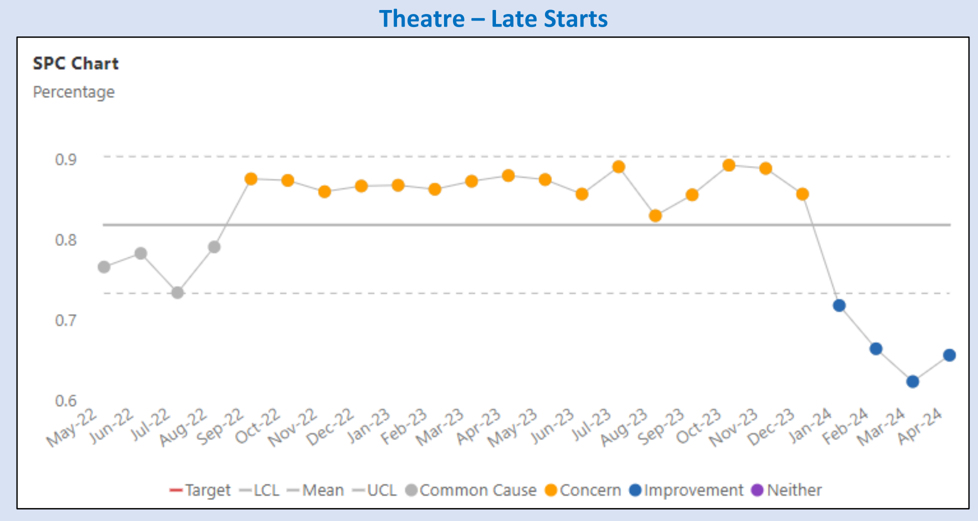



**Key Themes**

- HUTH sits at 1.35% of operations cancelled on the day for non-clinical reasons against a performance tolerance of 0.5%.
- In April there were 129 cancelled operations on the day for non-clinical reasons.
- Most of these reasons are recorded as "no bed" or "theatre list over-ran"
  - 30 x Vascular surgery
  - 21 x Interventional Radiology
  - 11 x T&O

Critical Enabler

**Theatre – Late Starts**




**Actions**

- Cancelled operations Standard Operating Procedure (SOP) has been reissue at Group level with the Operations Director for Theatres responsible for approving on the day cancellations
- Cancelled operations performance monitoring including 28 day re-bookings to reviewed weekly by Site Managing Director from May 2024
- Review of cancellations trends and themes escalated to the speciality / pre-assessment teams.
- Focus at operational meetings regarding beds required for elective procedures to take place with review of 7/5/2 day pre-op to commence in Orthopaedics and ENT.
- Progress with GIRFT actions for High Volume Low Complexity activity.

# 11. Cancelled Operations - NLAG

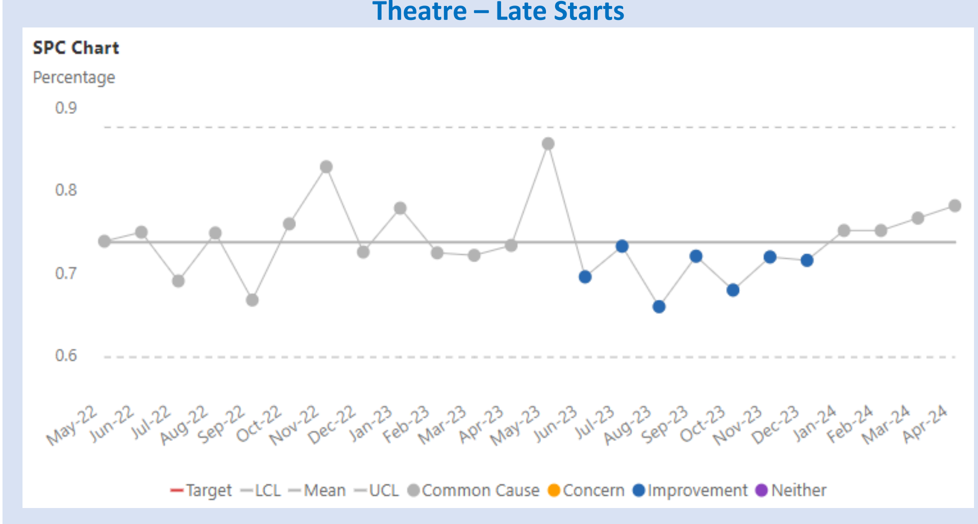
Compliance

### Cancelled Operations for non-clinical reasons

### Key Themes

- NLAG sits at 0.66% just above the 0.5% standard.
- Review of cancellations trends and themes show 11 out of 77 (14%) were due to non-clinical reasons:
    - 7 due to list over-runs,
    - 2 due to admin error,
    - 1 due to equipment/failure,
    - 1 due to no ward bed being available
    - 1 cancellation was due to the patient being an inpatient the day before the surgery.

### Theatre – Late Starts

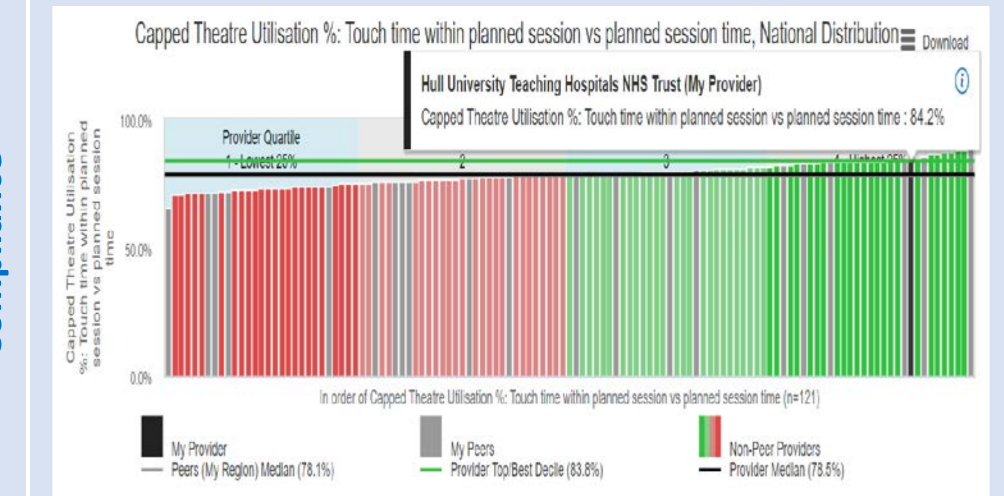



### Actions

- Enhanced BIU support to pull national data set and review/resolve all DQ errors.
- Additional daily scrutiny and feed back to specialities regarding capped utilisation and the additional minor patient to be added to all lists not delivering 85% utilisation.

## 12. Capped Theatre Utilisation - HUTH

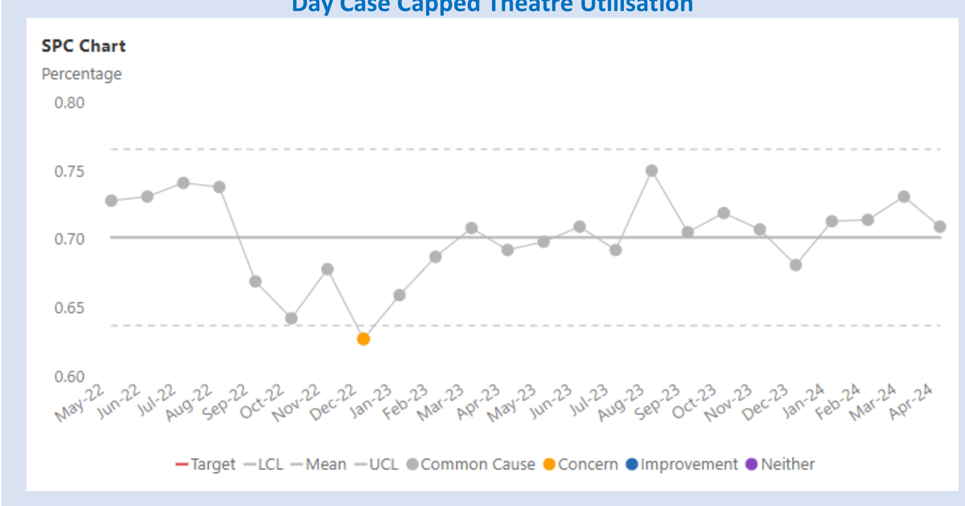
Compliance




**Key Themes**

- Improved capped theatre utilisation with latest Model Health data showing performance at 84.2% placing the Trust in the top quartile nationally.
- Day Case capped theatre utilisation is trending at 70% - improving this element of delivery is the critical enabler to improve beyond the 85% standard.

**Day Case Capped Theatre Utilisation**

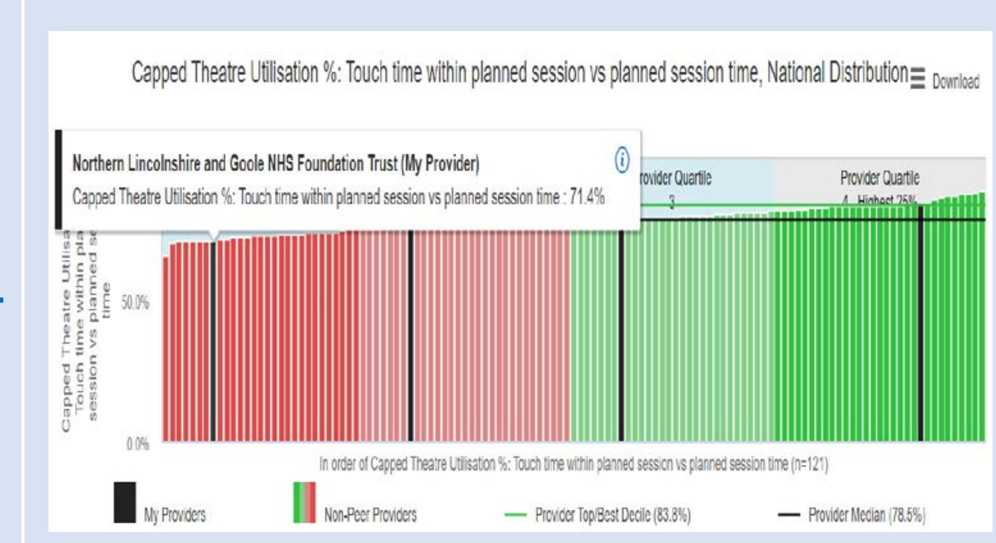



**Actions**

- Theatres Insights Model to be implemented – testing underway by the Information Team using HUTH data.
- Roll out commences in June and will proved the essential intelligence required to target theatres needing to improve recording of data and achieve the 85% standard
- Improve recording of day case touch points in ORMIS
- BI Theatre Data Quality dashboard in place which is managed daily by the Theatres, Anaesthetics and Critical Care Group

## 13. Capped Theatre Utilisation - NLAG

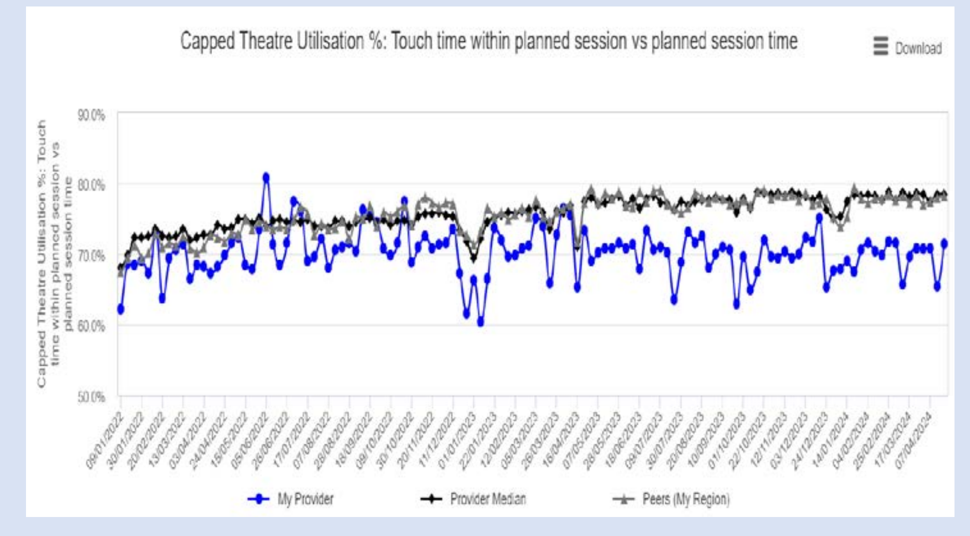
**Compliance**




### Key Themes

- In the lower quartile nationally at 71.4% on Model Hospital
- This relates to ongoing issues with data alignment to Model Hospital methodologies, with delay in rectification linked to redirection of all available analytical resource to activity reporting for income generation post InSource data warehouse deployment.

**Critical Enabler**




### Actions

- CAP meeting set up in May with all provider Theatre and Analytical leads. Purpose for Hull to feedback to other analysts on improvement work undertaken on data quality issues with the fortnightly submissions to Model Health and the methodologies applied.
- BI reporting being reviewed due to issues with how the theatre sessions are recorded on WebV, currently sessions are not differentiated between day case and elective theatres, which creates significant issues based on Model Hospital calculation methodologies.

# 14. Pathway Summary – Benchmark Report – Diagnostics

## HUTH

| Indicator | Period | Target | | SPC | Last 12 Months | Centile |
|---|---|---|---|---|---|---|
| Audiology | Mar 24 | 5.00% | 0.8% | | | 87 |
| Barium Enema | Mar 24 | 5.00% | - | | | - |
| Colonoscopy | Mar 24 | 5.00% | **38.9%** | | | 19 |
| Computed Tomography | Mar 24 | 5.00% | **14.1%** | | | 21 |
| Cystoscopy | Mar 24 | 5.00% | **37.0%** | | | 28 |
| DEXA Scan | Mar 24 | 5.00% | **77.0%** | | | 0 |
| DM01 Waiting <13 Weeks | Mar 24 | 100.00% | **90.6%** | | | 24 |
| Diagnostic activity levels - Audiology Assessments | Mar 24 | - | 475 | | | 57 |
| Diagnostic activity levels - Barium Enema | Mar 24 | - | 0 | | | 73 |
| Diagnostic activity levels - CT | Mar 24 | - | 6,226 | | | 71 |
| Diagnostic activity levels - Colonoscopy | Mar 24 | - | 326 | | | 50 |
| Diagnostic activity levels - Cystoscopy | Mar 24 | - | 543 | | | 95 |
| Diagnostic activity levels - Dexa Scan | Mar 24 | - | 543 | | | 90 |
| Diagnostic activity levels - Echocardiography | Mar 24 | - | 682 | | | 45 |
| Diagnostic activity levels - Endoscopy | Mar 24 | - | 1,541 | | | 78 |
| Diagnostic activity levels - Flexi Sigmoidoscopy | Mar 24 | - | 136 | | | 73 |
| Diagnostic activity levels - Gastroscopy | Mar 24 | - | 536 | | | 77 |
| Diagnostic activity levels - Imaging | Mar 24 | - | 14,823 | | | 72 |
| Diagnostic activity levels - Non Obstetric Ultrasound | Mar 24 | - | 4,828 | | | 66 |
| Diagnostic activity levels - Total | Mar 24 | - | 18,009 | | | 68 |
| Diagnostic activity levels - Urodynamics | Mar 24 | - | 49 | | | 76 |
| Diagnostics - 6 Week Standard | Mar 24 | 5.00% | **24.5%** | | | 30 |
| Diagnostics - 6 Week Standard Reversed | Mar 24 | 95.00% | **75.5%** | | | 30 |
| Echocardiography | Mar 24 | 5.00% | **26.1%** | | | 37 |
| Electrophysiology | Mar 24 | 5.00% | - | | | - |
| Gastroscopy | Mar 24 | 5.00% | **30.4%** | | | 28 |
| Magnetic Resonance Imaging | Mar 24 | 5.00% | 2.1% | | | 72 |
| Neurophysiology | Mar 24 | 5.00% | **9.8%** | | | 53 |
| Non-obstetric Ultrasound | Mar 24 | 5.00% | **7.2%** | | | 45 |
| Urodynamics | Mar 24 | 5.00% | **79.4%** | | | 7 |

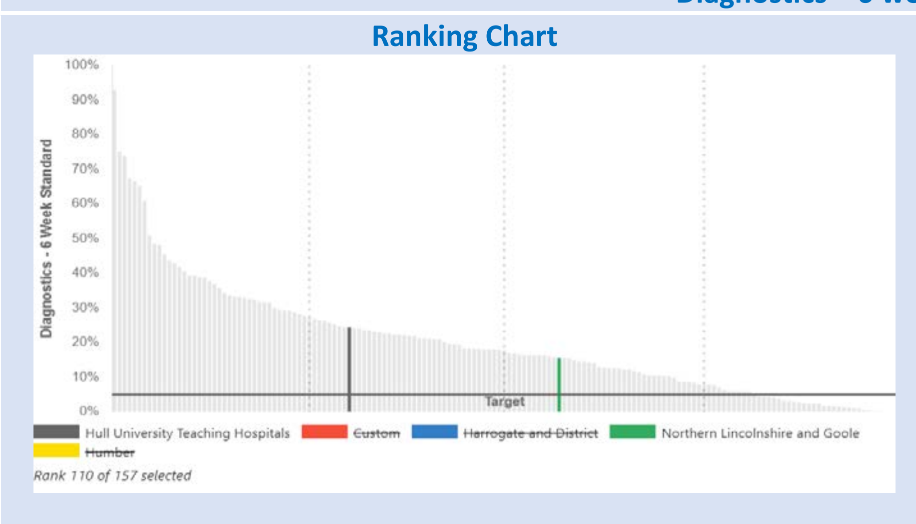
## NLAG

| Indicator | Period | Target | | SPC | Last 12 Months | Centile |
|---|---|---|---|---|---|---|
| Audiology | Mar 24 | 5.00% | **38.7%** | | | 36 |
| Colonoscopy | Mar 24 | 5.00% | **13.3%** | | | 47 |
| Computed Tomography | Mar 24 | 5.00% | **5.2%** | | | 44 |
| Cystoscopy | Mar 24 | 5.00% | **13.2%** | | | 63 |
| DEXA Scan | Mar 24 | 5.00% | **7.1%** | | | 34 |
| DM01 Waiting <13 Weeks | Mar 24 | 100.00% | **97.3%** | | | 49 |
| Diagnostic activity levels - Audiology Assessments | Mar 24 | - | 490 | | | 58 |
| Diagnostic activity levels - Barium Enema | Mar 24 | - | 0 | | | 73 |
| Diagnostic activity levels - CT | Mar 24 | - | 11,215 | | | 97 |
| Diagnostic activity levels - Colonoscopy | Mar 24 | - | 376 | | | 56 |
| Diagnostic activity levels - Cystoscopy | Mar 24 | - | 348 | | | 83 |
| Diagnostic activity levels - Dexa Scan | Mar 24 | - | 243 | | | 48 |
| Diagnostic activity levels - Echocardiography | Mar 24 | - | 999 | | | 63 |
| Diagnostic activity levels - Endoscopy | Mar 24 | - | 1,354 | | | 73 |
| Diagnostic activity levels - Flexi Sigmoidoscopy | Mar 24 | - | 140 | | | 75 |
| Diagnostic activity levels - Gastroscopy | Mar 24 | - | 490 | | | 72 |
| Diagnostic activity levels - Imaging | Mar 24 | - | 20,885 | | | 90 |
| Diagnostic activity levels - Non Obstetric Ultrasound | Mar 24 | - | 4,114 | | | 57 |
| Diagnostic activity levels - Total | Mar 24 | - | 24,052 | | | 89 |
| Diagnostic activity levels - Urodynamics | Mar 24 | - | 74 | | | 84 |
| Diagnostics - 6 Week Standard | Mar 24 | 5.00% | **15.5%** | | | 57 |
| Diagnostics - 6 Week Standard Reversed | Mar 24 | 95.00% | **84.5%** | | | 57 |
| Echocardiography | Mar 24 | 5.00% | **24.0%** | | | 41 |
| Gastroscopy | Mar 24 | 5.00% | **18.4%** | | | 44 |
| Magnetic Resonance Imaging | Mar 24 | 5.00% | **14.5%** | | | 36 |
| Neurophysiology | Mar 24 | 5.00% | **30.6%** | | | 35 |
| Non-obstetric Ultrasound | Mar 24 | 5.00% | **11.3%** | | | 36 |
| Urodynamics | Mar 24 | 5.00% | 4.3% | | | 83 |

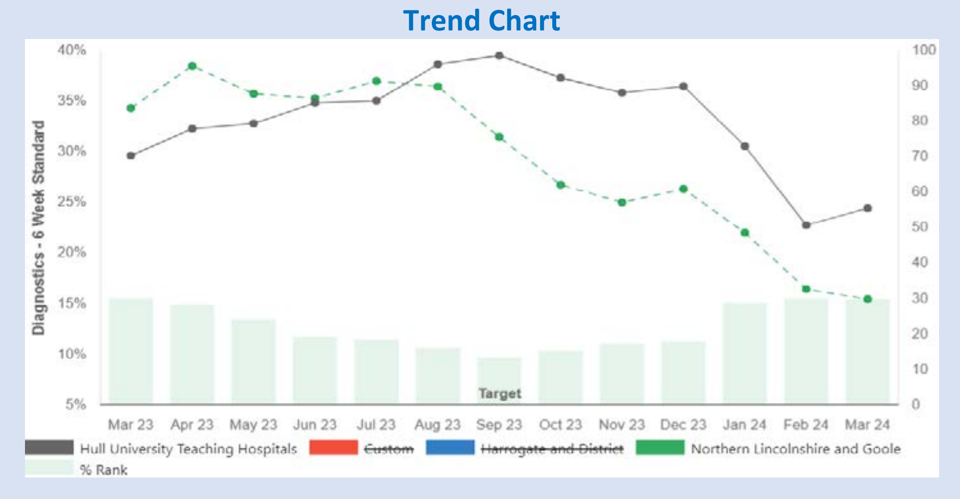
## 15. Pathway Trending – Diagnostics

### Diagnostics – 6 week Performance Standard

#### Ranking Chart

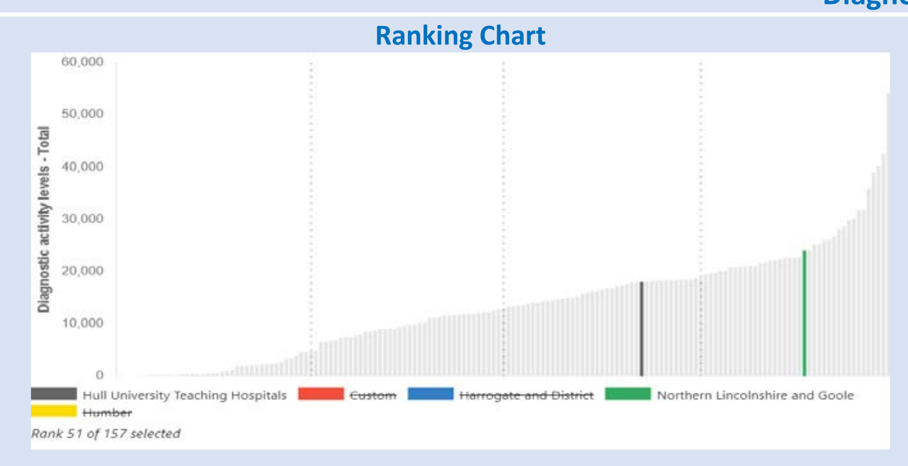



#### Trend Chart

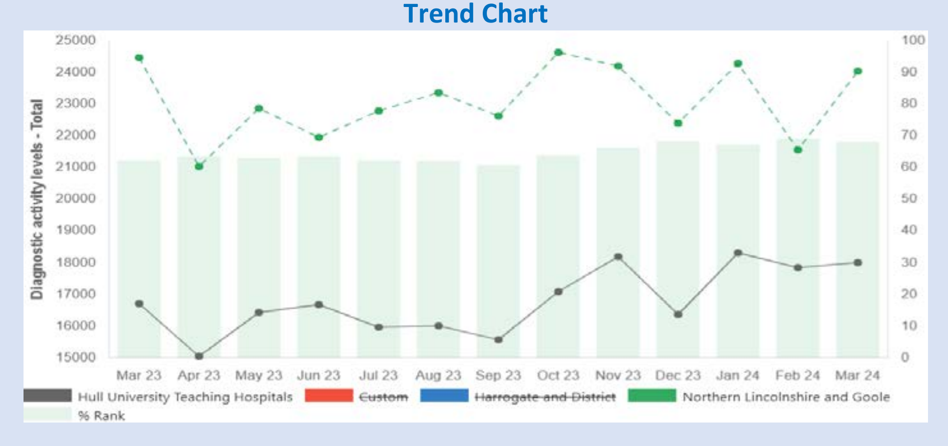



### Diagnostics – Activity

#### Ranking Chart

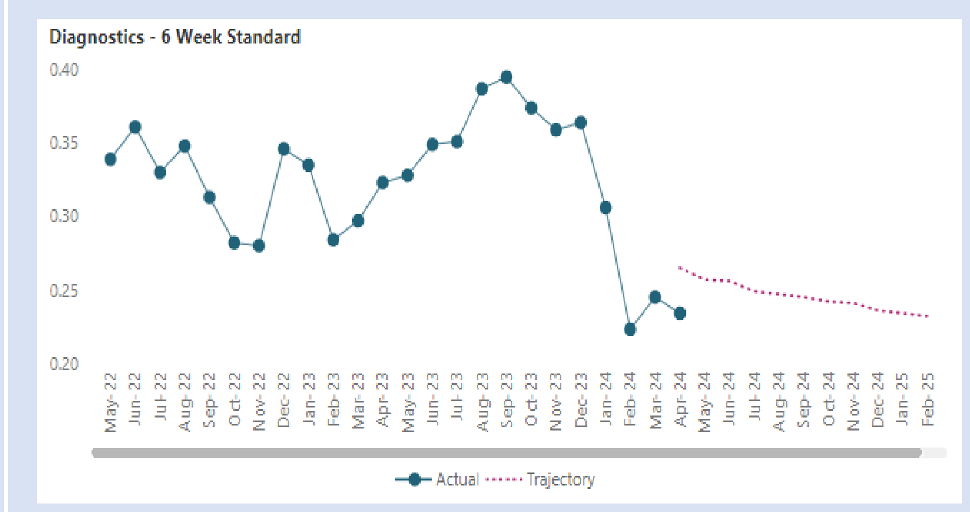



#### Trend Chart



## 16. Diagnostic 6 Week Standard - HUTH

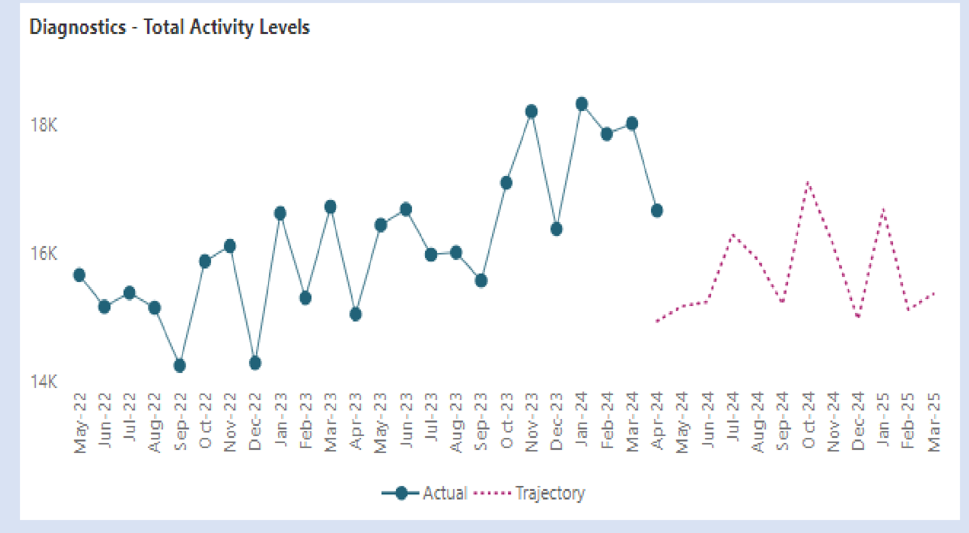
**Compliance**




**Key Themes**

- Critical objectives identified:
  - Most modalities at HUTH are improving and have increased activity levels over 23/24, driving improved performance over the quarter.
  - DEXA is however a national outlier with Trust compliance being the third worst in the country
  - There is significant variation in compliance at HUTH versus NLAG, driving a need to equalise waits within the Group

**Critical Enabler**

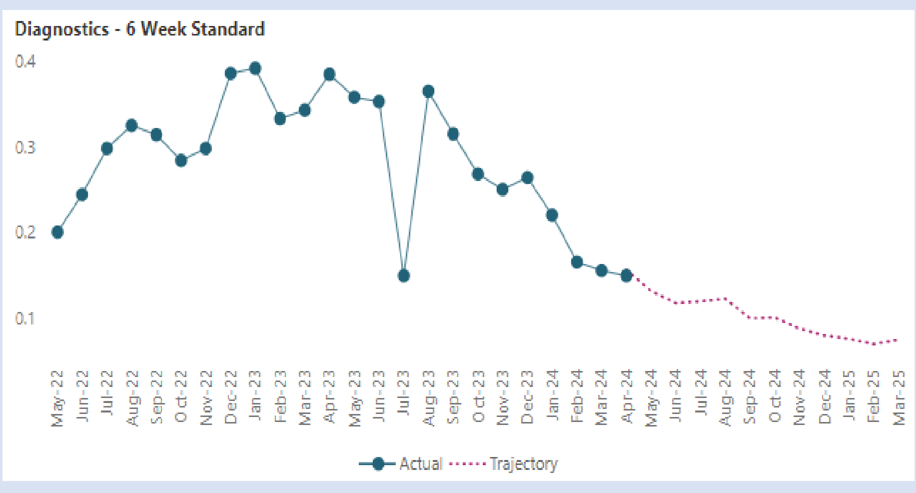



**Actions**

- Critical actions in place:
  - Services developing improvement plans to create additional diagnostic activity levels and utilise mutual aid opportunities across the Group.
- Dedicated investment case submitted to address DEXA waiting list backlog via increased throughput and testing volume capacity.

## 17. Diagnostic 6 Week Standard - NLAG

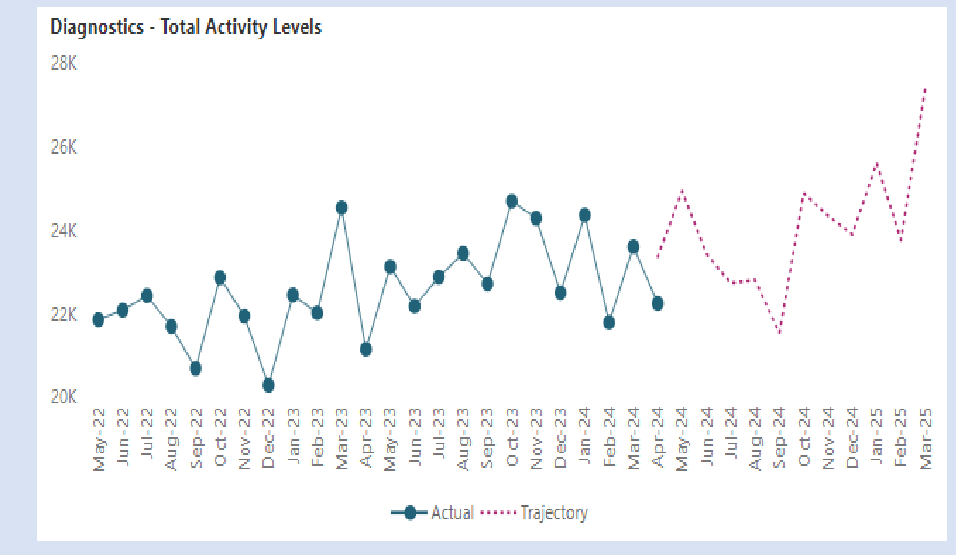
**Compliance**




### Key Themes

- Diagnostic activity levels in most modalities decreasing at NLAG – offset by an increase in imaging link to mobile scanners
- Performance continues to improve through increased activity levels in imaging.
- Main pressures are within Audiology and Neurophysiology.
- Imaging activity is artificially high because of historic practice of recording based on body parts scanned, rather than overall scan volume, which leads to NLAG having higher reported activity levels than HUTH.

**Critical Enabler**




### Actions

- Services developing improvement plans to create additional diagnostic activity levels and utilise mutual aid opportunities across the Group.
- Full clinical review of Audiology completed, and action plan being implemented to improve service delivery.
- Workforce pressures in Neurophysiology has reduced capacity throughout the last few months. Interviews held in May, HUTH colleagues now signed on to NLaG bank to provide support in reducing the backlog.

# 18. Pathway Summary – Benchmark Report – Cancer Waiting Times

## HUTH

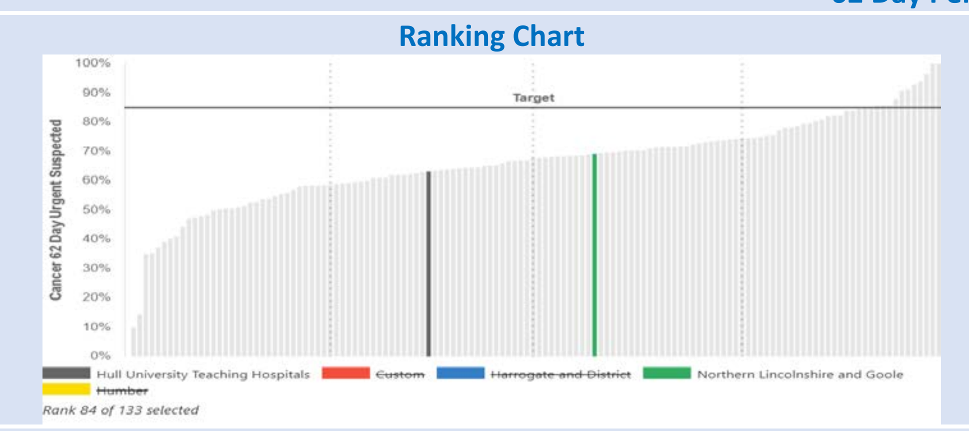
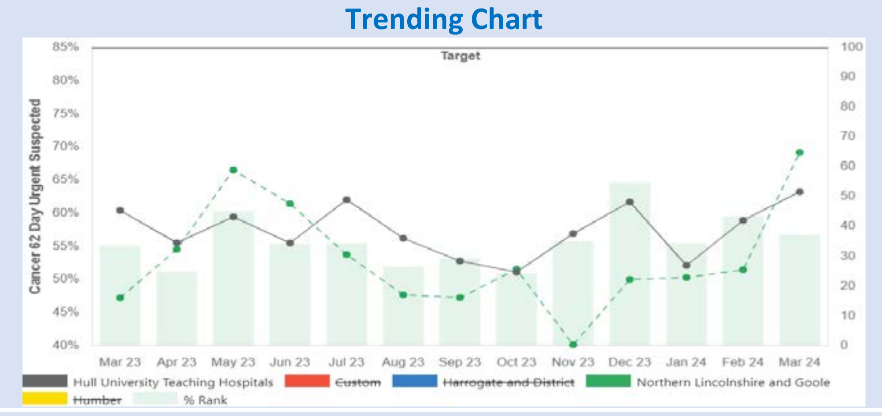
| Indicator | Period | Target | | SPC | Last 12 Months | Centile |
|---|---|---|---|---|---|---|
| Cancer - 28 Day Faster Diagnosis | Mar 24 | 75.0% | 81.8% | | | 73 |
| Cancer 2 Week Wait | Mar 24 | 93.00% | 90.3% | | | 64 |
| Cancer 2 Week Wait Breast Symptomatic | Mar 24 | 93.0% | 38.9% | | | 28 |
| Cancer 31 Day All Stages | Mar 24 | 96.0% | 76.3% | | | 3 |
| Cancer 31 Day First Treatment | Mar 24 | 96.00% | 81.7% | | | 4 |
| Cancer 31 Day Subsequent Treatment | Mar 24 | 96.0% | 70.4% | | | 4 |
| Cancer 62 Day All Routes | Mar 24 | 85.00% | 59.6% | | | 16 |
| Cancer 62 Day Consultant Upgrade | Mar 24 | 85.0% | 37.3% | | | 1 |
| Cancer 62 Day Screening | Mar 24 | 90.0% | 59.4% | | | 24 |
| Cancer 62 Day Urgent Suspected | Mar 24 | 85.00% | 63.2% | | | 37 |
| Cancer Sub Treat Drugs | Mar 24 | 96.0% | 99.3% | | | 42 |
| Cancer Sub Treat Radiotherapy | Mar 24 | 96.0% | 59.3% | | | 5 |
| Cancer of bronchus; lung | Dec 23 | 100.0 | 115.4 | | | 26 |
| FDS Acute Leukaemia | Mar 24 | 75.0% | - | | | - |
| FDS Brain Tumours | Mar 24 | 75.0% | 100% | | | 100 |
| FDS Breast Cancer | Mar 24 | 75.0% | 95.0% | | | 68 |
| FDS Breast Symptoms | Mar 24 | 75.0% | 81.2% | | | 14 |
| FDS Children's Cancer | Mar 24 | 75.0% | 80.0% | | | 22 |
| FDS Gynaecological Cancer | Mar 24 | 75.0% | 53.7% | | | 15 |
| FDS Haematological Malignancies | Mar 24 | 75.0% | 50.0% | | | 38 |
| FDS Head & Neck Cancer | Mar 24 | 75.0% | 96.7% | | | 98 |
| FDS Lower Gastrointestinal Cancer | Mar 24 | 75.0% | 61.4% | | | 33 |
| FDS Lung Cancer | Mar 24 | 75.0% | 81.8% | | | 50 |
| FDS Missing or Invalid | Mar 24 | 75.0% | 100% | | | 100 |
| FDS Other Cancer | Mar 24 | 75.0% | - | | | - |
| FDS Skin Cancer | Mar 24 | 75.0% | 97.7% | | | 89 |
| FDS Testicular Cancer | Mar 24 | 75.0% | - | | | - |
| FDS Upper Gastrointestinal Cancer | Mar 24 | 75.0% | 99.2% | | | 100 |
| FDS Urological Malignancies | Mar 24 | 75.0% | 58.2% | | | 51 |

## NLAG

| Indicator | Period | Target | | SPC | Last 12 Months | Centile |
|---|---|---|---|---|---|---|
| Cancer - 28 Day Faster Diagnosis | Mar 24 | 75.0% | 73.7% | | | 19 |
| Cancer 2 Week Wait | Mar 24 | 93.00% | 85.2% | | | 47 |
| Cancer 2 Week Wait Breast Symptomatic | Mar 24 | 93.0% | 21.6% | | | 17 |
| Cancer 31 Day All Stages | Mar 24 | 96.0% | 95.7% | | | 57 |
| Cancer 31 Day First Treatment | Mar 24 | 96.00% | 95.5% | | | 57 |
| Cancer 31 Day Subsequent Treatment | Mar 24 | 96.0% | 95.8% | | | 58 |
| Cancer 62 Day All Routes | Mar 24 | 85.00% | 69.8% | | | 41 |
| Cancer 62 Day Consultant Upgrade | Mar 24 | 85.0% | 72.2% | | | 26 |
| Cancer 62 Day Screening | Mar 24 | 90.0% | 100% | | | 100 |
| Cancer 62 Day Urgent Suspected | Mar 24 | 85.00% | 69.2% | | | 58 |
| Cancer Sub Treat Drugs | Mar 24 | 96.0% | 95.7% | | | 10 |
| Cancer of bronchus; lung | Dec 23 | 100.0 | 114.1 | | | 30 |
| FDS Breast Cancer | Mar 24 | 75.0% | 89.6% | | | 30 |
| FDS Breast Symptoms | Mar 24 | 75.0% | 88.9% | | | 28 |
| FDS Gynaecological Cancer | Mar 24 | 75.0% | 69.9% | | | 50 |
| FDS Haematological Malignancies | Mar 24 | 75.0% | - | | | - |
| FDS Head & Neck Cancer | Mar 24 | 75.0% | 63.6% | | | 5 |
| FDS Lower Gastrointestinal Cancer | Mar 24 | 75.0% | 59.3% | | | 28 |
| FDS Lung Cancer | Mar 24 | 75.0% | 54.5% | | | 4 |
| FDS Missing or Invalid | Mar 24 | 75.0% | - | | | - |
| FDS Other Cancer | Mar 24 | 75.0% | 100% | | | 100 |
| FDS Sarcoma | Mar 24 | 75.0% | - | | | - |
| FDS Skin Cancer | Mar 24 | 75.0% | - | | | - |
| FDS Testicular Cancer | Mar 24 | 75.0% | 100% | | | 100 |
| FDS Upper Gastrointestinal Cancer | Mar 24 | 75.0% | 85.6% | | | 74 |
| FDS Urological Malignancies | Mar 24 | 75.0% | 76.6% | | | 87 |

## 19. Pathway Trending – Cancer Waiting Times

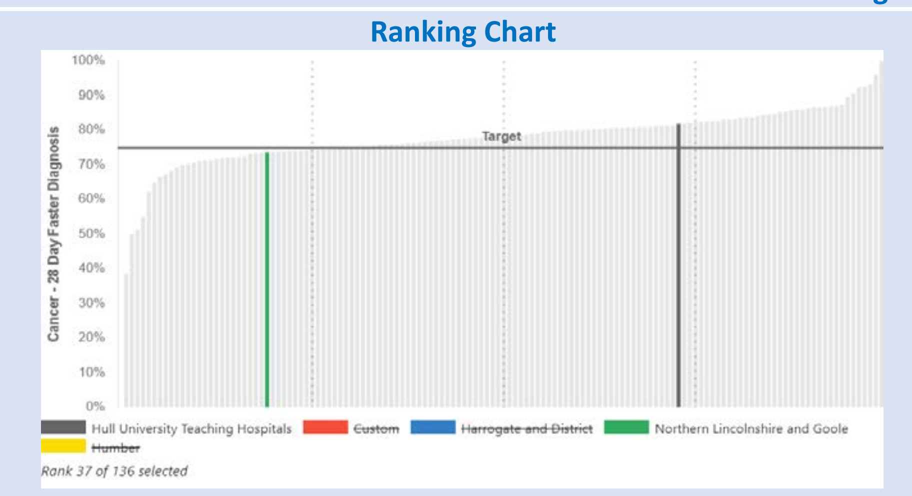
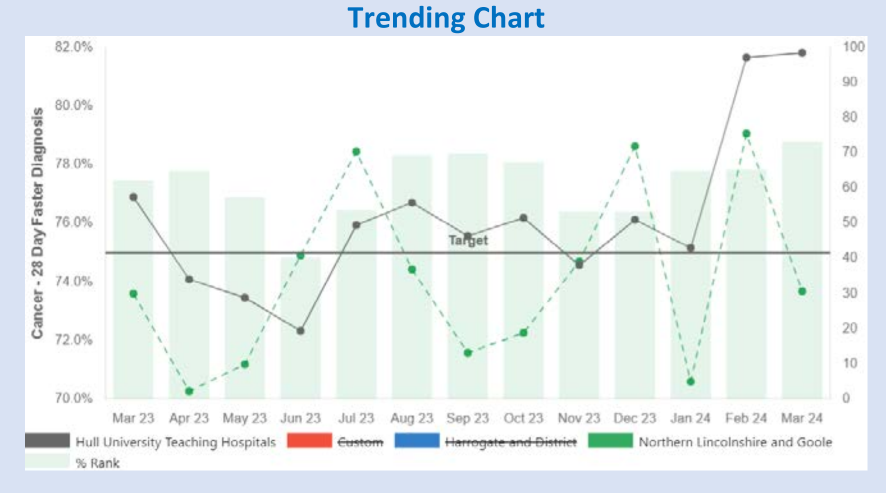
### 62 Day Performance

| Ranking Chart | Trending Chart |
|---|---|
|  |  |



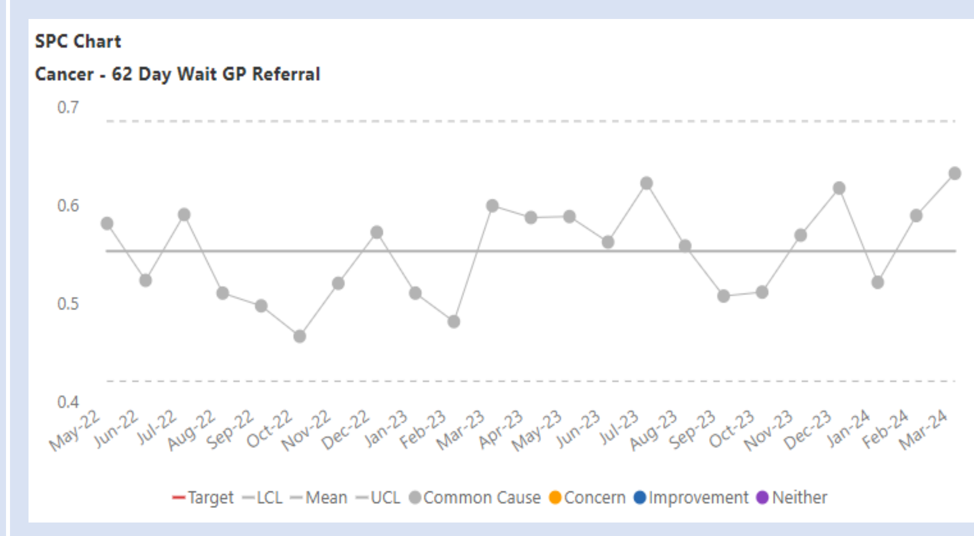


### Faster Diagnosis Performance

| Ranking Chart | Trending Chart |
|---|---|
|  |  |

## 20. 62 Day Cancer Performance - HUTH

Compliance




**Key Themes**

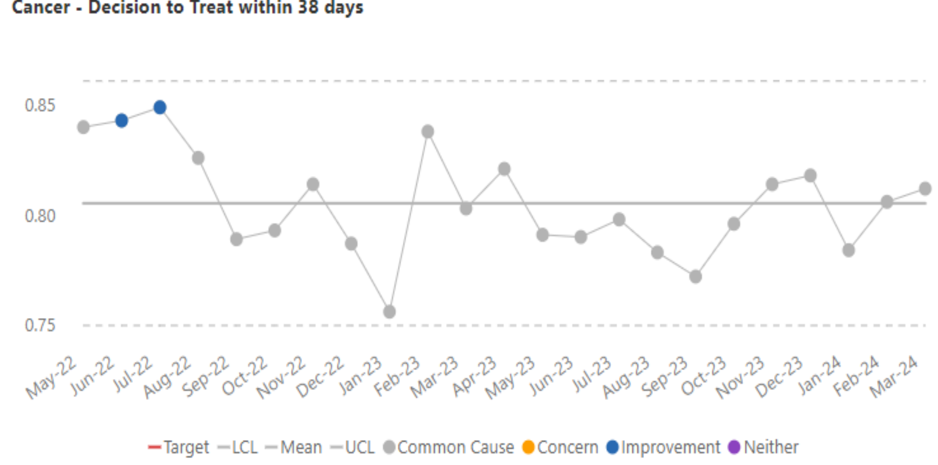
63.2% actual performance for March 2024

49.6% provisional performance for April 2024. **This is subject to significant validation and inclusion of shared pathways in formal compliance assessment.**

Significant issues:

- Breast DIEP capacity (due to volume)
- Navigational Bronchoscopy equipment failure – replacement approved; consideration of loan of equipment from NLAG.
- Contrast supply issues (national) limiting x2 scans per week.
- Late IHT – breach RCAs being undertaken plus HNY Cancer Alliance support analysis and pathways.
- Oncology capacity (vacancies plus increased demand) – clinical prioritisation in Breast, and now Urology
- HNY CA IPT SOP – ensure embedded; develop inter-Group IPT improvements.

Critical Enabler

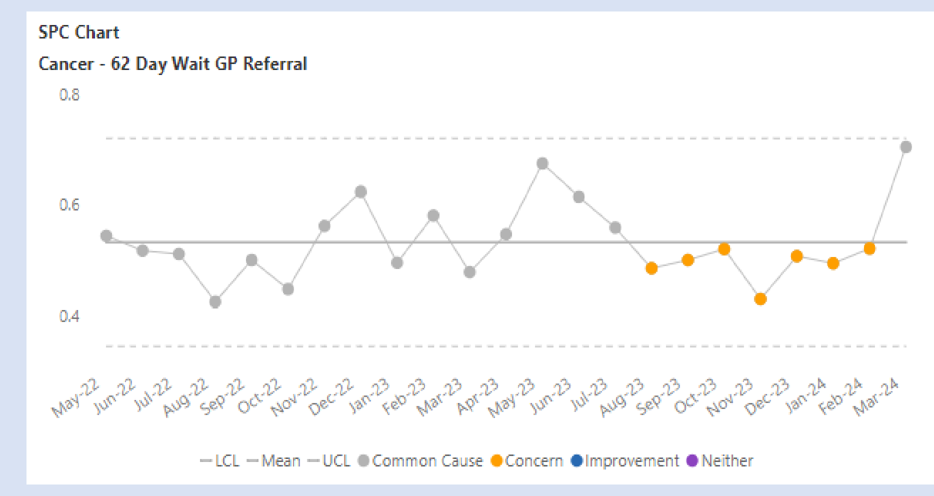



**Actions**

- Revised governance in place – Group level Cancer Delivery Group (tactical) with Exec oversight via Planned Care Board with enhanced stage of treatment management of time to diagnostics, diagnostic reporting turnaround, decision to treat by day 38 and histology reporting.
- Review of April 2024 breaches on-going as part of BAU DQ processes
- Radiotherapy recovery plan implemented to include mutual aid from Lincoln.
- In-sourced capacity for Gynae-oncology and urology
- Histology TATs (turnaround time) – Scarborough, Hull and York Pathology Service (SHYPS) TAT Improvement Plan developed
- Late Inter Provider Transfers (IHT) – breach RCAs being undertaken plus HNY Cancer Alliance support analysis and pathways.
- Oncology capacity (vacancies plus increased demand) – clinical prioritisation in Breast and Urology

# 21. 62 Day Cancer Performance - NLAG

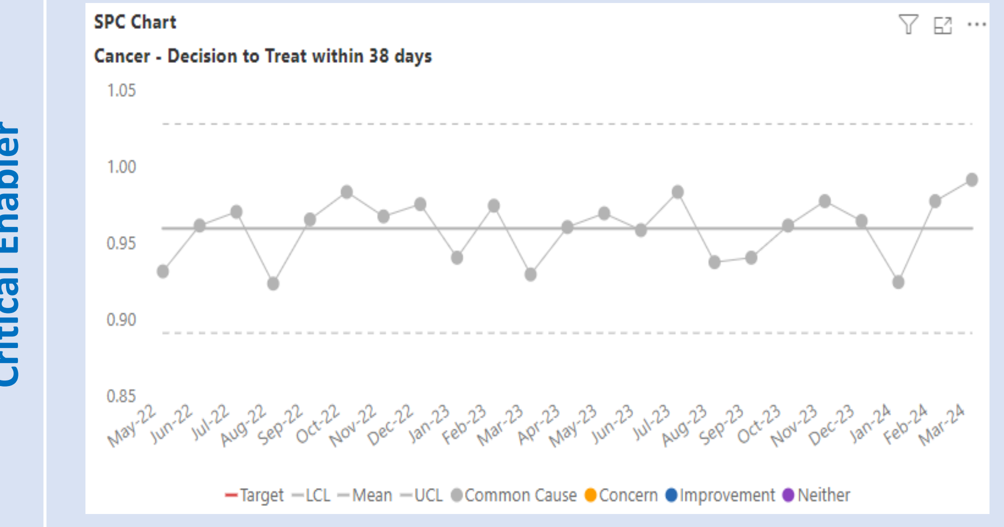
**Compliance**




**Key Themes**

- 71.6% actual performance March 2024– investment through CA SDF slippage funding has improved performance to end March 2024.
- 55.3% provisional performance April 2024 – **this is subject to significant validation and inclusion of shared pathways in formal compliance assessment.**

**Critical Enabler**

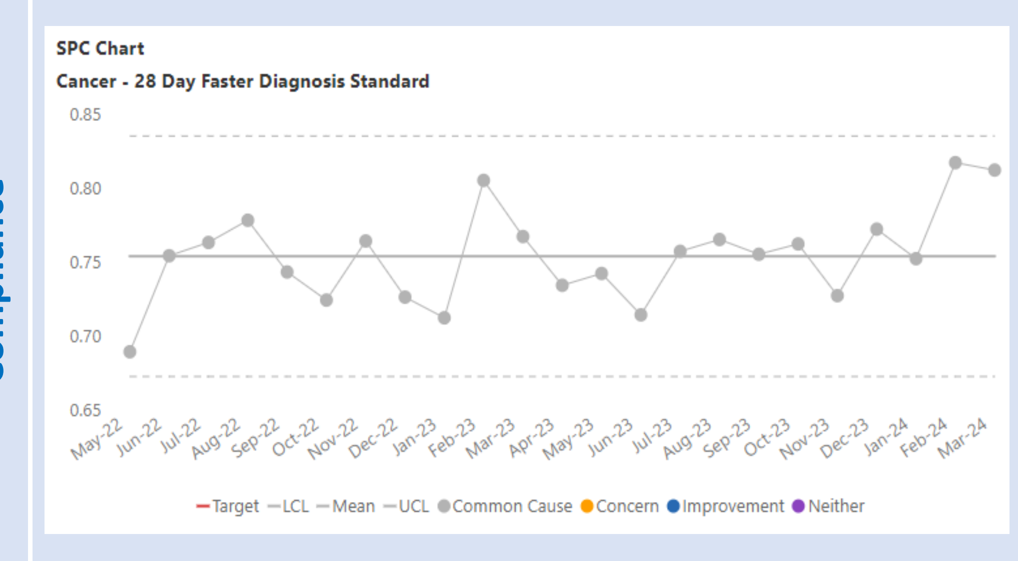



**Actions**

- Revised governance in place – Group level Cancer Delivery Group (tactical) with Exec oversight via Planned Care Board with enhanced stage of treatment management of time to diagnostics, diagnostic reporting turnaround, decision to treat by day 38 and histology reporting
- Delays in sending IPTs to be further investigated (IPTs accepted by cancer centre should not be double-counted).
- Capacity for navigational bronchoscopy, EUS, oncology appointments (to determine surgical vs. /oncology treatment, & therefore treatment provider).
- Lung – workforce capacity (Lung physician vacancies x 2).
- Surgical capacity in Urology (vacancy).

## 22. 28 Day Faster Diagnosis Standard - HUTH

Compliance




**Key Themes**

- March 2024 – confirmed performance of **81.8%,** achieving the national target and the Trust trajectory of 79%.
- April 2024 provisional performance of **80.7%**, currently achieving the national target and the Trust trajectory of 77%.
- On-going validation ahead of upload on 4 June 2024.

Critical Enabler

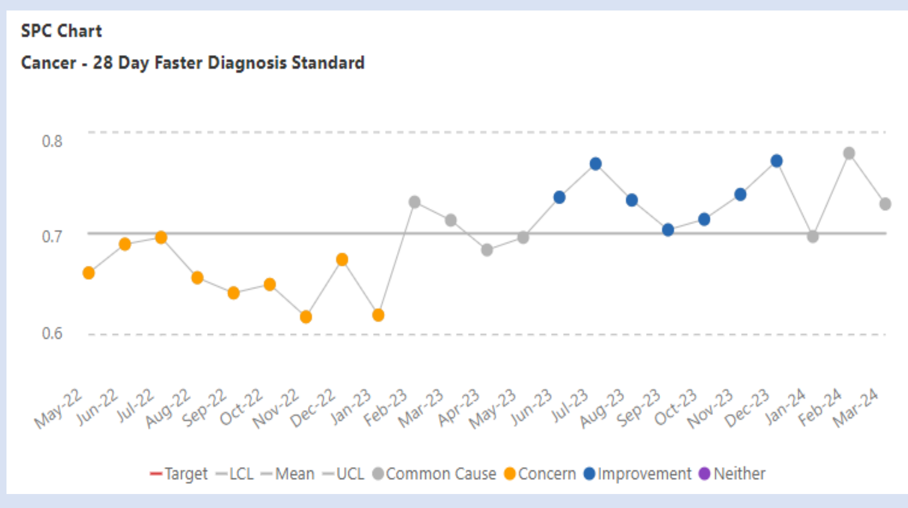
Request to test in 7 days (Data in Development)

**Actions**

- Tumour site Delivery Improvement Plans in development to improve or sustain FDS performance at 80% - supported by Improvement Team:
  - Urology – existing improvement plan and group in place
  - Gynaecology – existing improvement plan, being revised; CNS led results clinics being developed, review of MDT approach & breach analysis.
  - LGI – review of April 2024 breaches underway, and further FDS improvements to be identified, especially in relation to endoscopy.

## 23. 28 Day Faster Diagnosis Standard - NLAG

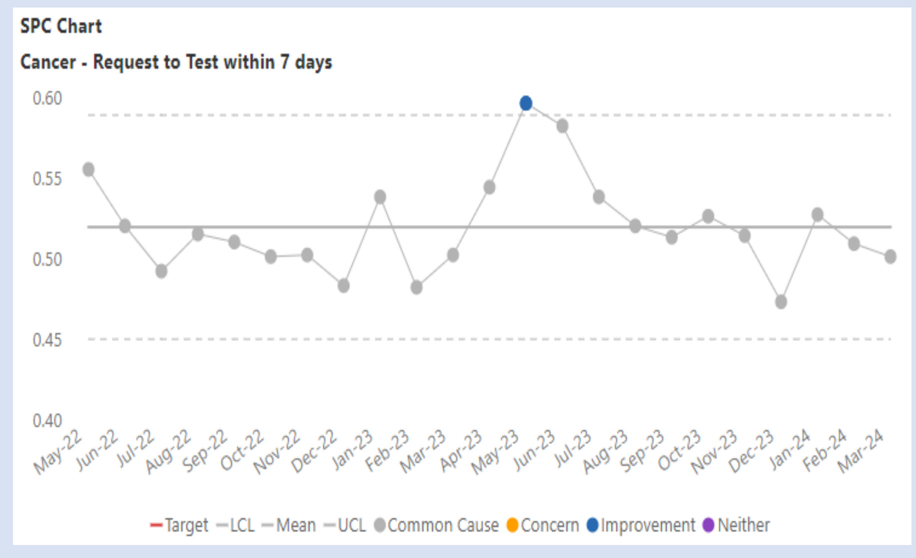
**Compliance**




**Key Themes**

- Inconsistent performance during 2023/24 against 75% target
- March 2024 performance not achieved at 71.4%
- April 2024 performance not achieving at 67.1%, deterioration since March 2024 under review

**Critical Enabler**




**Actions**

- Tumour site Delivery Improvement Plans in development to improve or sustain FDS performance at 80% - supported by Improvement Team
- Review of patient pathways including screening programmes
- Colorectal - Patient initiated delays due to health, compliance, etc. – implementation of the HUTH escalation SOP & frailty pathway being urgently reviewed.
- Gynae – capacity issues in the pathway to be understood.
- Head & Neck – repeat diagnostics (lack of U/S guided FNA/one stop clinic) & histology delays >14 days for reporting.
- Lung – clinical workforce concerns (vacancies) & impact of targeted lung health checks
- Urology – pathway review/improvement options in line with HUTH to be considered.

# 24. Pathway Summary – Benchmark Report – Unscheduled Care

## HUTH

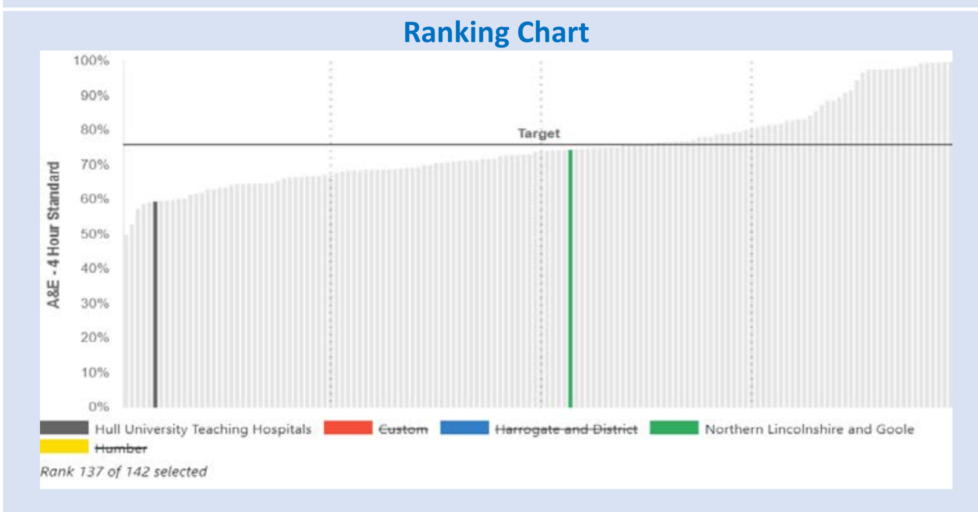
| Indicator | Period | Target | 🏆 | SPC | Last 12 Months | Centile |
|---|---|---|---|---|---|---|
| A&E - 4 Hour Standard | Apr 24 | 76.00% | **59.6%** | | | 4 |
| A&E - 4 Hour Standard (Type 1) | Apr 24 | 76.0% | **42.9%** | | | 3 |
| A&E - 4 Hour Standard (Type 2 or 3) | Apr 24 | 95.0% | **91.8%** | | | 11 |
| A&E - Conversion Rate | Apr 24 | 25.0% | **25.5%** | | | 20 |
| A&E - DTA to Admission >12 Hours | Apr 24 | 0.0% | **11.9%** | | | 36 |
| A&E - DTA to Admission >12 Hours# | Apr 24 | 0.0 | **413.0** | | | 28 |
| A&E - DTA to Admission >4 Hours | Apr 24 | 10.00% | **41.8%** | | | 30 |
| A&E - Left Without Being Seen | Mar 24 | 5.00% | **10.2%** | | | 3 |
| A&E - Reattendance Rate | Mar 24 | 5.0% | **7.8%** | | | 66 |
| A&E - Time to Initial Assessment | Mar 24 | 15.0 | **25.0** | | | 6 |
| A&E - Time to Treatment | Mar 24 | 60.0 | **118.0** | | | 5 |
| A&E - Total Time in A&E | Mar 24 | 160.0 | **238.0** | | | 5 |
| A&E - Total Time in A&E (Admitted) | Mar 24 | 180.0 | **255.0** | | | 63 |
| A&E - Total Time in A&E (Non-Admitted) | Mar 24 | 140.0 | **236.0** | | | 2 |
| A&E Attendances All | Apr 24 | - | 13,574 | | | 50 |
| A&E Attendances Type 1 | Apr 24 | - | 8,942 | | | 61 |
| A&E Attendances Type 3 | Apr 24 | - | 4,632 | | | 55 |
| Complaints - Emergency | Q4 21/22 | - | 0.6 | | | 46 |
| Emergency Admissions Type 1 | Apr 24 | - | 3,458 | | | 40 |
| Emergency Admissions via A&E | Apr 24 | - | 3,458 | | | 37 |
| Friends & Family A&E Score | Mar 24 | 85% | 72% | | | 23 |
| Other Emergency Admissions | Apr 24 | - | 1,903 | | | 14 |
| Total Emergency Admissions | Apr 24 | - | 5,361 | | | 24 |

## NLAG

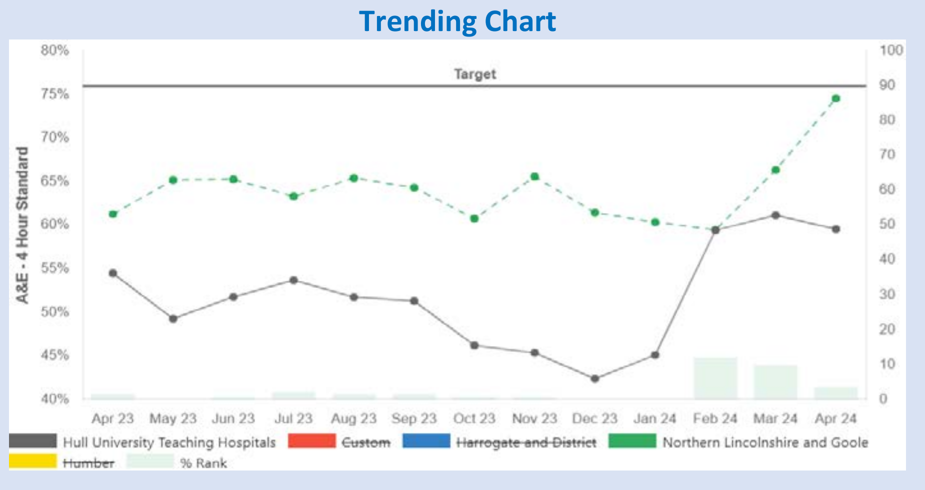
| Indicator | Period | Target | 🏆 | SPC | Last 12 Months | Centile |
|---|---|---|---|---|---|---|
| A&E - 4 Hour Standard | Apr 24 | 76.00% | **74.6%** | | | 54 |
| A&E - 4 Hour Standard (Type 1) | Apr 24 | 76.0% | **73.8%** | | | 94 |
| A&E - 4 Hour Standard (Type 2 or 3) | Apr 24 | 95.0% | 99.6% | | | 75 |
| A&E - Conversion Rate | Apr 24 | 25.0% | **31.0%** | | | 5 |
| A&E - DTA to Admission >12 Hours | Apr 24 | 0.0% | **15.0%** | | | 32 |
| A&E - DTA to Admission >12 Hours# | Apr 24 | 0.0 | **723.0** | | | 13 |
| A&E - DTA to Admission >4 Hours | Apr 24 | 10.00% | **27.3%** | | | 60 |
| A&E - Left Without Being Seen | Mar 24 | 5.00% | 3.4% | | | 74 |
| A&E - Reattendance Rate | Mar 24 | 5.0% | **9.1%** | | | 37 |
| A&E - Time to Initial Assessment | Mar 24 | 15.0 | **23.0** | | | 9 |
| A&E - Time to Treatment | Mar 24 | 60.0 | **62.0** | | | 69 |
| A&E - Total Time in A&E | Mar 24 | 160.0 | **161.0** | | | 72 |
| A&E - Total Time in A&E (Admitted) | Mar 24 | 180.0 | **298.0** | | | 50 |
| A&E - Total Time in A&E (Non-Admitted) | Mar 24 | 140.0 | **141.0** | | | 72 |
| A&E Attendances All | Apr 24 | - | 15,524 | | | 43 |
| A&E Attendances Type 1 | Apr 24 | - | 15,035 | | | 18 |
| A&E Attendances Type 3 | Apr 24 | - | 489 | | | 96 |
| Complaints - Emergency | Q4 21/22 | - | 0.7 | | | 36 |
| Emergency Admissions Type 1 | Apr 24 | - | 4,816 | | | 13 |
| Emergency Admissions Type 3 | Apr 24 | - | - | | | - |
| Emergency Admissions via A&E | Apr 24 | - | 4,816 | | | 12 |
| Friends & Family A&E Score | Mar 24 | 85% | **74%** | | | 30 |
| Other Emergency Admissions | Apr 24 | - | 356 | | | 74 |
| Total Emergency Admissions | Apr 24 | - | 5,172 | | | 28 |

# 25. Pathway Trending – Unscheduled Care

## Ranking Chart

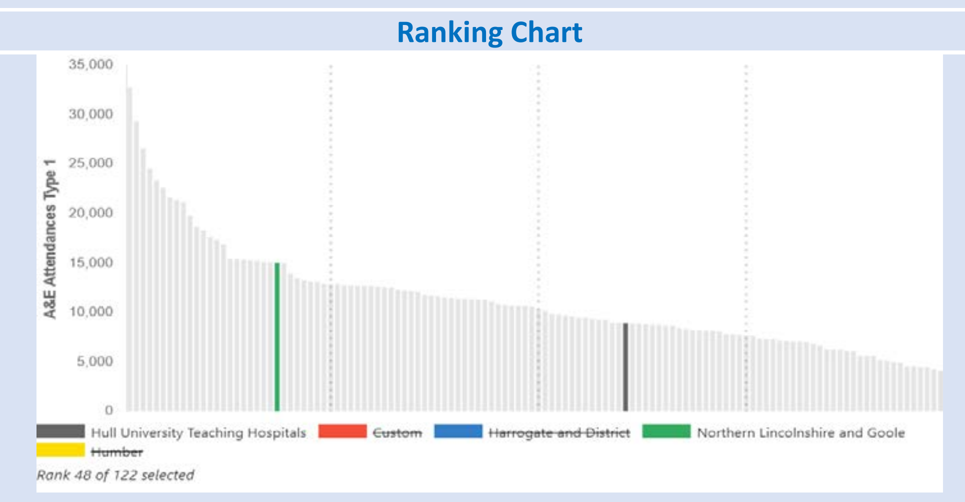



## Trending Chart

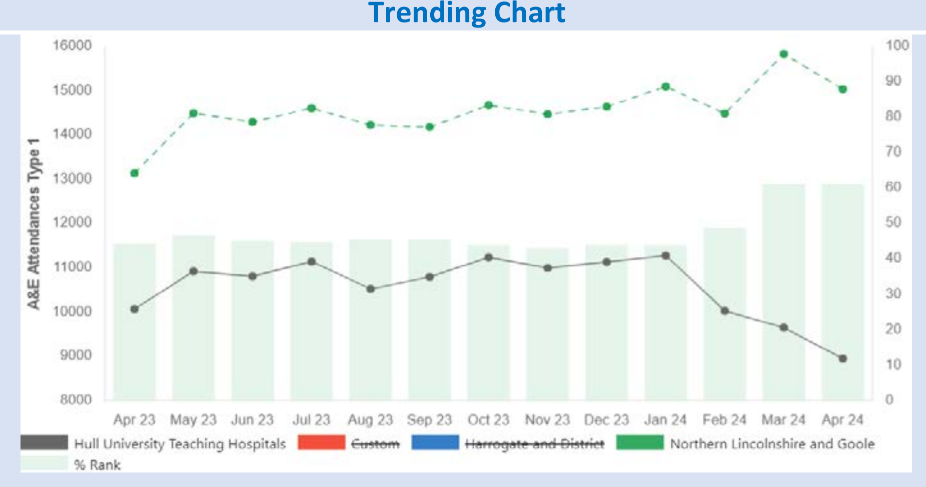



## A&E – Attendances

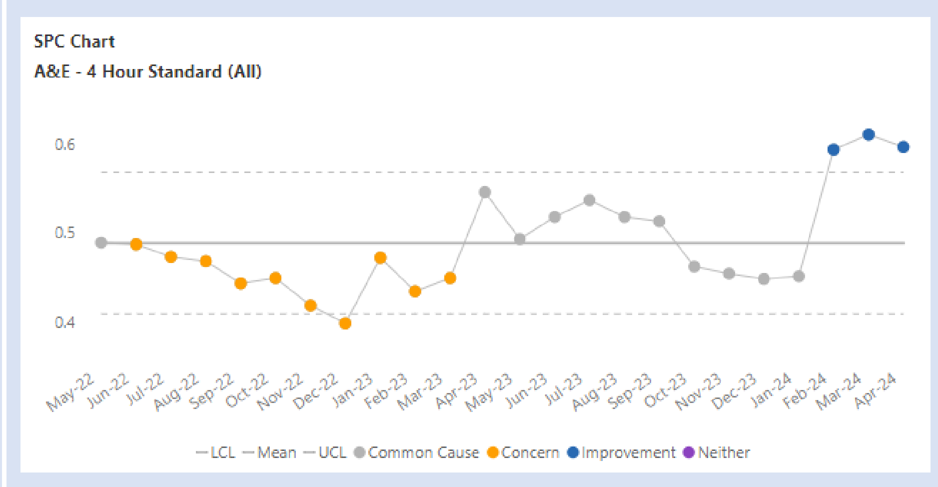
## Ranking Chart




## Trending Chart



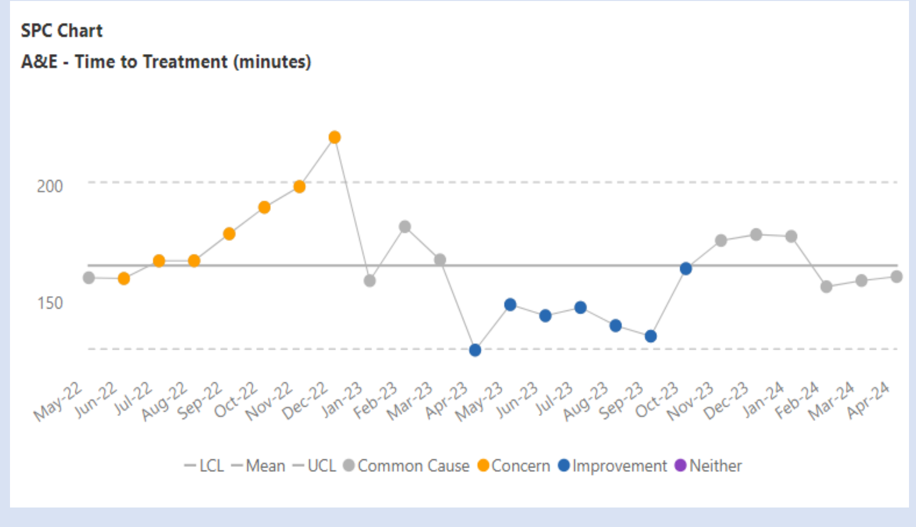
## 26. Emergency Care Standards – 4 hour Performance - HUTH




**Key Themes**

- Compliance boosted by inclusion of UTC at HUTH from Feb '23
- Type 1 performance continues to deteriorate over the quarter though attendances have reduced. National ranking is 137 of 142 in April, a decline from 128 of 142 in March.
- Type 3 performance has deteriorated over the quarter however, attendances have increased.
- HUTH remains within the lowest quartile for patients seen by a clinician within 60 minutes of arrival. The Trust has an monthly average that routinely exceeds 120 minutes.
- HUTH is at the bottom of the lowest quartile for patients leaving A&E without being seen (10.2% in April)

Critical Enabler

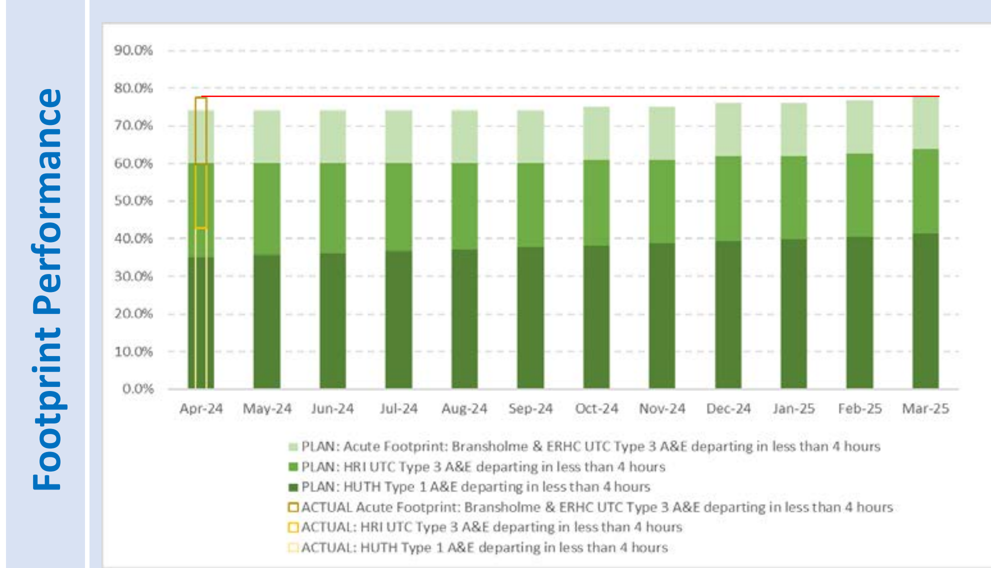



**Actions**

3 critical objectives identified:

1. Reducing non-admitted breaches (60% of all Type 1 breaches at HUTH).
2. Delivery of mean time to first clinician of 30 mins. HUTH mean is 119 minutes being the 7th worst nationally.
3. Improved frailty assessment - patients aged >80 wait twice as long as patients <44 – regardless of whether they are admitted or not.
    - Review of clinical rota to align consultant, middle grade, and junior doctor capacity to both meet demand and maintain patient safety.
    - Work with Specialist teams to review Internal Professional standards to ensure in reach into urgent care is provided in a timely manner.
    - Initiate QI to review impact of a single walk-in queue.
    - Establish single walk-in to UTC and streaming to ED as required.
    - Focus on the non-admitted patients seen through the Emergency Care Area (Minors) to quickly drive overall 4 hour performance up and reduce ED congestion.

## Footprint Performance




Based on the Regional planning instruction for 24/25 compliance against 78% should be measured based on Acute footprint compliance i.e. inclusive of all Type 3 provision in the Trust catchment.

HUTH FOOTPRINT (inc. Bransholme/ERHC): April = 77.5%

# 27. Emergency Care Standards – 4 hour Performance - NLAG

**Compliance**

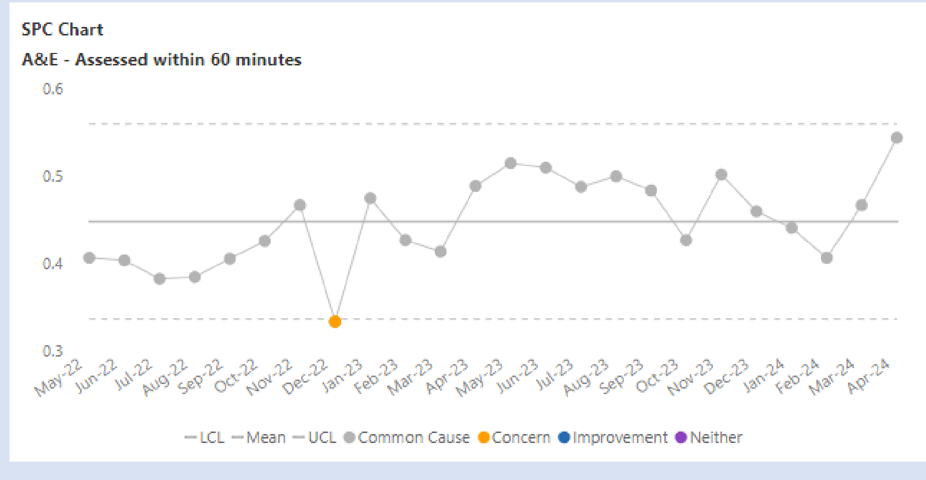
SPC Chart
A&E - 4 Hour Standard (All)

0.7
0.6
0.5
May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24
LCL Mean UCL Common Cause Concern Improvement Neither

## Key Themes

- Improved combined performance over the quarter, April value is 74.6%, Type 1 performance 54.74% and Type 3 performance 98.87%.
- NLaG moved from the lower into the inter-quartile range and ranking increased from 113 in March to 66 of 142 in April.
- Attendances remain static within the expected range.
- Variation between south bank sites regarding the streaming of minor cases.
- Total time in A&E remains static circa 227 minutes.
- NLaG aligns to the national mean and sits within the interquartile range at 62 minutes for A&E 'Time to First Clinician' though this value would not support consistent compliance with the 4-hour standard.

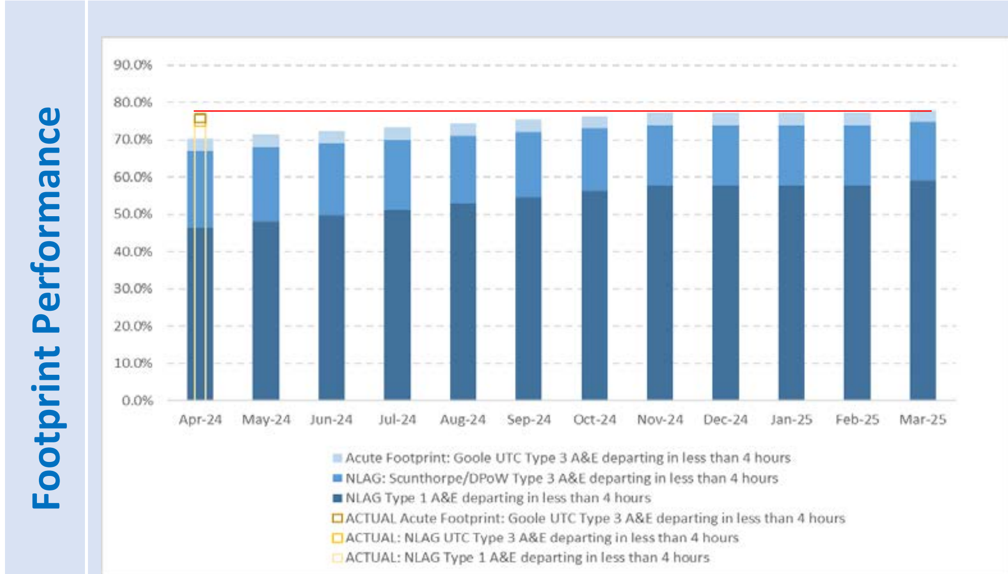
**Critical Enabler**




## Actions

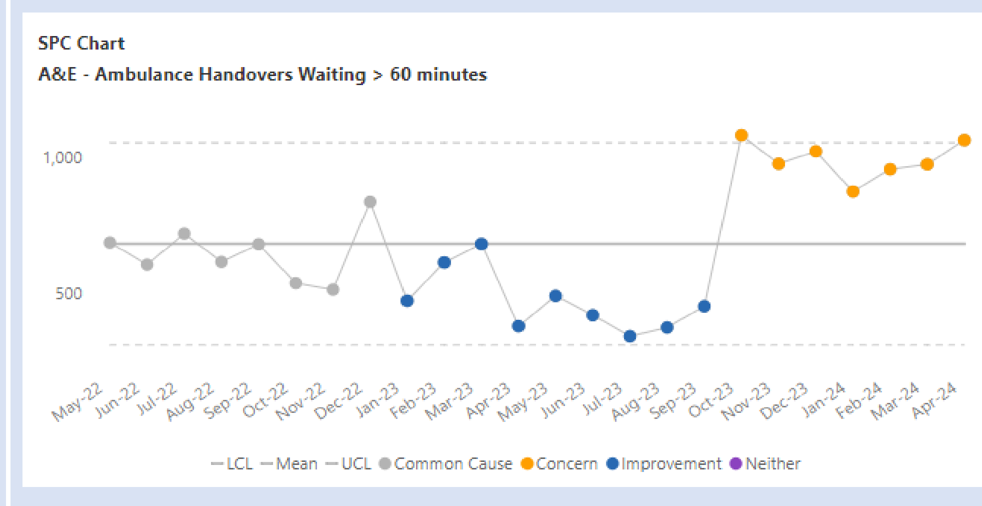
3 critical objectives identified:

1. Reducing non-admitted breaches (50% of NLAG breaches).
2. Delivery of mean time to first clinician of 30 mins with the NLAG mean being 62 minutes.
3. Improved frailty assessment (patients aged >80 wait twice as long as patients <44 – regardless of whether they are admitted or not)
   - Pathway review at DPoW to understand why there are a greater number of minor patients streamed to ED rather than UTC.
   - Demand and capacity review to align workforce to demand.
   - Creation of CDU within ED for specialty assessment, diagnostics, and complex cases.
   - To improve time to see doctor to reduce overall time in A&E.

| Footprint Performance |  | Based on the Regional planning instruction for 24/25 compliance against 78% should be measured based on Acute footprint compliance i.e. inclusive of all Type 3 provision in the Trust catchment.<br><br>NLAG FOOTPRINT (inc. Goole UTC) April = 76.9% |
|---|---|---|

## 28. Ambulance Handovers >60 minutes - HUTH

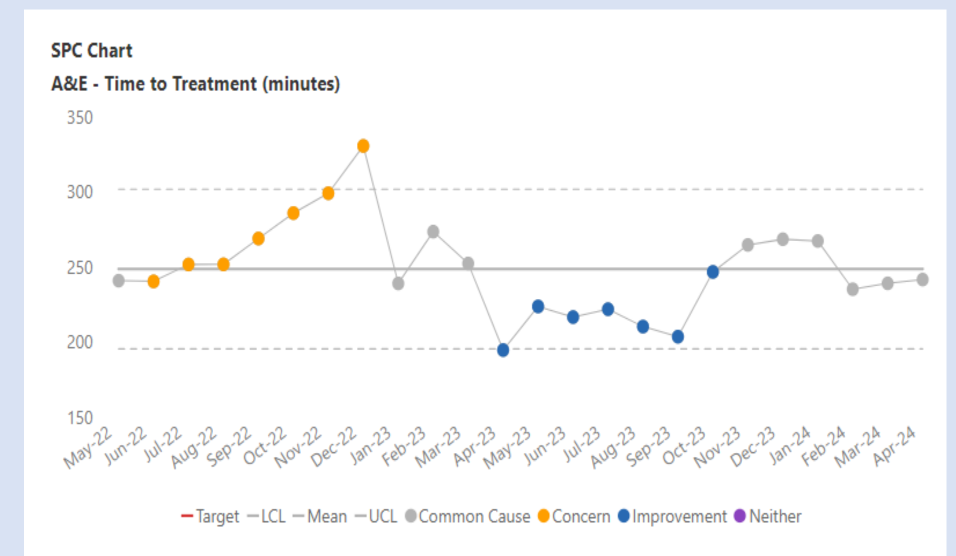
**Compliance**




**Key Themes**

- Deteriorating performance in Ambulance Handover over the quarter.
- No improvement in time to clinical assessment in the quarter.

**Critical Enabler**

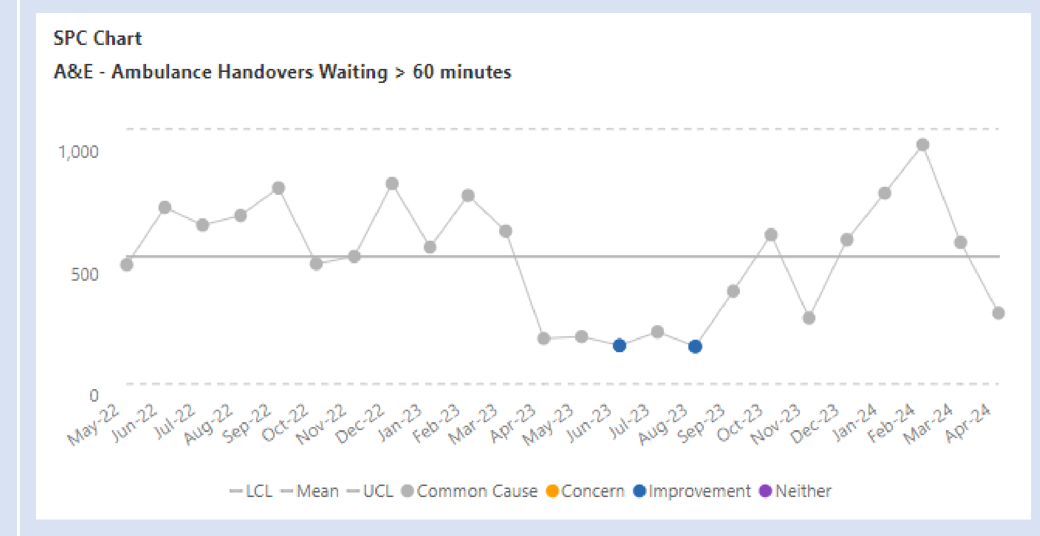



**Actions**

- Root cause linked to patient volumes in A&E. Focus on actions in previous section of this report relating to 4 hour delivery will significantly lower patient volumes in department, increase assessment spaces and minimise handover delays.
- Triggers and Escalation/SOP for ambulance handovers to be reviewed and adapted linked to national OPEL system, helping 30-minute Cat 2 responses for YAS.
- Work with YAS to bring forward clinical assessment through proposing changes to current practice.

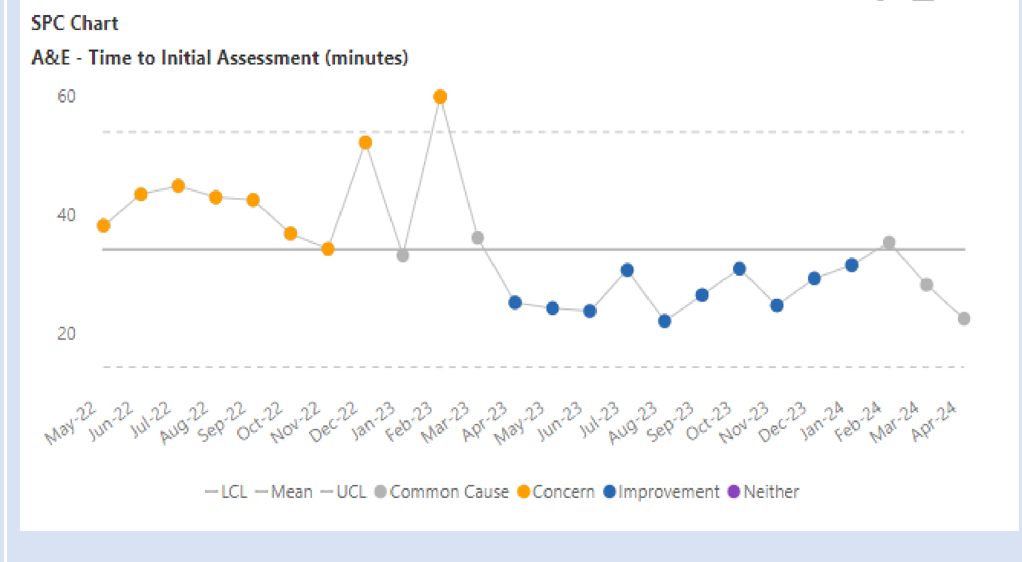
## 29. Ambulance Handovers >60 minutes - NLAG

**Compliance**




### Key Themes

- Improving performance in ambulance handovers
- Time to initial assessment continues to improve.




### Actions

- Root cause linked to patient volumes in A&E. Focus on actions in previous section of this report relating to the 4 hour target will significantly lower patient volumes in department, increase assessment spaces and minimise handover delays.
- Rapid Assessment and Treatment model to be embedded to reduce waiting time to be seen.
- Rota Alignment planned based on service demand.
- Working toward zero tolerance of >45-minute handover, Aim to deliver 100% ambulance handovers under 45min and 80% under 30 minutes.

## 30. No Criteria To Reside - HUTH

| | | |
|---|---|---|
| **Compliance** | NCTR number<br>To be available in month 2<br><br>Aligned data provision being developed. NLAG historically reported lost beddays, whereas HUTH reporting occupied beds | **Key Themes** |
| **Critical Enabler** | Trending by each pathway | **Actions** |

## 31. No Criteria To Reside - NLAG

| Compliance | To be available in month 2<br><br>Aligned data provision being developed. NLAG historically reported lost beddays, whereas HUTH reporting occupied beds | **Key Themes** |
| --- | --- | --- |
| Critical Enabler | | **Actions** |

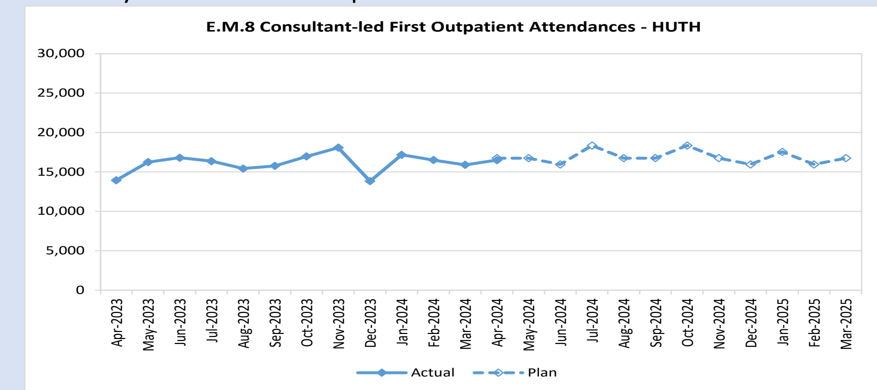
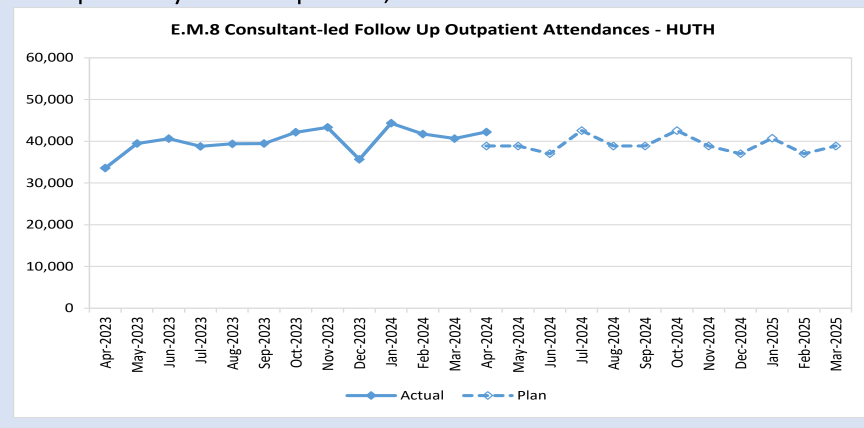
## 32. Discharge Ready Date - HUTH

| Compliance | % Achieving DRD<br><br>To be available in month 2 | **Key Themes** |
|---|---|---|
| **Critical Enabler** | | **Actions** |

## 33. Discharge Ready Date - NLAG

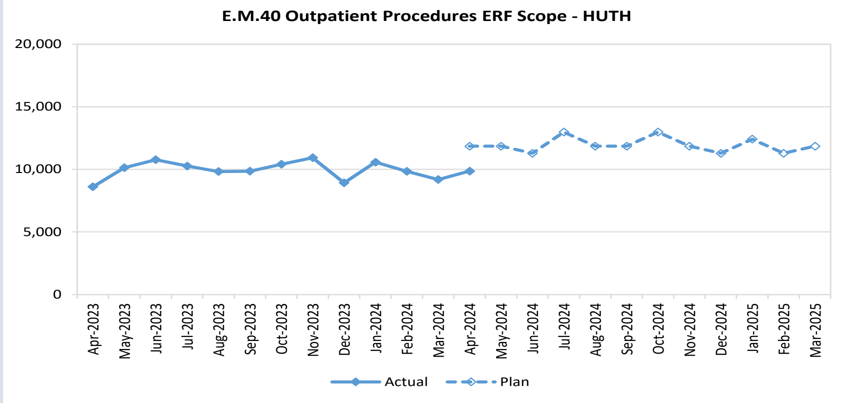
| | | |
|---|---|---|
| Compliance | To be available in month 2 | **Key Themes** |
| Critical Enabler | | **Actions** |

# 34. Activity

| HUTH | NLAG |
|---|---|
| **New Outpatient Attendances vs Plan**<br><br>New activity is in line with the plan.<br><br><br><br>**Follow up Outpatient Attendances vs Plan**<br><br>Follow up activity is above plan +3,350<br><br> | Reporting of NLaG activity delayed by Data Warehouse issues preventing automated SUS submissions.<br><br>Detail provided to Performance, Estates and Finance Committees in Common as part of the Information Management Update – Item 4.5 of the 29th May Agenda. |

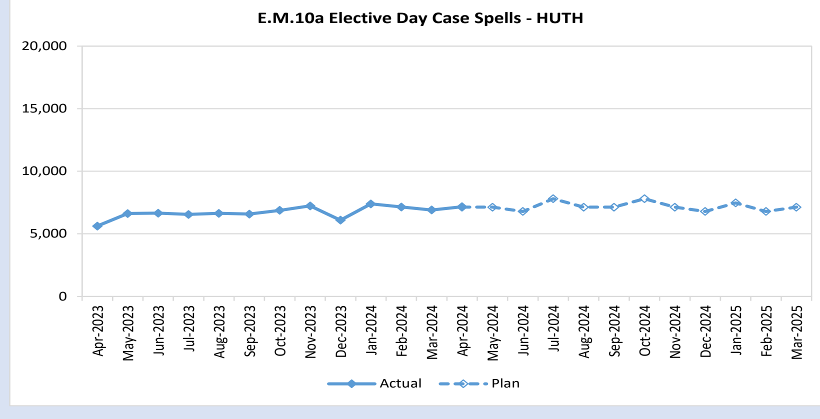
### Outpatient Procedures vs Plan

Outpatient procedure is under plan by -1,989.  Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



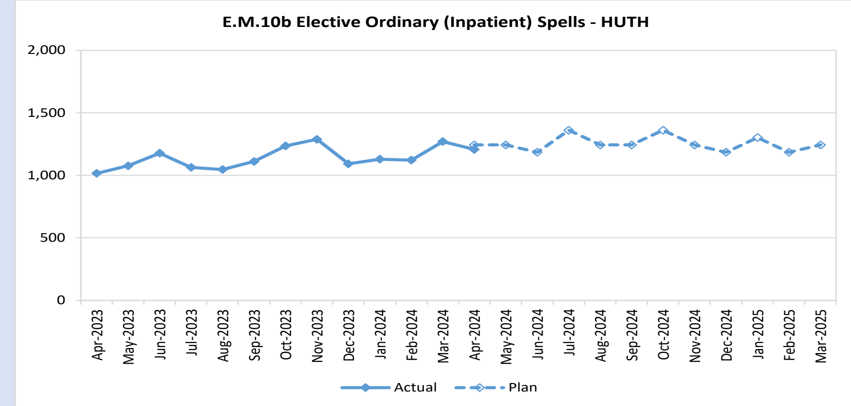

### Day Case Admissions vs Plan

Day case elective spells on plan.



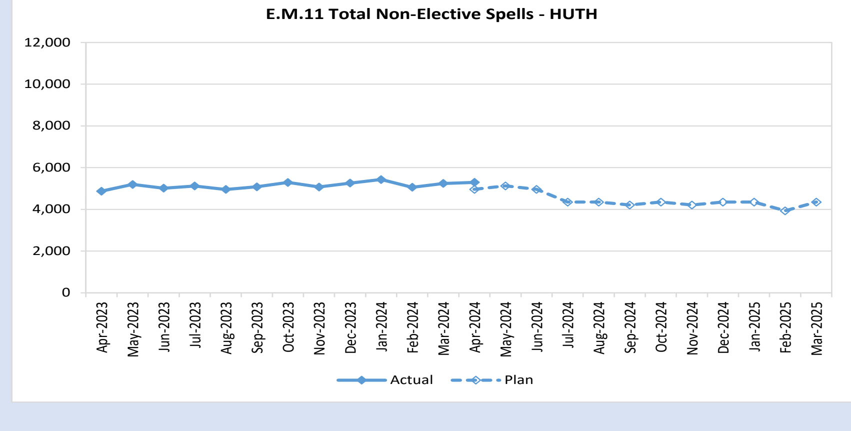
## Elective Admissions vs Plan

Inpatient spells 36 under plan.




## Non-Elective Admissions vs Plan

Non-elective spells +334 over plan.



## 35. Elective Recovery Fund - HUTH

ERF will be available from M2

## 36. Elective Recovery Fund - NLAG

ERF will be available from M2

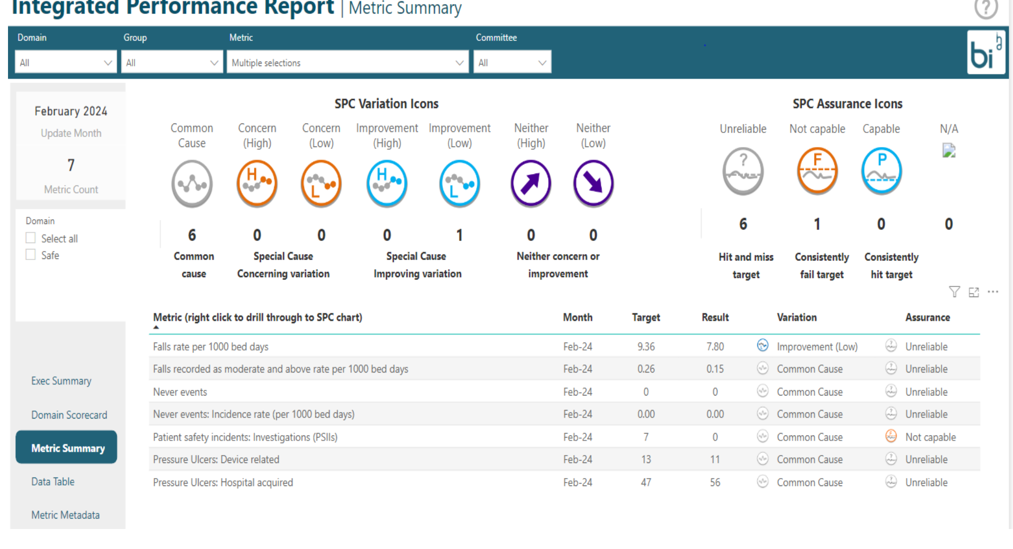
## 1. EXECUTIVE SUMMARY

| Hull University Teaching Hospitals | Northern Lincolnshire and Goole Hospitals |
|---|---|
| Highlights:<br>• The Trust reported two incidents meeting PSII criteria in April 2024. PSIIs framework is now used. Staff are able to use a variety of alternative investigation learning responses and tools, enabling individual reports, after-action reviews, and thematic reviews to be undertaken.<br>• Tissue Viability now using PSIRF framework in the investigation of hospital acquired pressure ulcers.<br>• Improvements in Friends Family Test (FFT) scores are starting progressing with sustained improved in A&E FFT scores over winter (reducing national trend and significant local capacity pressures). A&E has improved from worst in region and improved over the winter period. FFT positivity score for ED –70 %<br><br>Lowlights:<br>• SHMI: Latest available data November 2023 - HUTH SHMI: of 1.1391 conditions for which a SHMI is calculated identified as being higher than expected. Mortality deep dive, development strategy with NLAG under development & the Appointment of an Associate CMO for Quality and Safety.<br>• VTE risk assessment rate remains within common cause variation. Compliance is below the Trusts 95% target. A VTE steering group addressing low compliance, NLAG are providing additional support using their prior learning.<br>• IPC team are working to address outbreaks and the breached infection threshholds focussing on gram negative infections. | Highlights:<br>• The Clostridium Difficile overall target for 2023/2024 was 20 with an outcome of 18 for the year.<br>• 95% of Complaints were responded to within the set KPI of 85%<br>• The HSMR rolling 12-month position is below the England average (100) with a value of 96.3 in January 2024<br><br>Lowlights:<br>• The information services previously provide IPR report on quality has ceased being produced. The reporting of quality data has been significantly hampered and so some limited reporting has been made in some elements of this report.<br>• One National Patient Safety Alert, Medical beds trolleys bed rails bed grab handles and lateral turning devices: risk of death from entrapment or fails breached the 1 March 2024 deadline date.<br>• There are some end of year trajectories that have been breached in IPC data. |

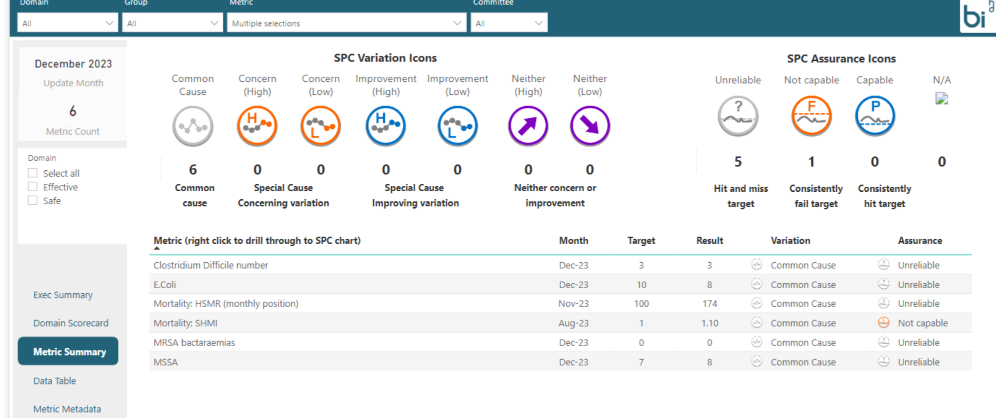
# 2. SCORECARD – Quality and Safety

## Hull University Teaching Hospitals

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.




| Metric (right click to drill through to SPC chart) | Month | Target | Result | Variation | Assurance |
|---|---|---|---|---|---|
| Falls rate per 1000 bed days | Feb-24 | 9.36 | 7.80 | Improvement (Low) | Unreliable |
| Falls recorded as moderate and above rate per 1000 bed days | Feb-24 | 0.26 | 0.15 | Common Cause | Unreliable |
| Never events | Feb-24 | 0 | 0 | Common Cause | Unreliable |
| Never events: Incidence rate (per 1000 bed days) | Feb-24 | 0.00 | 0.00 | Common Cause | Unreliable |
| Patient safety incidents: Investigations (PSIIs) | Feb-24 | 7 | 0 | Common Cause | Not capable |
| Pressure Ulcers: Device related | Feb-24 | 13 | 11 | Common Cause | Unreliable |
| Pressure Ulcers: Hospital acquired | Feb-24 | 47 | 56 | Common Cause | Unreliable |




| Metric (right click to drill through to SPC chart) | Month | Target | Result | Variation | Assurance |
|---|---|---|---|---|---|
| Clostridium Difficile number | Dec-23 | 3 | 3 | Common Cause | Unreliable |
| E.Coli | Dec-23 | 10 | 8 | Common Cause | Unreliable |
| Mortality: HSMR (monthly position) | Nov-23 | 100 | 174 | Common Cause | Unreliable |
| Mortality: SHMI | Aug-23 | 1 | 1.10 | Common Cause | Not capable |
| MRSA bactaraemias | Dec-23 | 0 | 0 | Common Cause | Unreliable |
| MSSA | Dec-23 | 7 | 8 | Common Cause | Unreliable |

## Northern Lincolnshire and Goole Hospitals

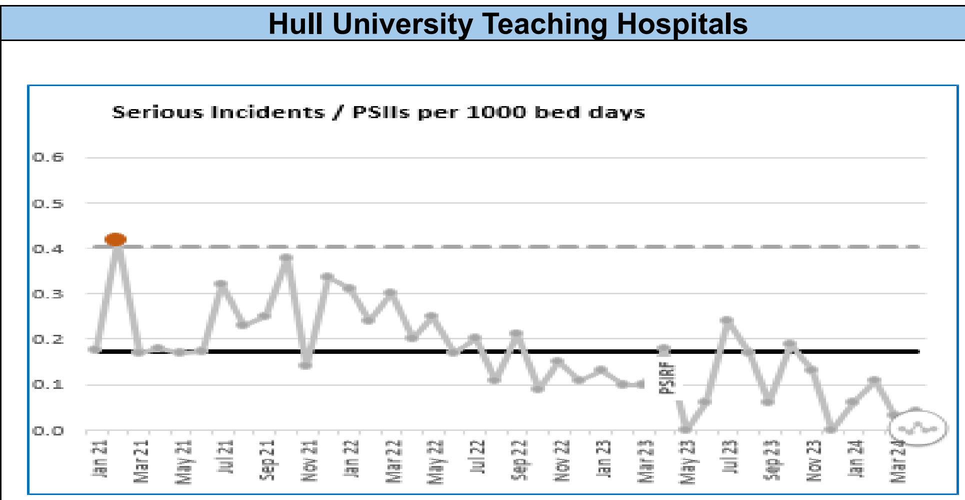
### Overview scorecard

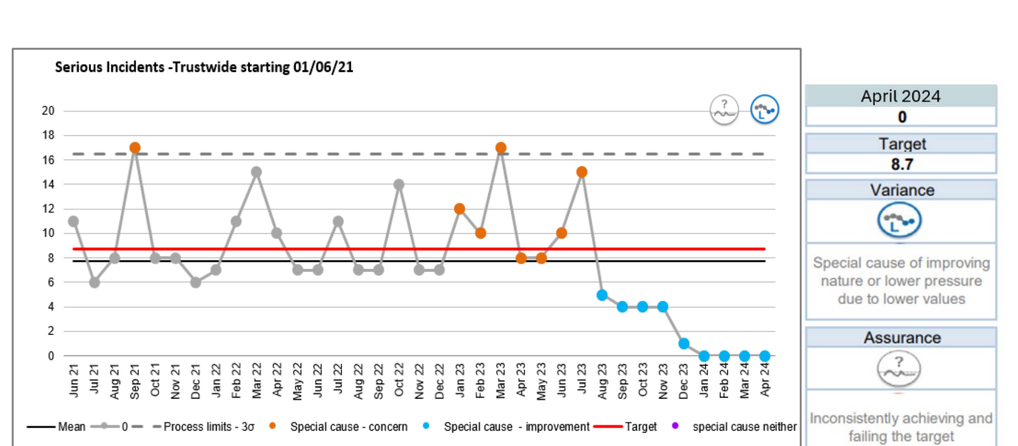
The information team have ceased providing the previous quality IPR and are in transition to their revised reporting framework for Board and Board sub-committees.

## 2.1 Quality and Safety – Serious Incidents/PSIIs (inc. Never Events) (per 1000 bed days)

| PSII Target: None set | HUTH: 0.04 | NLAG: 0 |
|---|---|---|

| Hull University Teaching Hospitals | Northern Lincolnshire and Goole Hospitals |
|---|---|




### HUTH Updates in Month

**Data Analysis:**

The data indicates that there has been a change in the quantity of SIs and PSIIs reported in the previous year. This is due to the changes within the framework used to review and determine incidents meeting the full investigation criteria. This allows for a variety of alternative investigation learning responses tools to be used, enabling individual reports, after-action reviews, and thematic reviews to be undertaken.

**Commentary:**

The Trust reported Two incidents meeting PSII criteria in April 2024.

**Digestive Diseases**

A patient was discharged from H11 after an acute stroke and was meant to be seen by gastro/endoscopy as an outpatient after been diagnosed with severe anaemia as an inpatient and needed a transfusion. An access plan was created and the plan was for the patient to be seen as an outpatient. The patient never received an appointment and later died after a bowel obstruction secondary to colon cancer.

**Emergency Medicine**

### NLAG Updates in Month

**Data Analysis:**

The reduction of serious incidents reported reduced in August 2023 and there have been no incidents reported under the PSII arrangements since January 2024.

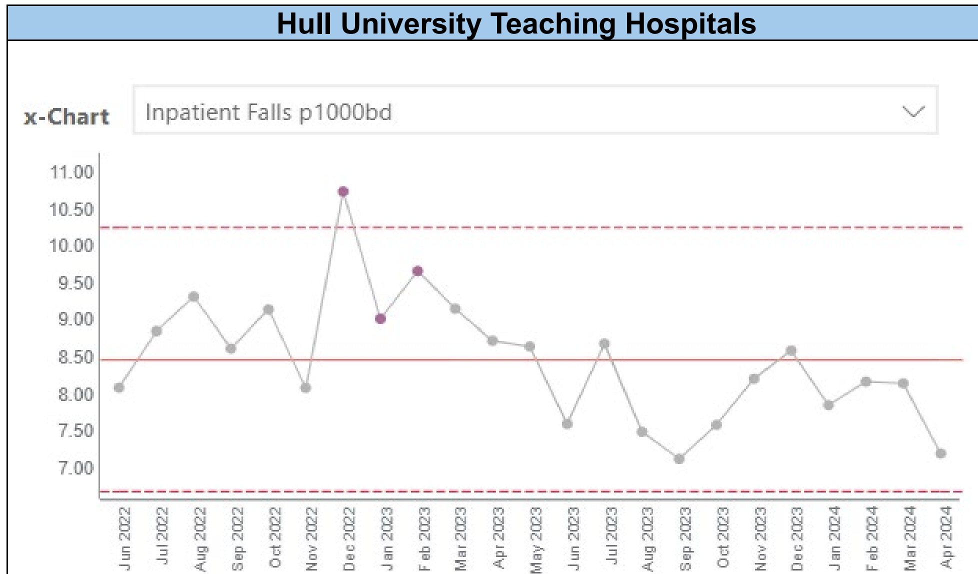
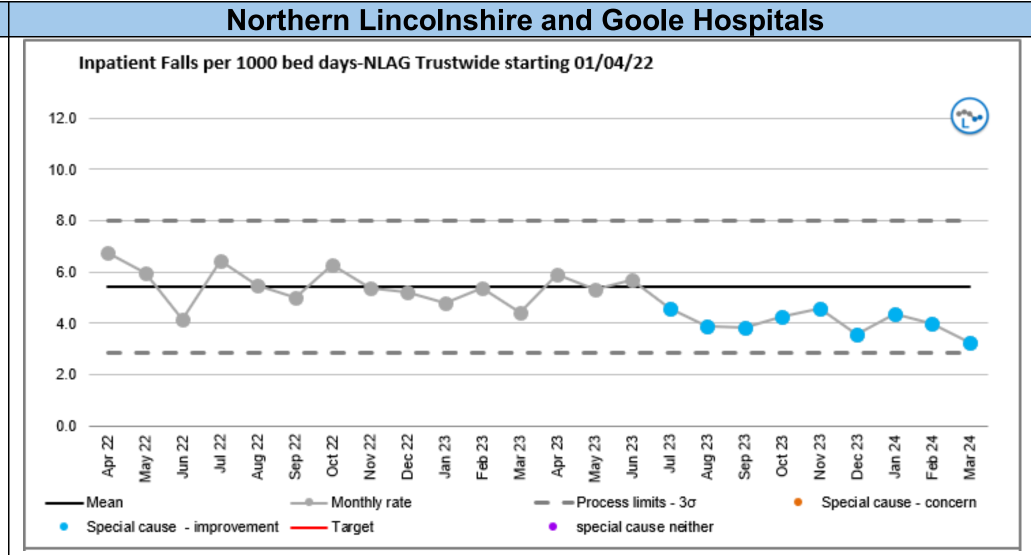
**Commentary:**

With the transition to the Patient Safety Incident Response Framework (PSIRF), the forecast was that there would be a reduced number of cases meeting the national PSII criteria was likely to less than 10 per year. Proportional alternative investigations are being undertaken for incidents in alignment with the Patient Safety Incident Response Plan.

| | |
|---|---|
| A patient with a history of atrial fibrillation and COPD attended the ED with shortness of breath, chest pain and tachycardia. The working diagnosis was pulmonary oedema (heart failure) or sepsis and the patient received treatment for both. Bloods were taken and two troponin level tests were high (265 & 801) but these were not reviewed by ED staff. The patient was transferred from the ED to a high observation bed HOB); once in the HOB cardiology was contacted. The patient died two days later as a result of myocardial infarction. | |

## 2.2 Quality and Safety – Inpatient falls resulting in moderate and above harm (per 1000 bed days)

| Target: No traget | HUTH: 0.20 | NLAG: 3.3 |
|---|---|---|

| Hull University Teaching Hospitals | Northern Lincolnshire and Goole Hospitals |
|---|---|
|   |   |

### HUTH Updates in Month

Inpatients fall rates are shown, with a reduction shift from December 2023 until March 2024, 7 per 1000 bed days.

There were 261 falls in total in April 2024, 0.20 falls (per 1000 bed days) (n=7) resulted in moderate or major harm.

Ongoing work by falls teams, introducing falls prevention processes across wards.

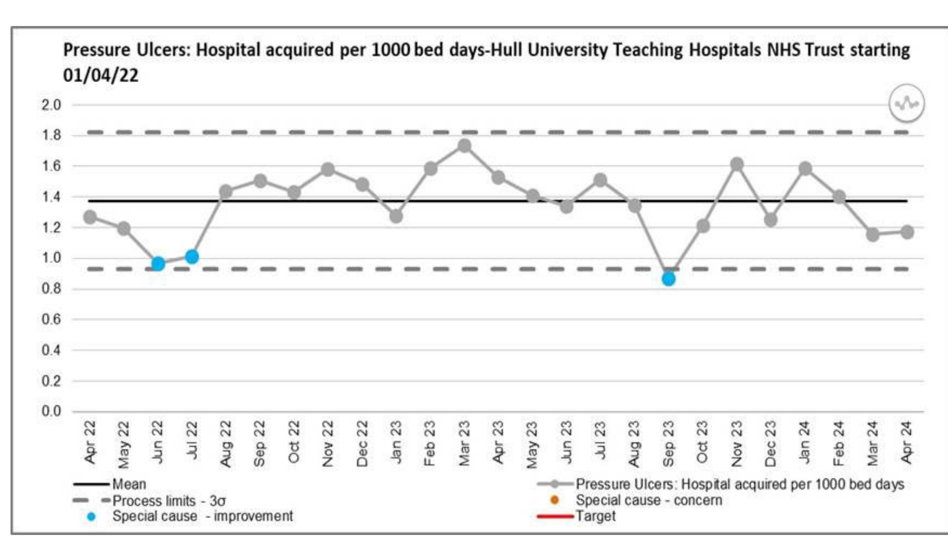
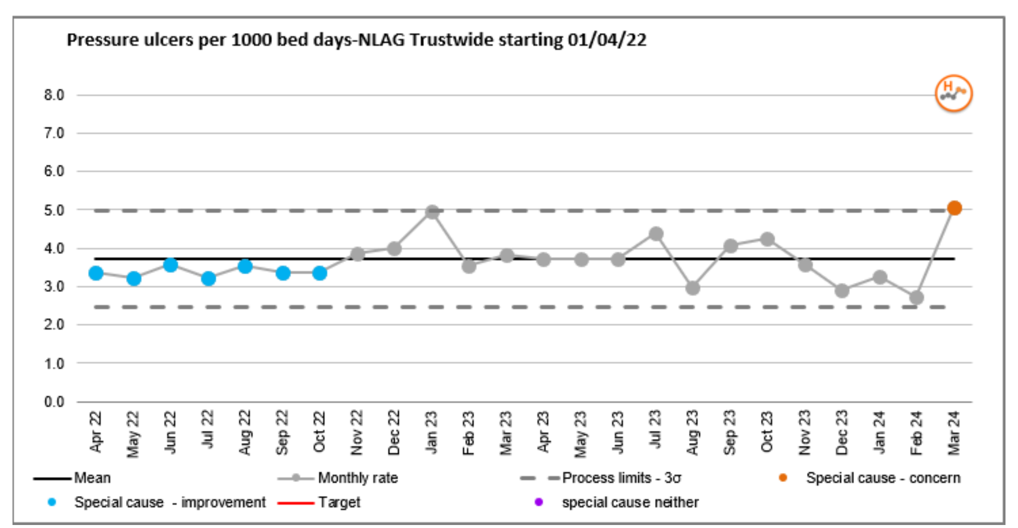
### NLAG Updates in month

Inpatients fall rates are shown, with a reduction shift from July 2023 until March 2024. For March 2024, the proportion of moderate or greater harm is 1.64% of the incidents reported, which provides a value of 0.05 falls per thousand bed days, where moderate or greater harm has occurred.

The reduction is believed to be due to:

- Embedding of:
  - risk assessment
  - individualised care planning using the AFLOAT tool with supportive interventions
- Establishment reviews which have supported increased observation of patients.
- Greater "ownership" of falls at ward level with Matrons now overseeing reviews of patients who have repeat falls.

| 2.3 Quality and Safety – Hospital Acquired Pressure Ulcers resulting in harm (per 1000 bed days) | | |
|---|---|---|
| **Target: TBC** | **HUTH: 1.32** | **NLAG: 5.06** |

| **Hull University Teaching Hospitals** | **Northern Lincolnshire and Goole Hospitals** |
|---|---|
|  |  |





## HUTH Updates in Month

There were 1.2 pressure ulcers per 1,000 bed days of these 1.14 pressure ulcers per 1,000 bed days were moderate and above harm. In April (26 pressure ulcers [non-device] 12 pressure ulcers [device related] 38 total), there were 1.14 pressure ulcers per 1,000 bed days resulting in moderate and above harm in April (26 pressure ulcers [non-device] 12 pressure ulcers [device related] 38 total).

In April there were

- 1 Category 3 pressure ulcer reported which was device related.
- 20 Category 2 pressure ulcers reported; 9 of which were device related.
- 1 Category 1 pressure ulcers reported
- 9 Deep Tissue Injuries (DTI) One and 7 Unstageable pressure injuries.

Moderate harm is defined as a breech in the integrity of the skin a Category/Stage II: partial thickness skin loss, this is on a on a scale of 6.

## NLAG Updates in month

In March there were 4 incidents of Category 3 pressure ulcers and 84 Category 2 pressure ulcers. The dataset uses categories rather than harm rates so unable to provide a direct comparison to the HUTH moderate harm or greater rate.

A review of the incidents reported in March 2024 has demonstrated that a higher proportion are reported in the 7 days following admission to the Trust highlighting the importance of accurate skin inspections and risk assessments from admission. This has been shared with the senior nursing teams at the Nursing Metrics Meeting for dissemination and action.

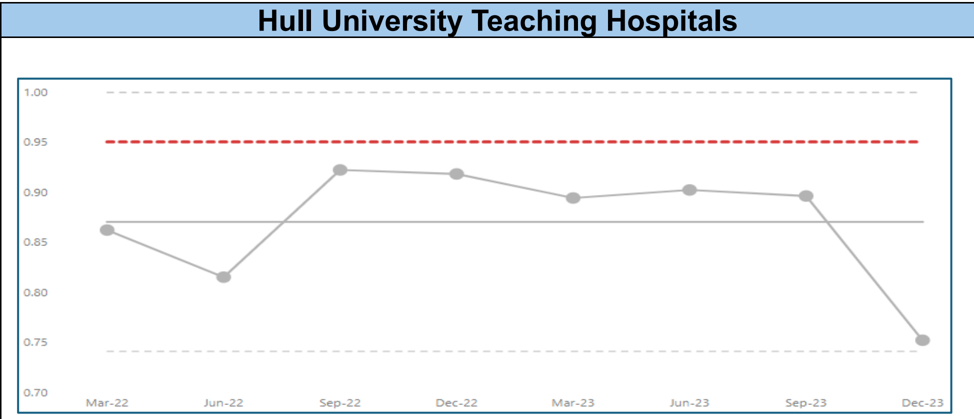
There is provisional data showing a reduced rate in April incidents by ~20 category 2 cases, which will return the rate to ~3.9 close to the mean.

| In the future the National Wound Care Strategy Programme (NWCSP) is changing the category to a numerical 1-4 system. As of April 1st 2024 Tissue Viability have moved over to the PSIRF framework in the investigation of hospital acquired pressure ulcers. | |
|---|---|

## 2.4 Quality and Safety – Venous Thromboembolism (VTE) Risk Assessment Compliance

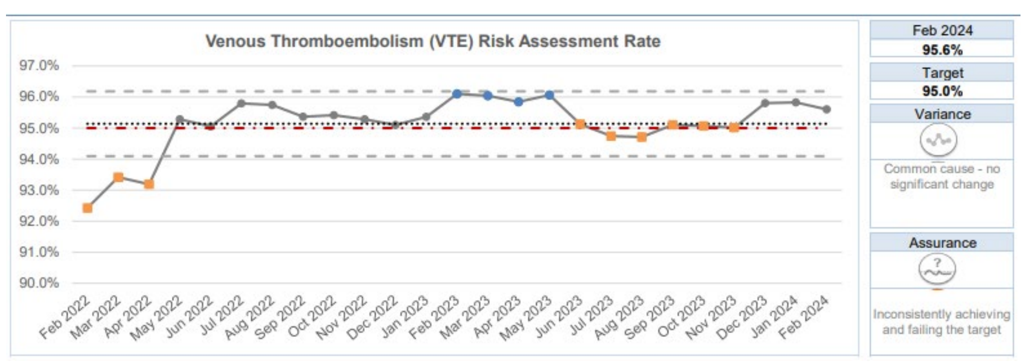
| Target: 95% | HUTH: 75.2% | NLAG: 95.6% |
|---|---|---|

### Hull University Teaching Hospitals




* Data available up to December 2023, note this is nationally validated date which is updated to BI quarterly, The most recent update has not been received at the time of report production.

### Northern Lincolnshire and Goole Hospitals




**HUTH Updates in Month**

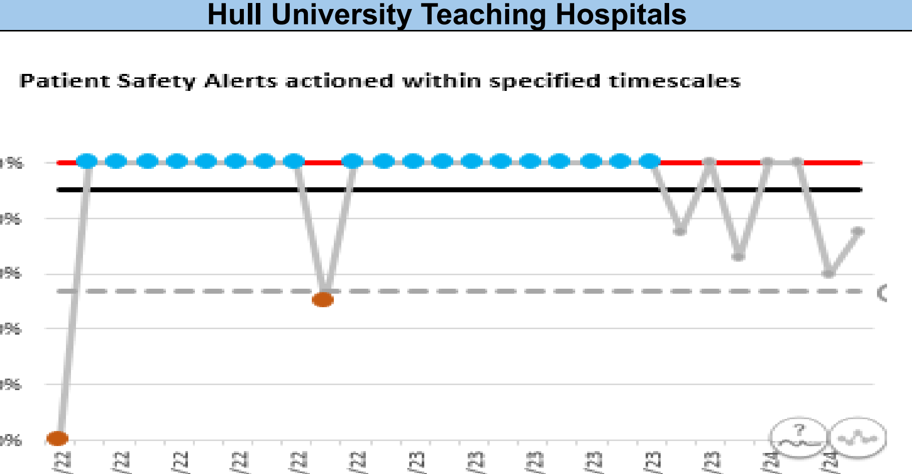
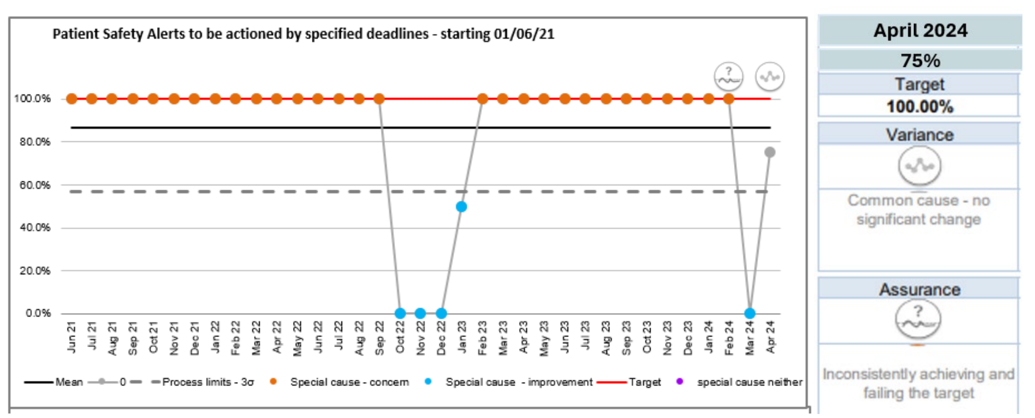
VTE risk assessment rate remains within common cause variation. Compliance is below the Trusts 95% target at 91.9%. A VTE steering groups has been meeting monthly to address low compliance and to identify improvement actions. Pilot wards agreed, working with digital nurse team.

**NLAG Updates in Month**

**The latest available date is February 2024.** VTE risk assessment compliance continues to exceed the 95% target achieving 95.6%.

## 2.5 Quality and Safety – Compliance with CAS Patient Safety Alerts actioned by specific deadlines

| Target: 100% | HUTH: 75 | NLAG:75 |
|---|---|---|

| Hull University Teaching Hospitals | Northern Lincolnshire and Goole Hospitals |
|---|---|
|   |   |

**HUTH Updates in Month**

There were no Patient Safety Alerts with expected deadlines for completion of actions in April. One alert remains open and overdue in relation to Medical beds trolleys bed rails bed grab handles and lateral turning devices: risk of death from entrapment or falls. This alert breached the deadline of 1 March 2024 and is currently on the Trust Risk Register (Risk 4315 with a current Risk rating of High (15)). This has been escalated to the executive team and the alert is being managed by a task and finish group. The numbers involved are low and in months where there are no alerts due for closure are recorded as compliant (100%).

**NLAG Updates in Month**

**Data Analysis:**

**Patient Safety Alerts:** Performance has fallen below the average value of the data but remains within the expected range. The numbers involved are low

**Commentary:**

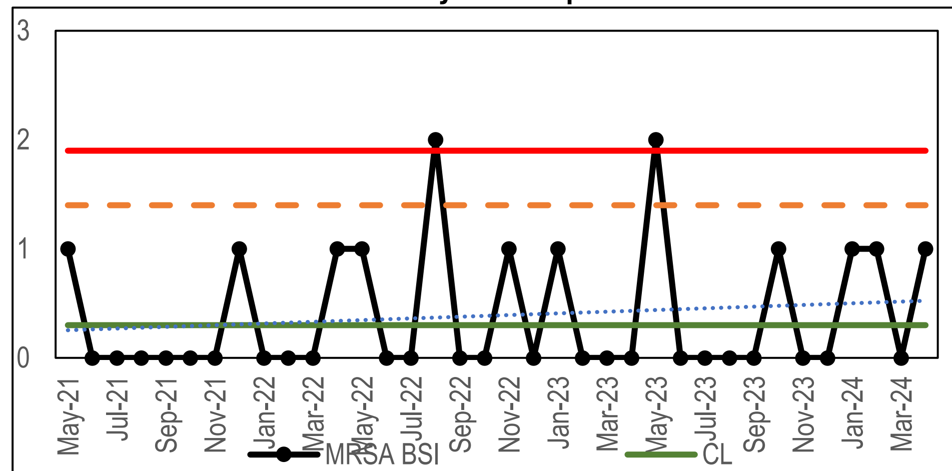
One National Patient Safety Alert, Medical beds trolleys bed rails bed grab handles and lateral turning devices: risk of death from entrapment or falls breached the 1 March 2024 deadline date. There is a working group overseeing progress with this alert and 53% of the recommended actions are complete.

## 2.6 Quality and Safety – Infection Control

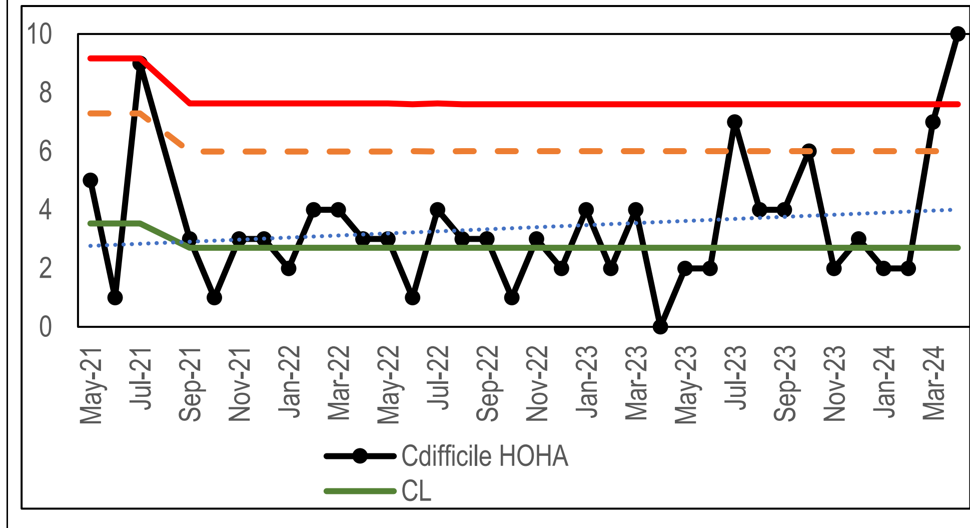
| Target: see narrative | HUTH: 0 | NLAG:0.05 |
|---|---|---|

| Hull University Teaching Hospitals | Northern Lincolnshire and Goole Hospitals |
|---|---|

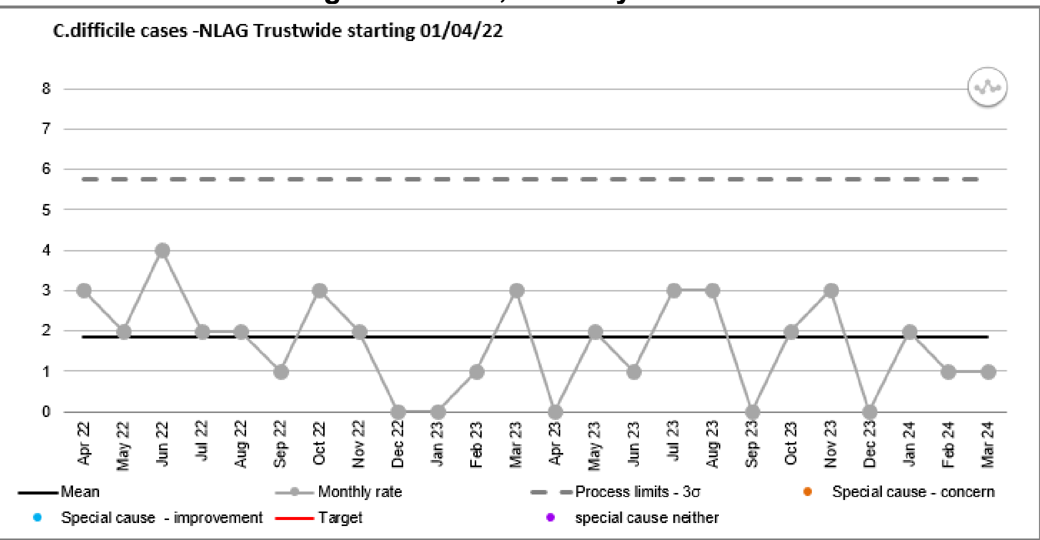
**Number of HOHA MRSA BSIs May 2021 – April 2024**



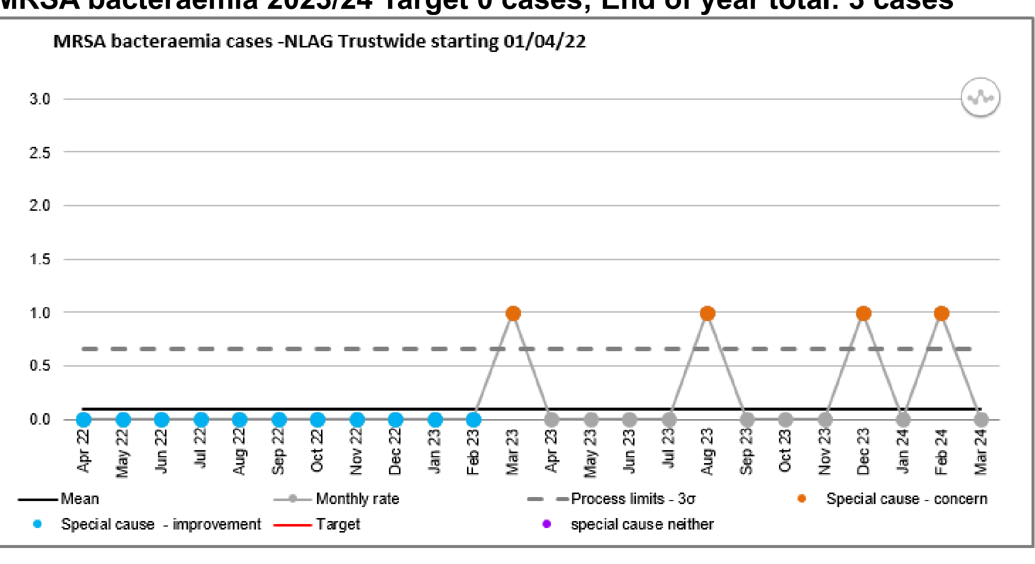

**Number of HOHA *C.difficile* Infections May 2021 – April 2024**



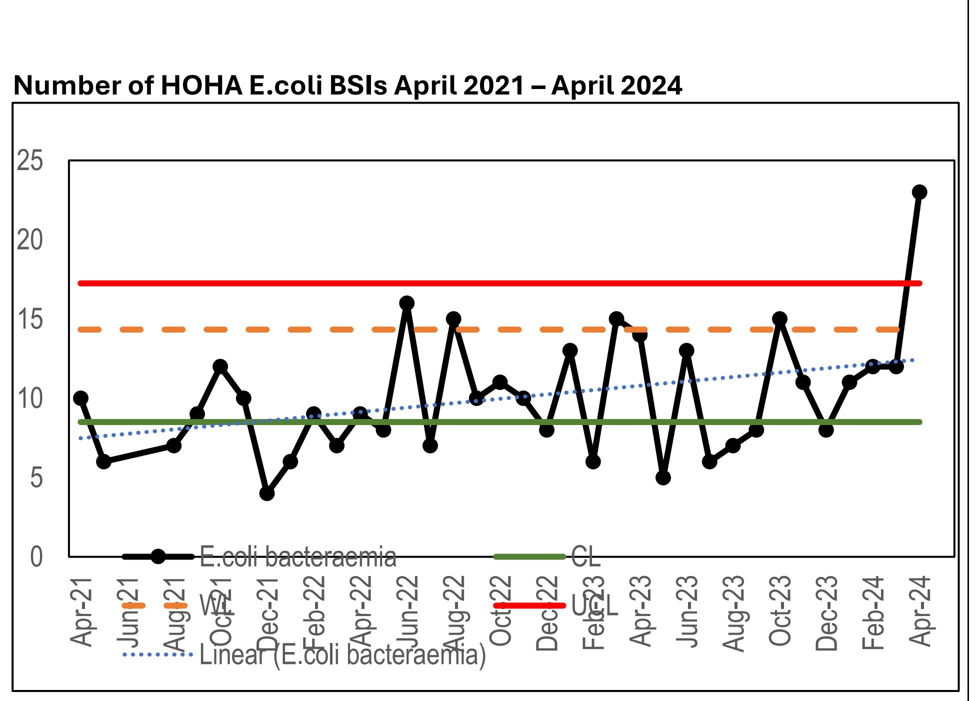
**C-Difficile – 2023/34 Target 20 cases; End of year total 18 cases.**



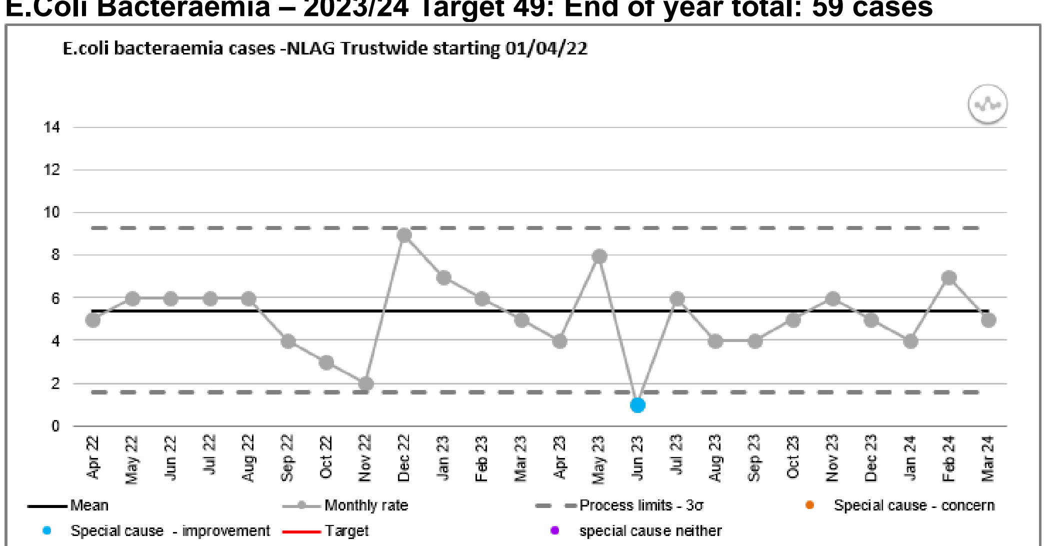

**MRSA bacteraemia 2023/24 Target 0 cases; End of year total: 3 cases**



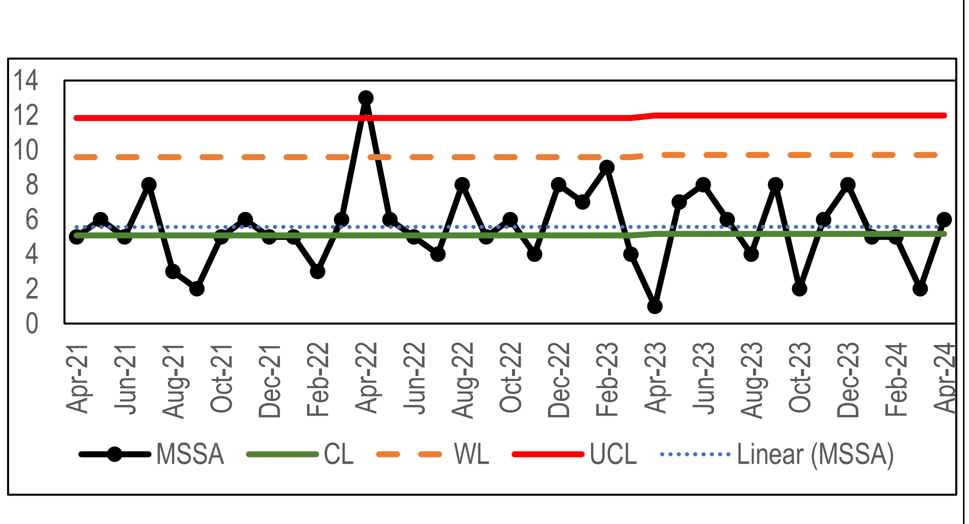
**Number of HOHA E.coli BSIs April 2021 – April 2024**



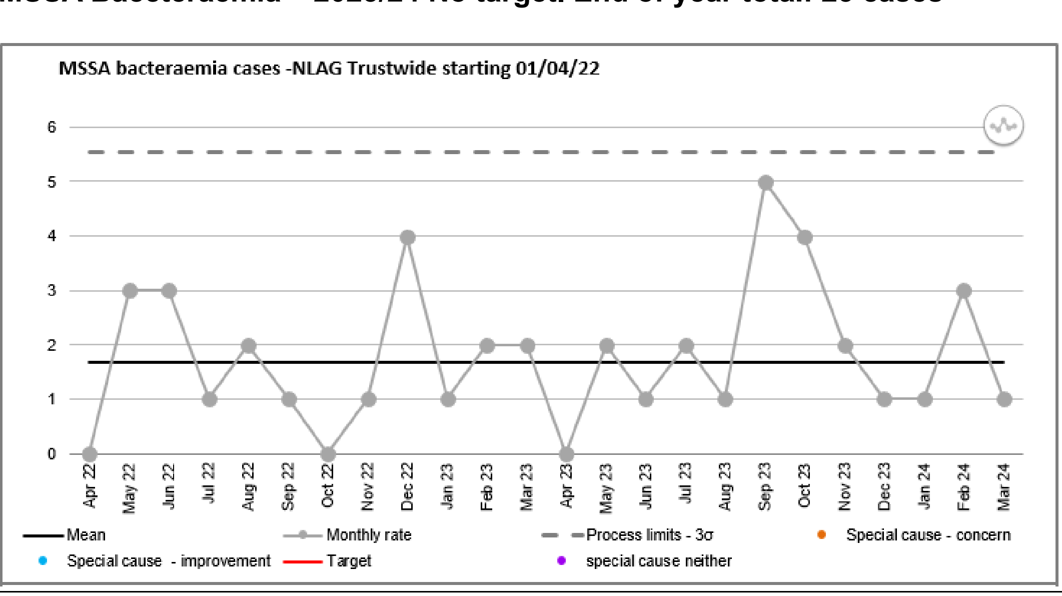

**E.Coli Bacteraemia – 2023/24 Target 49: End of year total: 59 cases**

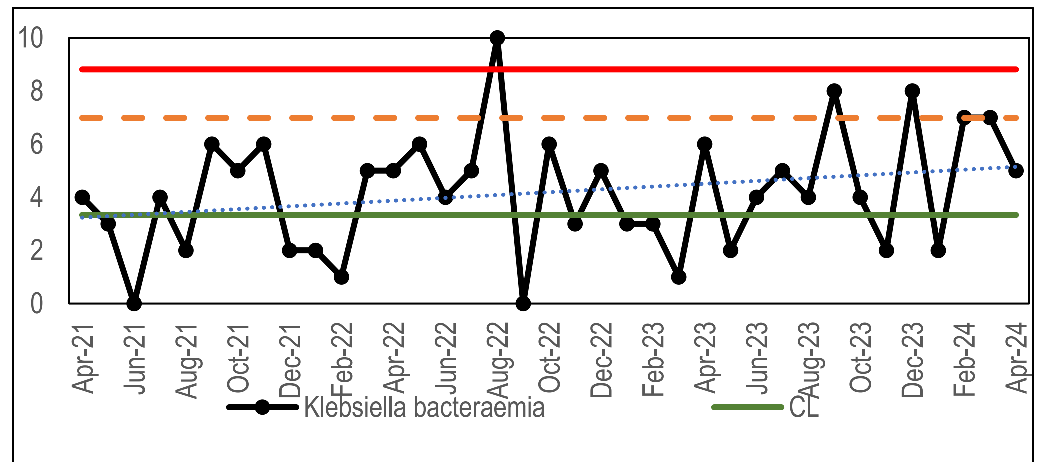
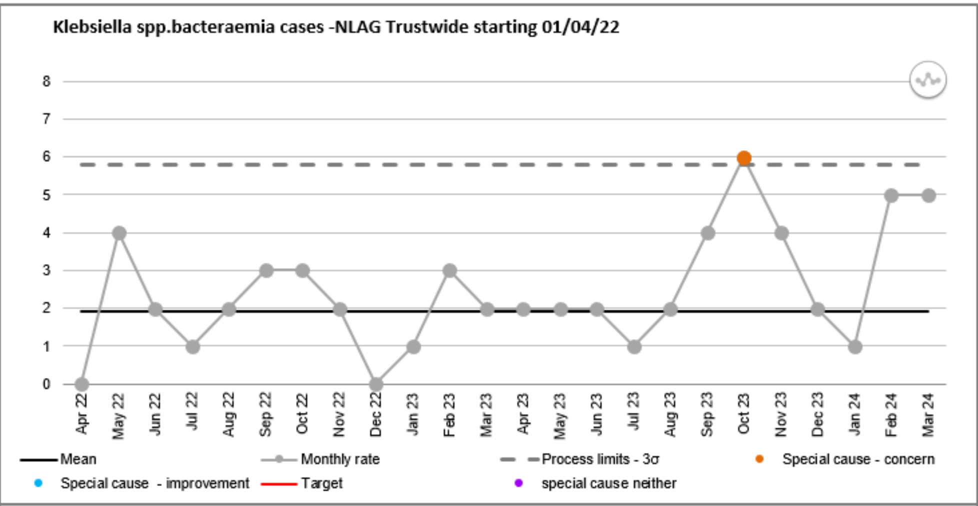
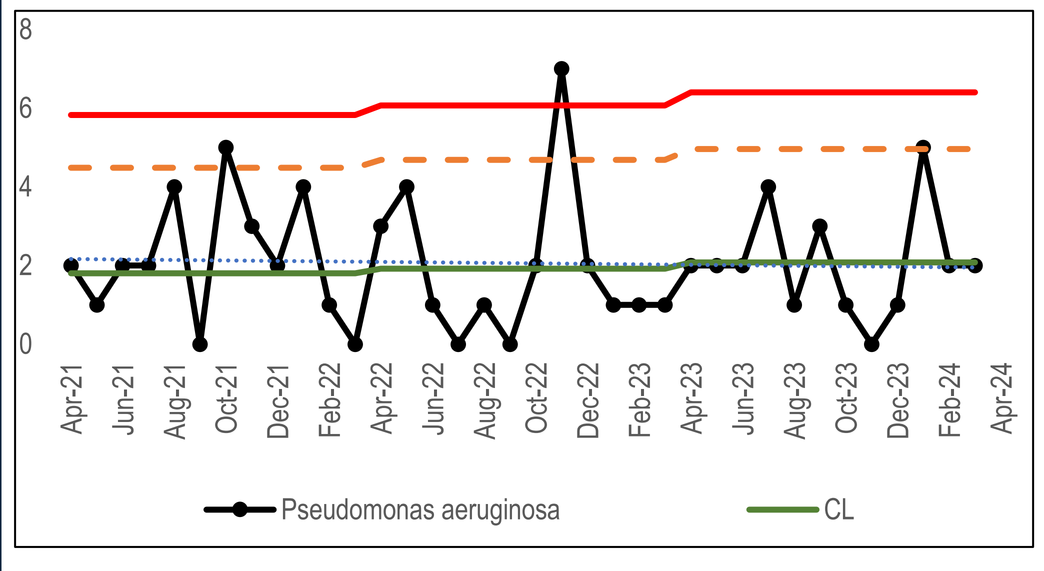
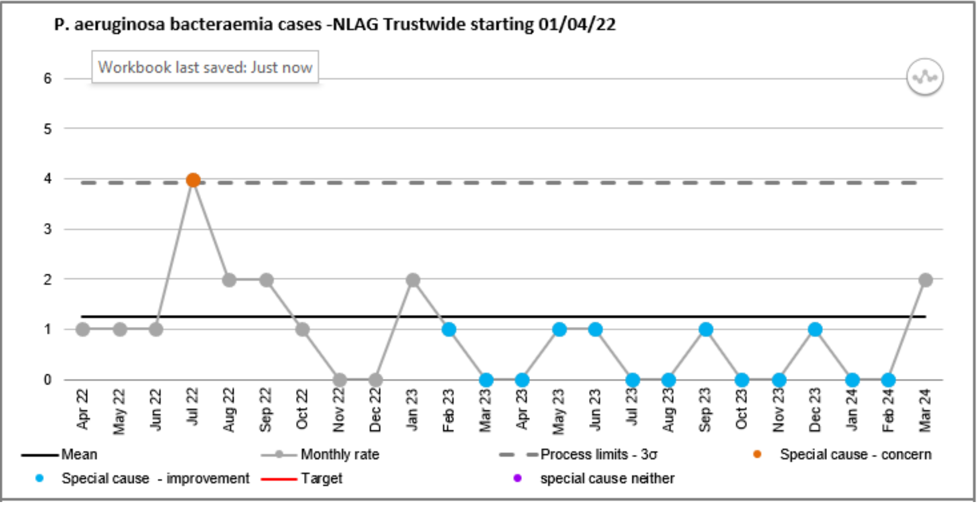



**Number of HOHA MSSA BSIs April 2021 – April 2024**




**MSSA Baccteraemia – 2023/24 No target. End of year total: 23 cases**



| **Number of Gram Negative Infections April 2021 – April 2024**<br>**Klebsiella HOHA BSIs April 2021 – April 2024** | **Klebsiella spp. Bacteraemia 2023/24 Target 22; End of year total: 36 cases** |
|---|---|
|  |  |
| **Number of Gram Negative Infections April 2021 – April 2024**<br>**Pseudomonas aeruginosa HOHA BSIs April 2021 – April 2024** | **P aeruginosa bacteraemia 2023/24 Target 7 cases; End of year: 6 cases** |
|  |  |

| HCAI THRESHOLDS | | |
|---|---|---|
| **HCAI** | **2023/24 Threshold HOHA & COHA** | **Reported cases YTD (April 2024) HOHA & COHA** |
| MRSA BSI | Zero tolerance | **1 HOHA cases** |
| MSSA BSI | No national threshold | **6 cases (3 HOHA & 3 COHA cases)** |
| E.coli BSI | 157 | **23 cases (9 HOHA & 14 COHA cases)** |
| Pseudomonas Aeruginosa BSI | 25 | **2 cases (0 HOHA & 2 COHA cases)** |
| Klebsiella BSI | 64 | **6 Cases (2 HOHA & 4 COHA cases)** |
| *Clostridioides difficile* | 53 | **10 (6 HOHA & 4 COHA)** |

**HUTH Updates in April 2024**

No thresholds have been set for 2024/2025 yet; therefore 2023/2024 remain in place until we are informed of the new thresholds.

***Clostridioides difficile*:** Ten in total were reported for April 2024. Six HOHA CDI cases were reported in April 2024. Two within Digestive diseases on H60 one HOHA & COHA, having reviewed these they are not linked to time nor place, further investigations, however both are unavoidable due to patient clinical condition. There were two within acute and emergency medicine, two in specialist medicine and one in community frailty and therapy.

**E.coli BSIs:** Twenty three in total E.coli BSIs reported during April 2024, a reduction by three case from the previous month.

**Outbreaks**

During April 2024 reports of respiratory infections continued, with COVID19. The increase in respiratory infections across the Trust resulted in some ward closures and bay closures in adult areas.

**Measles**

During April 2024, a patient with confirmed measles was admitted to HRI, via ED. The patient was transferred to Paediatrics and isolated during their patient journey. This resulted in a small group of contact tracing exercise.

Further isolated (non-linked) measles cases have been reported via ED in both adult and paediatric cases and have been managed in line with national guidance suggesting learning from the original incident. Contact tracing external to the Trust has been managed by UKHSA.

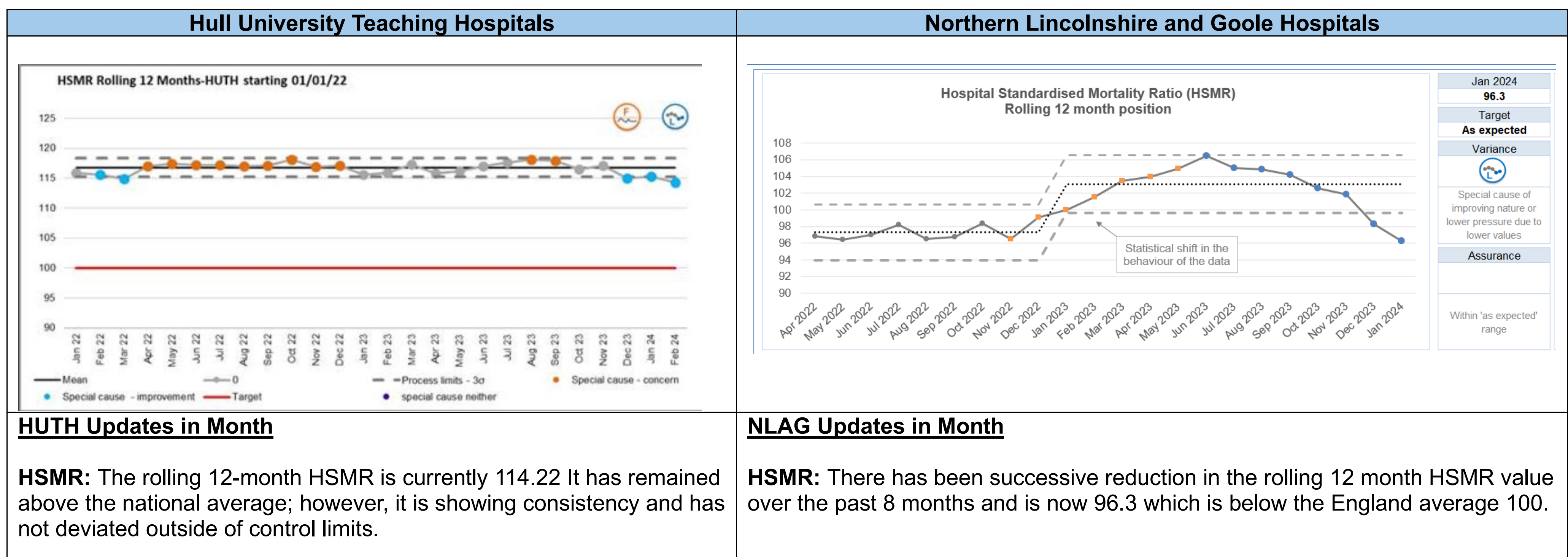
**NLAG Updates in month**

- **MRSA:** The YTD figure is 3 against an annual target of 0.
- **C Diff:** Performance is stable and within the expected range of the data. The YTD figure is 18 against an annual target of 20.
- **E.Coli:** Performance is stable and within the expected range of the data. The YTD figure is 59 against an annual target of 46.
- **MSSA:** Performance is stable and within the expected range of the data. The YTD figure is 23, there is no annual target.
- **Klebsiella:** The YTD figure is 36 against a target of 22.
- **P. Aeriginosa:** Performance is stable and within the expected range. The YTD figure is 6 cases against a target of 7.

## 2.9 Mortality – HSMR Hospitalised Standardised Mortality Ratio

| Target: <100 | HUTH: 114.22 | NLAG: 96.3 |
|---|---|---|

| Hull University Teaching Hospitals | Northern Lincolnshire and Goole Hospitals |
|---|---|




### HUTH Updates in Month

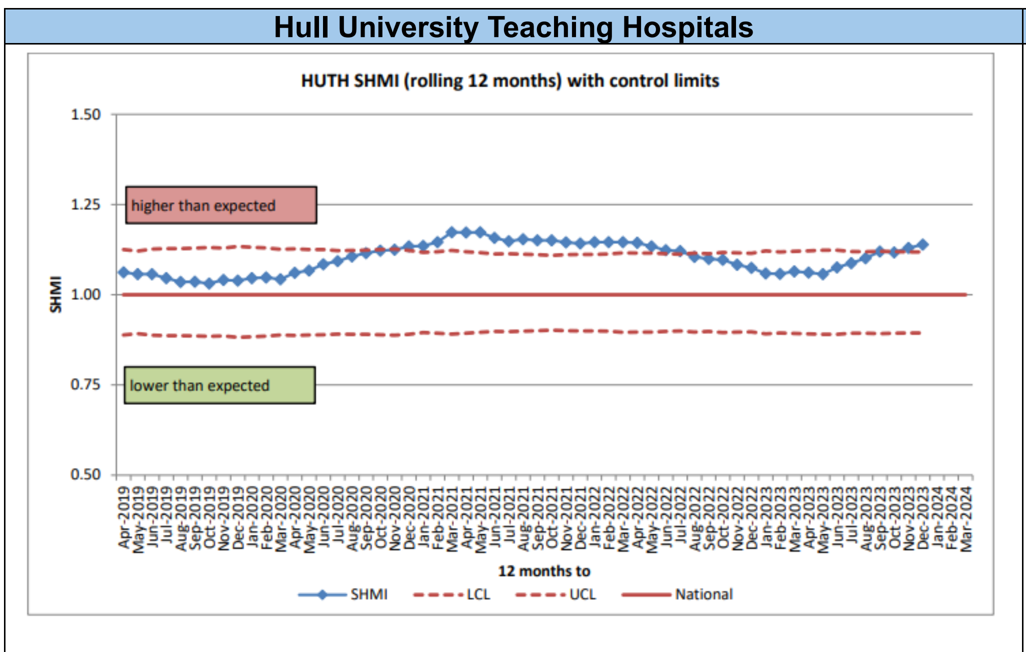
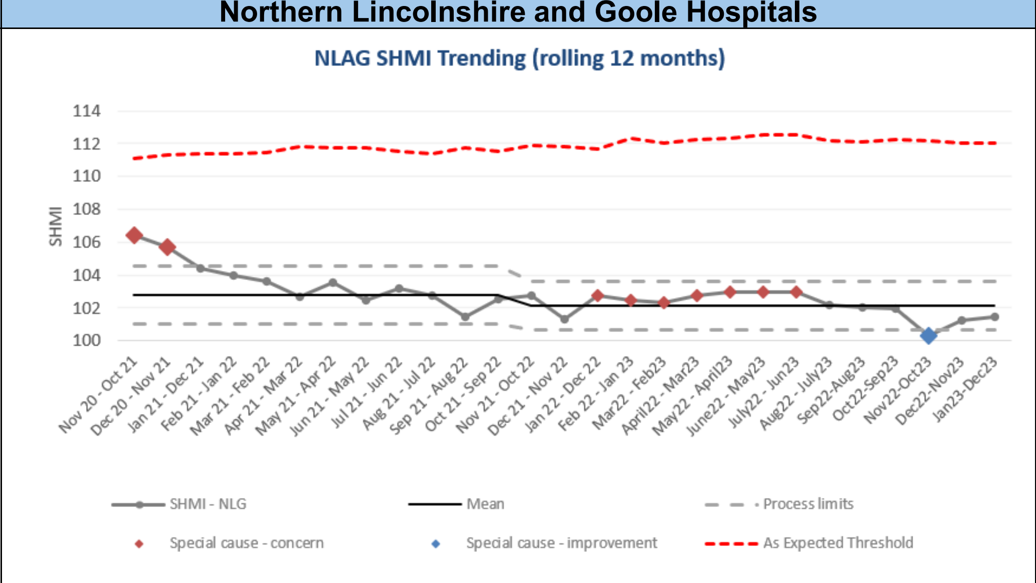
**HSMR:** The rolling 12-month HSMR is currently 114.22 It has remained above the national average; however, it is showing consistency and has not deviated outside of control limits.

### NLAG Updates in Month

**HSMR:** There has been successive reduction in the rolling 12 month HSMR value over the past 8 months and is now 96.3 which is below the England average 100.

## 2.10 Mortality – SHMI Summary Hospital Mortality Indicator

| Target: <100 (<1.0) | HUTH: 1.1391 | NLAG: 1.0144 |
|---|---|---|

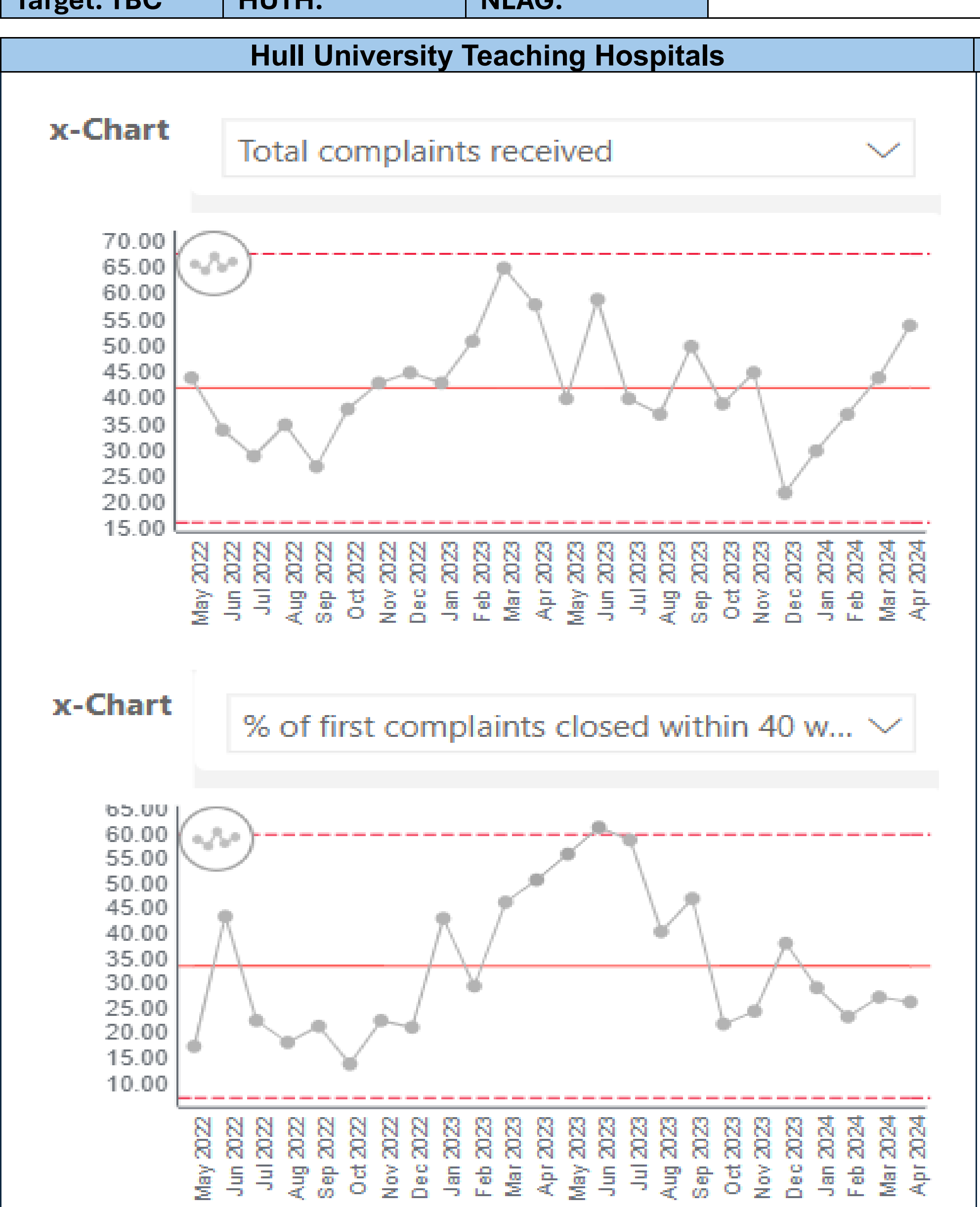
| Hull University Teaching Hospitals | Northern Lincolnshire and Goole Hospitals |
|---|---|
|   |   |
| **SHMI:** Latest available data December 2023 - HUTH SHMI: 1.1391. Of the conditions for which a SHMI is calculated by NHSD, HUTH is identified as having a **higher** than expected SHMI for:<br>Fracture of neck of femur (hip)<br>Secondary malignancies<br>Septicaemia<br><br>• HRI 1.0943 (previously 1.0953 as expected)<br>• Castle Hill is 1.2899; 'higher than expected' (previously 1.2390 higher than expected') | **SHMI:** The Trust has a SHMI value 1.0144 for the latest period November 2022 – December 2023, which is in the 'as expected' banding.<br>• Grimsby – 1.0146; 'as expected' (previously 1.0228 and 'as expected')<br>• Scunthorpe – 1.0134; 'as expected' (previously 1.006 and 'as expected') |

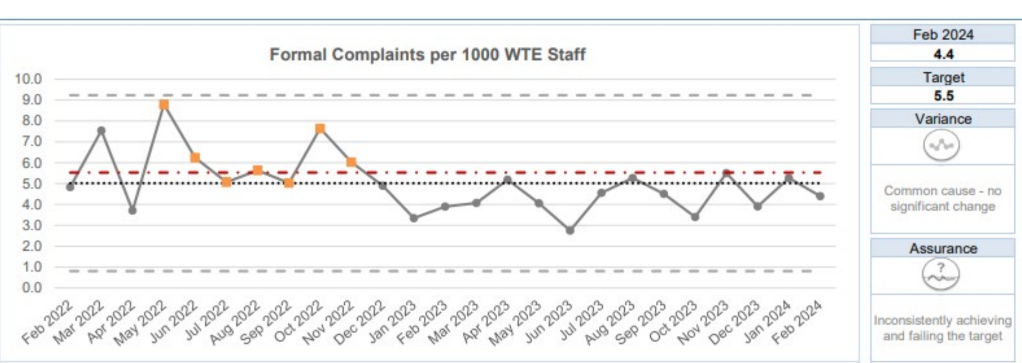
| **Actions Taken**<br>• Development of a Mortality Strategy for HUTH, aligning with NLaG including development of current learning from deaths policy reflecting collaborative working between the two Trusts.<br>• Development of Terms of Reference for Specialty level Mortality and Morbidity Review.<br>• Support in the identification and delivery of QI initiatives within areas of high SHMI.<br>• Explorative deep dive assessment of mortality statistics to aid identification of possible areas that may be having an impact on overall SHMI.<br>• Monthly collaborative reviews undertaken with Yorkshire Ambulance Service allowing a joined up approach in reviewing patient care and wider system learning.<br>• Appointment of an Associate CMO for Quality and Safety. | |
|---|---|

## 2.11 Patient Experience – Complaints

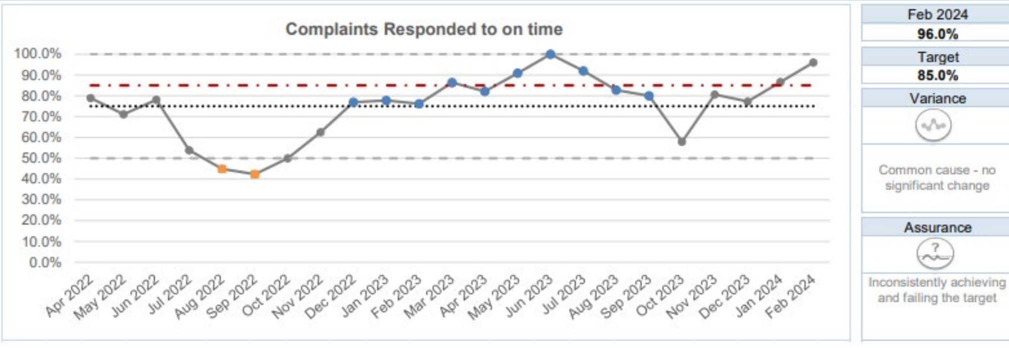
| Target: TBC | HUTH: | NLAG: |
|---|---|---|

| Hull University Teaching Hospitals | Northern Lincolnshire and Goole Hospitals |
|---|---|




The data from information services has ceased being provide for the quality IPR, so the chart above is the previously available data. The latest data available, for April 2024 is finding 30 complaints were received and this equeates to ~5.08 complaints per 1000 staff.

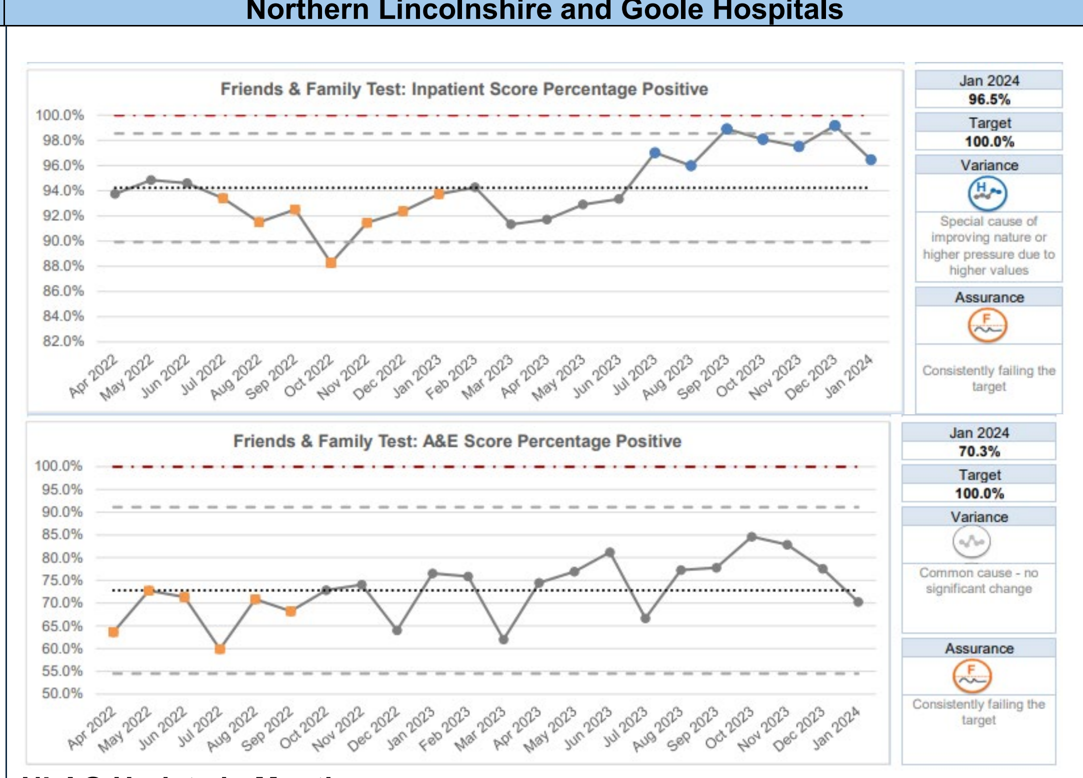



Complaint closed on time performance is 95% for April 2024.

| **HUTH Updates in Month** | **NLAG Updates in Month** |
|---|---|
| **Formal Complaints:**<br>In April 2024, the Trust received 54 formal complaints; 47 new (initial) and 7 re-opened complaints.<br>**Complaints Responded to on time:** 32 complaints were closed in April 2024. 16 complaints were closed within the 40 working day target. 19 complaints were closed within the 60 working day target.<br>**Commentary** Ongoing work from the PE the team to support Health groups | **Commentary**<br>The number of complaints responded to in the timeframe has maintained a positive position. The complaints received remain complex and across different Care Groups so joint working is ongoing to answer in a timely manner. |

## 2.12 Patient Experience – Friends and Family Test (FFT)

| Target: TBC | HUTH: | NLAG: |
|---|---|---|

| Hull University Teaching Hospitals | Northern Lincolnshire and Goole Hospitals |
|---|---|
| The Director of Quality Governance has undertaken a review of FFT responses since April 2022. The focus in April 2024 was to look back at the improvements, agreeing how to continue to drive improvements using FFT feedback triangulating with other experience data to inform further learning from experience. Since 1 April 2022, HUTH has had electronic data collection processes in place and has increased its collection via SMS. The Trust collected 116k responses in 2022/23 and 120k responses in 2023/24.<br><br>A&E has improved from worst in region and improved over the winter period.<br><br>There has been a change in reporting so historical charts provided above, with April 2024 data below:<br>FFT positivity score for ED –70 %<br>FFT positivity score for inpatients – 91%%<br>FFT positivity score for outpatients – 94 %<br>FFT positivity score for maternity – 100% | <br><br>**NLAG Update in Month:**<br>There has been a change in reporting so historical charts provided above, with April 2024 data below: |

| | |
|---|---|
| | FFT positivity score for inpatients – 97%<br>FFT positivity score for ED – 84% |

# Group People Directorate

# Workforce Integrated Performance Report

April 2024

All data below relates to March 2024

## Group Actions

| Indicator | Key Issues to address this Period | What actions are in place to mitigate? |
|---|---|---|
| **Turnover** | NLAG current Turnover rate is at 10.5% against a target of 10%<br><br>As a Group both Trusts have a high number of leavers with less than 1 years' service in Additional Clinical Services, Estates and Ancillary and Admin and Clerical staff groups | Recruitment and Retention Marketing Group Strategy developed – to include the setting of realistic expectations |
| | | Succession Planning – better use of existing workforce to avoid agency dependency. Pipelines to meet demand. |
| | | Review of local induction |
| | | Exit Questionnaire - will give greater insight |
| | | People Promise Manager now appointed (NLaG 1st May) |
| | | Itchy feet clinics |
| | | Transfer policy to include non-registered Nursing. |
| **Consultant and SAS - Job Plans** | As a Group both Trusts not meeting target.<br>HUTH - All but corporate failing to meet the target.<br>NLAG – All but Clinical Support Services and Surgery failing to meet the target. | Data on compliance is available to clinical leads via a Power BI dashboard for HUTH. NLAG to adopt the same process and transfer Job Planning data on Power BI in May 24. Monthly job planning accountability meetings to continue with new Care Groups. |
| | | Mitigation on-going for certain services. |
| **Sickness** | As a Group both Trusts not meeting target of 4%<br>HUTH 4.27%<br>NLAG 4.87%<br><br>The data shows us that the highest absence reason is stress, anxiety, and depression. | The HR team continue to support managers to take ownership of management of absence providing additional training. Leadership development continues to support managers within compassionate leadership practices and supporting the early signs and triggers of mental instability. |
| | | Power BI to include Sickness data for NLAG to be introduced May 24 to ensure Managers can identify triggers |
| | | Group Well-being strategy to be refreshed and launched in June 24 |

| | | |
|---|---|---|
| **Appraisal** | Both Trust's not meeting AFC target.<br>HUTH, all but 3 staff groups are not meeting the target.<br>NLAG, all but 3 staff groups not meeting target. | Monthly meetings with managers utilising reports available (e.g. HR Dashboard reports) to identify staff who have not had an appraisal. Regular communications to staff out of compliance |
| | | Data sent from HEY 24/7 via the HR team to target areas which are not compliant. |
| | | NLAG - The ESR team continue with targeted communication to managers for out of compliance PADRs. The ESR Team continue to support managers around PADR compliance with myth busting, gentle reminders and education. |
| **Core Mandatory Training** | HUTH sees all but 4 care groups meeting target. Cardiovascular, Neuroscience, Specialist Surgery and Corporate.<br><br>NLAG sees all but 2 care groups meeting target. Acute and Emergency Medicine and Specialist Surgery<br><br>Medical & Dental all grades are a concern for Core Mandatory training for both Trusts | Monthly meetings with managers utilising reports available (e.g. HR Dashboard reports) to identify staff who are out of compliance. The training team are working through a training needs analysis to right size the ask of medical and dental staff with concerns that the current ask is too generic for specific roles. |
| **Role Specific Training** | Staff Group Medical and Dental continue to report low compliance rates for role specific training | NLAG - Following feedback from this group on barriers to accessing / attending training, various actions have been set. These include a 2-month trial in extending the opening hours of the Learning and Development Helpline facility so that staff are able to speak to an advisor in real time rather than waiting for an email response. |

# HUTH Substantive and Temporary Staffing by Health Group

*Please note that Temporary Workforce data is unavailable for March 24, this is due to the new Care Group Infrastructure changes, this will be available next month

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| | HUTH | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Substantive Workforce | | | | Temporary Workforce | | | |
| **Health Group/Directorate** | **Establishment WTE** | **Staff in Post WTE** | **Vacancies WTE** | **Vacancy Rate %** | **Agency WTE** | **Bank WTE** | **Adjusted Vacancies WTE** | **Adjusted Vacancy Rate %** |
| Cancer Network | 33.2 | 36.9 | -3.7 | -11.0 | | | | |
| Cardiovascular | 394.4 | 383.3 | 11.2 | 2.8 | | | | |
| Digestive Diseases | 459.5 | 461.5 | -2.0 | -0.4 | | | | |
| Head & Neck | 261.8 | 230.9 | 30.8 | 11.8 | | | | |
| Major Trauma Network | 113.4 | 98.1 | 15.3 | 13.5 | | | | |
| Patient Services | 897.6 | 899.7 | -2.1 | -0.2 | | | | |
| Specialist Cancer and Support Services | 1376.6 | 1303.7 | 72.9 | 5.3 | | | | |
| Chief Delivery Officer | 67.2 | 68.4 | -1.2 | -1.8 | | | | |
| Theatres, Anaesthetics and Critical Care | 1052.2 | 1061.7 | -9.5 | -0.9 | | | | |
| Acute and Emergency Medicine | 518.9 | 480.0 | 39.0 | 7.5 | | | | |
| Community, Frailty & Therapy | 746.4 | 694.2 | 52.1 | 7.0 | | | | |
| Family Services | 757.6 | 740.4 | 17.2 | 2.3 | | | | |
| Neuroscience | 269.1 | 257.9 | 11.2 | 4.1 | | | | |
| Pathology Network Group | 60.5 | 53.8 | 6.7 | 11.0 | | | | |
| Site Management & Discharge Teams | 51.3 | 53.0 | -1.7 | -3.4 | | | | |
| Specialist Medicine | 289.1 | 291.1 | -2.0 | -0.7 | | | | |
| Specialist Surgery | 388.6 | 381.1 | 7.5 | 1.9 | | | | |
| Corporate | 756.7 | 800.4 | -43.7 | -5.8 | | | | |
| Estates, Facilities and Development | 511.9 | 478.9 | 33.0 | 6.4 | | | | |

# NLAG Substantive and Temporary Staffing by Health Group

| | NLAG | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Substantive Workforce | | | | Temporary Workforce | | | |
| **Health Group/Directorate** | **Establishment WTE** | **Staff in Post WTE** | **Vacancies WTE** | **Vacancy Rate %** | **Agency WTE** | **Bank WTE** | **Adjusted Vacancies WTE** | **Adjusted Vacancy Rate %** |
| Cancer Network | 24.5 | 29.6 | -5.2 | -21.1 | 0.0 | 1.2 | -6.4 | -26.0 |
| Cardiovascular | 114.0 | 100.9 | 13.2 | 11.5 | 3.0 | 7.3 | 2.9 | 2.5 |
| Digestive Diseases | 373.8 | 348.6 | 25.2 | 6.8 | 6.6 | 25.7 | -7.1 | -1.9 |
| Head & Neck | 117.6 | 106.7 | 10.9 | 9.2 | 9.6 | 13.1 | -11.8 | -10.1 |
| Major Trauma Network | 47.6 | 42.6 | 5.0 | 10.4 | 0.0 | 0.0 | 5.0 | 10.4 |
| Patient Services | 642.0 | 603.8 | 38.2 | 6.0 | 0.6 | 21.9 | 15.8 | 2.5 |
| Specialist Cancer and Support Services | 449.6 | 411.9 | 37.8 | 8.4 | 14.2 | 17.1 | 6.4 | 1.4 |
| Chief Delivery Officer | 94.0 | 88.3 | 5.7 | 6.0 | 0.0 | 0.0 | 5.7 | 6.0 |
| Theatres, Anaesthetics and Critical Care | 507.5 | 471.9 | 35.6 | 7.0 | 20.6 | 24.6 | -9.6 | -1.9 |
| Acute and Emergency Medicine | 844.9 | 745.8 | 99.1 | 11.7 | 93.1 | 114.1 | -108.0 | -12.8 |
| Community, Frailty & Therapy | 901.7 | 875.4 | 26.3 | 2.9 | 8.2 | 35.8 | -17.7 | -2.0 |
| Family Services | 663.8 | 629.3 | 34.5 | 5.2 | 18.5 | 62.0 | -46.0 | -6.9 |
| Neuroscience | 112.9 | 104.9 | 8.0 | 7.1 | 12.9 | 19.2 | -24.1 | -21.4 |
| Pathology Network Group | 405.4 | 372.8 | 32.6 | 8.0 | 1.8 | 11.8 | 19.0 | 4.7 |
| Site Management & Discharge Teams | 51.8 | 45.2 | 6.6 | 12.7 | 1.5 | 11.1 | -6.0 | -11.7 |
| Specialist Medicine | 291.7 | 267.4 | 24.3 | 8.3 | 25.0 | 42.1 | -42.8 | -14.7 |
| Specialist Surgery | 199.3 | 179.9 | 19.4 | 9.7 | 12.6 | 23.5 | -16.7 | -8.4 |
| Corporate | 597.27 | 532.57 | 64.7 | 10.8 | 1.3 | 17.3 | 46.1 | 7.7 |
| Estates, Facilities and Development | 612.20 | 550.20 | 62.0 | 10.1 | 0.0 | 75.8 | -13.8 | -2.3 |

# HUTH Substantive and Temporary Staffing by Staff Group

| | HUTH | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Substantive Workforce | | | | Temporary Workforce | | | |
| **Staff Group** | **Establishment WTE** | **Staff in Post WTE** | **Vacancies WTE** | **Vacancy Rate %** | **Agency WTE** | **Bank WTE** | **Adjusted Vacancies WTE** | **Adjusted Vacancy Rate %** |
| Additional Clinical Services | 1584.5 | 1422.7 | 161.8 | 10.2 | 0.0 | 52.2 | 109.6 | 6.9 |
| Add Prof Scientific and Technical | 277.8 | 358.3 | -80.5 | -29.0 | 0.0 | 1.1 | -81.6 | -29.4 |
| Administrative and Clerical Staff | 1689.7 | 1744.8 | -55.1 | -3.3 | 0.4 | 4.8 | -60.3 | -3.6 |
| Allied Health Professionals | 666.6 | 550.2 | 116.4 | 17.5 | 5.2 | 0.2 | 111.0 | 16.7 |
| Estates and Ancillary | 629.9 | 577.2 | 52.7 | 8.4 | 0.0 | 0.1 | 52.6 | 8.4 |
| Healthcare Scientists | 185.2 | 162.5 | 22.7 | 12.3 | 0.0 | 0.0 | 22.7 | 12.3 |
| Medical & Dental - Consultant | 534.7 | 504.5 | 30.2 | 5.7 | 14.9 | 0.0 | 15.3 | 2.9 |
| Medical & Dental - SAS | 89.1 | 59.4 | 29.7 | 33.4 | 0.2 | 0.0 | 29.6 | 33.2 |
| Medical & Dental – Trainee Grades | 739.0 | 750.8 | -11.8 | -1.6 | 10.3 | 12.9 | -35.0 | -4.7 |
| Nursing and Midwifery Registered | 2609.4 | 2644.6 | -35.2 | -1.3 | 3.1 | 26.6 | -64.9 | -2.5 |
| **Trust Total** | **9005.9** | **8775.0** | **230.9** | **2.6** | **34.1** | **97.9** | **98.9** | **1.1** |

# NLAG Substantive and Temporary Staffing by Staff Group

| | NLAG | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Substantive Workforce | | | | Temporary Workforce | | | |
| **Staff Group** | **Establishment WTE** | **Staff in Post WTE** | **Vacancies WTE** | **Vacancy Rate %** | **Agency WTE** | **Bank WTE** | **Adjusted Vacancies WTE** | **Adjusted Vacancy Rate %** |
| Additional Clinical Services | 1467.2 | 1386.6 | 80.6 | 5.5 | 3.0 | 159.1 | -81.5 | -5.6 |
| Add Prof Scientific and Technical | 102.0 | 89.4 | 12.6 | 12.3 | 2.1 | 0.0 | 10.5 | 10.3 |
| Administrative and Clerical Staff | 1407.4 | 1307.8 | 99.6 | 7.1 | 1.3 | 63.0 | 35.3 | 2.5 |
| Allied Health Professionals | 452.1 | 453.2 | -1.2 | -0.3 | 9.7 | 0.7 | -11.6 | -2.6 |
| Estates and Ancillary | 588.2 | 532.5 | 55.7 | 9.5 | 0.0 | 83.2 | -27.5 | -4.7 |
| Healthcare Scientists | 223.2 | 200.5 | 22.8 | 10.2 | 4.6 | 0.0 | 18.2 | 8.1 |
| Medical & Dental - Consultant | 322.4 | 258.7 | 63.6 | 19.7 | 27.3 | 18.3 | 18.0 | 5.6 |
| Medical & Dental - SAS | 203.6 | 181.2 | 22.4 | 11.0 | 10.5 | 18.8 | -6.9 | -3.4 |
| Medical & Dental – Trainee Grades | 310.0 | 299.7 | 10.4 | 3.3 | 37.5 | 38.9 | -66.0 | -21.3 |
| Medical & Dental – Other | 6.4 | 5.8 | 0.6 | 9.4 | 0.0 | 0.0 | 0.6 | 9.4 |
| Nursing and Midwifery Registered | 1969.1 | 1792.4 | 176.7 | 9.0 | 133.4 | 146.3 | -103.0 | -5.2 |
| **Trust Total** | **7051.6** | **6507.8** | **543.8** | **7.7** | **229.4** | **528.4** | **-214.0** | **0.0** |

## Group Substantive and Temporary Staffing Comments

| HUTH | NLAG |
|---|---|
| The Trust has 8,775.0 WTE substantive staff and in March 24 resourced 132 WTE temporary staff | The Trust has 6,507.8 WTE substantive staff and in March 24 resourced 753.2 WTE temporary staff |
| The vacancy rate for the Trust is 230.9 WTE (2.6%) and this reduces to 98.9 WTE (1.1%) when adjusted for temporary staffing usage. | The vacancy rate for the Trust is 543.8 WTE (7.7%) and this reduces to -214 WTE (-3.0%) when adjusted for temporary staffing usage, taken this is above establishment. |
| Nursing and Midwifery Registered Staff are over establishment by 35.2 WTE (-1.3%) | Nursing and Midwifery Registered Staff have 176.7 WTE vacancies (9%) |
| Medical and Dental Consultants have 30.2 WTE (5.7%) vacancies. This reduces to 15.3 WTE (2.9%) when adjusted for temporary staffing usage. | Medical and Dental Consultants have 63.6 WTE (19.7%) vacancies. This reduces to 18 WTE (5.6%) when adjusted for temporary staffing usage. |

# Group Turnover by Health Group

| Health Group/Directorate | % Turnover March | | | | |
|---|---|---|---|---|---|
| | Target | HUTH Rate % | Variance % | NLAG Rate % | Variance % |
| Cancer Network | 10 | 14.2 | 4.2 | 0 | -10.0 |
| Cardiovascular | 10 | 8.2 | -1.8 | 4.9 | -5.1 |
| Digestive Diseases | 10 | 8.3 | -1.8 | 7.3 | -2.7 |
| Head & Neck | 10 | 11.9 | 1.9 | 13.6 | 3.6 |
| Major Trauma Network | 10 | 7.6 | -2.4 | 9.7 | -0.3 |
| Patient Services | 10 | 11.7 | 1.7 | 10.6 | 0.6 |
| Specialist Cancer and Support Services | 10 | 9.1 | -0.9 | 10.8 | 0.8 |
| Chief Delivery Officer | 10 | 9.9 | -0.1 | 12.1 | 2.1 |
| Theatres, Anaesthetics and Critical Care | 10 | 8.2 | -1.8 | 9.9 | -0.1 |
| Acute and Emergency Medicine | 10 | 9.3 | -0.7 | 10.5 | 0.5 |
| Community, Frailty & Therapy | 10 | 12.0 | 2.0 | 12.1 | 2.1 |
| Family Services | 10 | 5.9 | -4.1 | 9.6 | -0.4 |
| Neuroscience | 10 | 6.5 | -3.6 | 9.6 | -0.4 |
| Pathology Network Group | 10 | 21.7 | 11.7 | 13.8 | 3.8 |
| Site Management & Discharge Teams | 10 | 8.1 | -1.9 | 12 | 2.0 |
| Specialist Medicine | 10 | 6.0 | -4.0 | 11.2 | 1.2 |
| Specialist Surgery | 10 | 10.5 | 0.4 | 11.8 | 1.8 |
| Corporate | 10 | 10.1 | 0.1 | 11.9 | 1.9 |
| Estates, Facilities and Development | 10 | 13.0 | 3.0 | 7.6 | -2.4 |
| **Total** | 10 | **9.6** | -0.4 | **10.5** | **0.5** |

# Group Turnover by Staff Group

| | % Turnover March | | | | |
|---|---|---|---|---|---|
| **Staff Group** | **Target** | **HUTH Rate %** | **Variance %** | **NLAG Rate %** | **Variance %** |
| Additional Clinical Services | 10 | 14.3 | 4.3 | 12.2 | 2.2 |
| Add Prof Scientific and Technical | 10 | 7.0 | -3.0 | 11.7 | 1.7 |
| Administrative and Clerical Staff | 10 | 11.3 | 1.3 | 10.5 | 0.5 |
| Allied Health Professionals | 10 | 10.8 | 0.8 | 12.5 | 2.5 |
| Estates and Ancillary | 10 | 11.9 | 1.9 | 8.0 | -2.0 |
| Healthcare Scientists | 10 | 6.6 | -3.5 | 13.0 | 3.0 |
| Medical & Dental - Consultant | 10 | 3.3 | -6.7 | 7.6 | -2.4 |
| Medical & Dental - SAS | 10 | 11.2 | 1.2 | 13.9 | 3.9 |
| Nursing and Midwifery Registered | 10 | 7.0 | -3.0 | 9.1 | -0.9 |
| **Trust Total** | **10** | **9.6** | **-0.4** | **10.5** | **0.5** |

# Group Turnover – Tenure of Leavers by Health Group

| | Tenure of Leavers HUTH | | | Tenure of Leavers NLAG | | |
|---|---|---|---|---|---|---|
| **Health Group** | **Less than 1 Year WTE** | **More than 1 Year WTE** | **Less than 1 Year % of leavers** | **Less than 1 Year WTE** | **More than 1 Year WTE** | **Less than 1 Year % of leavers** |
| Cancer Network | 0.00 | 0.00 | 0.00% | 0.00 | 0.00 | 0.00% |
| Cardiovascular | 0.00 | 0.60 | 0.00% | 0.00 | 0.64 | 0.00% |
| Digestive Diseases | 1.00 | 2.60 | 27.78% | 0.00 | 0.00 | 0.00% |
| Head & Neck | 1.00 | 2.10 | 32.26% | 0.00 | 0.00 | 0.00% |
| Major Trauma Network | 0.00 | 0.00 | 0.00% | 0.00 | 0.00 | 0.00% |
| Patient Services | 2.80 | 6.05 | 31.64% | 3.70 | 2.62 | 58.54% |
| Specialist Cancer and Support Services | 1.50 | 11.24 | 11.77% | 0.00 | 4.90 | 0.00% |
| Chief Delivery Officer | 0.00 | 0.00 | 0.00% | 0.00 | 1.50 | 0.00% |
| Theatres, Anaesthetics and Critical Care | 0.76 | 5.90 | 11.41% | 0.00 | 2.92 | 0.00% |
| Acute and Emergency Medicine | 3.00 | 3.56 | 45.73% | 2.00 | 6.42 | 23.75% |
| Community, Frailty & Therapy | 1.00 | 4.80 | 17.24% | 2.00 | 7.54 | 20.96% |
| Family Services | 0.64 | 4.77 | 11.83% | 0.53 | 4.84 | 9.87% |
| Neuroscience | 0.00 | 0.00 | 0.00% | 0.00 | 1.00 | 0.00% |
| Pathology Network Group | 0.00 | 0.60 | 0.00% | 1.52 | 3.26 | 31.80% |
| Site Management & Discharge Teams | 0.00 | 0.00 | 0.00% | 0.00 | 0.00 | 0.00% |
| Specialist Medicine | 0.00 | 0.58 | 0.00% | 1.00 | 1.80 | 35.71% |
| Specialist Surgery | 0.00 | 2.80 | 0.00% | 1.00 | 1.00 | 50.00% |
| Corporate | 0.52 | 4.01 | 11.48% | 0.00 | 6.60 | 0.00% |
| Estates, Facilities and Development | 2.46 | 5.62 | 30.45% | 0.56 | 6.07 | 8.45% |
| **Trust Total** | **14.68** | **55.23** | **19.48%** | **12.31** | **51.11** | **19.41%** |

# Group Turnover – Tenure of Leavers by Staff Group

| | | Tenure of Leavers HUTH | | | Tenure of Leavers NLAG | | |
|---|---|---|---|---|---|---|---|
| **Staff Group** | **Less than 1 Year % of leavers Target** | **Less than 1 Year WTE** | **More than 1 Year WTE** | **Less than 1 Year % of leavers** | **Less than 1 Year WTE** | **More than 1 Year WTE** | **Less than 1 Year % of leavers** |
| Additional Clinical Services | 15% | 3.95 | 17.34 | 18.55% | 3.52 | 10.00 | 26.07% |
| Add Prof Scientific and Technical | 15% | 0.00 | 1.20 | 0.00% | 0.00 | 1.00 | 0.00% |
| Administrative and Clerical Staff | 15% | 5.38 | 13.39 | 28.66% | 4.70 | 8.83 | 34.74% |
| Allied Health Professionals | 15% | 1.00 | 4.73 | 17.45% | 1.00 | 5.52 | 15.34% |
| Estates and Ancillary | 15% | 2.46 | 7.52 | 24.65% | 0.59 | 6.15 | 8.75% |
| Healthcare Scientists | 15% | 0.00 | 2.00 | 0.00% | 0.00 | 2.64 | 0.00% |
| Medical & Dental - Consultant | 15% | 0.00 | 1.00 | 0.00% | 0.00 | 1.00 | 0.00% |
| Medical & Dental - SAS | 15% | 0.00 | 1.00 | 0.00% | 0.00 | 1.58 | 0.00% |
| Nursing and Midwifery Registered | 15% | 2.00 | 12.94 | 13.39% | 2.50 | 14.39 | 14.80% |
| **Trust Total** | **15%** | **14.8** | **61.1** | **19.48%** | **12.31** | **51.11** | **19.41%** |

# Group Turnover and Tenure Comments

| HUTH | NLAG |
|---|---|
| The Trust's current Turnover rate is 9.6% against a target of 10%. | The Trust's current Turnover rate is 10.5% against a target of 10%. |
| There is a high level of Turnover in Cancer Network, Community, Frailty and Therapy, Pathology Network Group and Estates, Facilities and Development Care Groups, these Care Groups are all above 12% | There is a high level of Turnover in Head & Neck, Chief Delivery Office, Community, Frailty and Therapy and Pathology Network Group Care Groups, these Care Groups are all above 12% |
| There is a high level of Turnover in Additional Clinical Services and Allied Health Professionals, these Staff Groups are all above 12% | There is a high level of Turnover in Additional Clinical Services and Allied Health Professionals, these Staff Groups are all above 12% |
| The Trust has seen 14.68 WTE (19.48% of leavers) that have left the Trust with less than 1 years' service. | The Trust has seen 12.31 WTE (19.41% of leavers) that have left the Trust with less than 1 years' service. |
| The main staff groups that see leavers within the 1st year of service are Admin & Clerical and Estates and Ancillary | The main staff groups that see leavers within the 1st year of service are Additional Clinical Services and Admin and Clerical |

# Consultant and SAS Workforce – Job Plans

| | HUTH % Signed off Job Plans | | | NLAG % Signed off Job Plans | | |
|---|---|---|---|---|---|---|
| **Health Group** | **Target** | **Rate** | **Variance %** | **Target** | **Rate** | **Variance %** |
| Cardiology | 90.0 | 63.6 | 26.4 | NA | NA | NA |
| Clinical Support Services | 90.0 | 66.9 | 23.1 | 90.0 | 93.0 | -3.0 |
| Corporate Directorates | 90.0 | 100.0 | -10.0 | NA | NA | NA |
| Emergency Medicine | 90.0 | 43.5 | 46.5 | NA | NA | NA |
| Family & Women's Health | 90.0 | 70.5 | 19.5 | 90.0 | 48.0 | 42.0 |
| Medicine | 90.0 | 83.8 | 6.2 | 90.0 | 77.0 | 13.0 |
| Surgery | 90.0 | 60.7 | 29.3 | 90.0 | 68.0 | 22.0 |
| Community & Therapy | NA | NA | NA | 90.0 | 93.0 | -3.0 |
| Path Links | NA | NA | NA | 90.0 | 86.0 | 4.0 |
| **Total** | 90.0 | 66.8 | 23.2 | 90.0 | 70.0 | 20.0 |

*Please note that Job Planning by new Care Group will be available from next month, this is due to the new Care Group Infrastructure changes, this data is not available for March 24 for both HUTH & NLAG

# Group Sickness by Health Group

| | | % Sickness | | | | | |
|---|---|---|---|---|---|---|---|
| | | HUTH | | | NLAG | | |
| **Health Group** | **Target** | **Rate** | **Long Term** | **Short Term** | **Rate** | **Long Term** | **Short Term** |
| Cancer Network | **4%** | 11.08% | 7.07% | 4.01% | 5.78% | 4.33% | 1.45% |
| Cardiovascular | **4%** | 3.60% | 1.26% | 2.34% | 3.27% | 1.47% | 1.81% |
| Digestive Diseases | **4%** | 3.98% | 2.02% | 1.96% | 4.10% | 1.47% | 2.63% |
| Head & Neck | **4%** | 2.94% | 1.20% | 1.74% | 4.15% | 2.26% | 1.89% |
| Major Trauma Network | **4%** | 3.77% | 1.17% | 2.60% | 3.97% | 1.27% | 2.71% |
| Patient Services | **4%** | 4.73% | 2.33% | 2.40% | 5.32% | 2.73% | 2.59% |
| Specialist Cancer and Support Services | **4%** | 3.30% | 1.42% | 1.88% | 4.98% | 2.36% | 2.62% |
| Chief Delivery Officer | **4%** | 2.07% | 1.44% | 0.63% | 4.36% | 1.69% | 2.67% |
| Theatres, Anaesthetics and Critical Care | **4%** | 5.14% | 2.80% | 2.34% | 5.68% | 2.91% | 2.77% |
| Acute and Emergency Medicine | **4%** | 4.26% | 2.58% | 1.68% | 4.25% | 1.23% | 3.01% |
| Community, Frailty & Therapy | **4%** | 3.91% | 1.64% | 2.27% | 6.79% | 3.63% | 3.16% |
| Family Services | **4%** | 5.26% | 3.32% | 1.94% | 4.65% | 2.43% | 2.23% |
| Neuroscience | **4%** | 2.91% | 1.67% | 1.23% | 3.52% | 1.82% | 1.70% |
| Pathology Network Group | **4%** | 9.73% | 5.57% | 4.16% | 3.31% | 1.27% | 2.04% |
| Site Management & Discharge Teams | **4%** | 5.68% | 4.85% | 0.83% | 6.47% | 4.40% | 2.08% |
| Specialist Medicine | **4%** | 4.67% | 2.24% | 2.44% | 5.29% | 1.84% | 3.45% |
| Specialist Surgery | **4%** | 5.11% | 2.43% | 2.68% | 5.65% | 2.51% | 3.14% |
| Corporate | **4%** | 3.68% | 2.18% | 1.49% | 2.90% | 1.35% | 1.55% |
| Estates, Facilities and Development | **4%** | 5.36% | 3.22% | 2.14% | 6.52% | 4.17% | 2.35% |
| **Trust Total** | **4%** | **4.27%** | **2.22%** | **2.05%** | **4.87%** | **2.39%** | **2.49%** |

# Workforce Performance - Group Sickness by Staff Group

| | | % Sickness | | | | | |
|---|---|---|---|---|---|---|---|
| | | HUTH | | | NLAG | | |
| **Staff Group** | **Target** | **Rate** | **Long Term** | **Short Term** | **Rate** | **Long Term** | **Short Term** |
| Additional Clinical Services | **4%** | 6.57% | 3.68% | 2.89% | 6.29% | 2.95% | 3.34% |
| Add Prof Scientific and Technical | **4%** | 3.61% | 1.56% | 2.05% | 3.36% | 1.38% | 1.98% |
| Administrative and Clerical Staff | **4%** | 4.12% | 2.19% | 1.93% | 4.02% | 2.22% | 1.80% |
| Allied Health Professionals | **4%** | 3.62% | 1.13% | 2.49% | 4.69% | 2.18% | 2.51% |
| Estates and Ancillary | **4%** | 5.60% | 2.98% | 2.61% | 6.83% | 4.48% | 2.35% |
| Healthcare Scientists | **4%** | 1.80% | 0.47% | 1.33% | 3.02% | 1.68% | 1.34% |
| Medical & Dental - Consultant | **4%** | 1.07% | 0.85% | 0.22% | 1.89% | 0.83% | 1.06% |
| Medical & Dental - SAS | **4%** | 2.38% | 0.00% | 2.38% | 3.29% | 1.74% | 1.55% |
| Medical & Dental – Trainee Grades | **4%** | 2.37% | 0.77% | 1.61% | 2.15% | 0.54% | 1.61% |
| Nursing and Midwifery Registered | **4%** | 4.52% | 2.52% | 2.00% | 5.11% | 2.20% | 2.91% |
| **Trust Total** | **4%** | **4.27%** | **2.22%** | **2.05%** | **4.87%** | **2.39%** | **2.49%** |

# Workforce Performance – Appraisals by Health Group

| | HUTH | | | | NLAG | | | |
|---|---|---|---|---|---|---|---|---|
| | % Appraisal AFC Staff | | % Medical PADR | | % Appraisal AFC Staff | | % Medical PADR | |
| **Health Group** | **Target** | **Rate** | **Target** | **Rate** | **Target** | **Rate** | **Target** | **Rate** |
| Cancer Network | 85% | 78.4% | 90% | N/A | 85% | 93.33% | 90% | N/A |
| Cardiovascular | 85% | 79.2% | 90% | 81.80% | 85% | 91.92% | 90% | 100% |
| Digestive Diseases | 85% | 81.6% | 90% | N/A | 85% | 94.55% | 90% | 97.87% |
| Head & Neck | 85% | 85.2% | 90% | N/A | 85% | 85.00% | 90% | 100% |
| Major Trauma Network | 85% | 91.8% | 90% | N/A | 85% | 93.10% | 90% | 100% |
| Patient Services | 85% | 83.9% | 90% | N/A | 85% | 86.68% | 90% | N/A |
| Specialist Cancer and Support Services | 85% | 81.0% | 90% | 96.90% | 85% | 83.33% | 90% | 100% |
| Chief Delivery Officer | 85% | 73.4% | 90% | N/A | 85% | 75.00% | 90% | N/A |
| Theatres, Anaesthetics and Critical Care | 85% | 88.8% | 90% | N/A | 85% | 88.92% | 90% | 100% |
| Acute and Emergency Medicine | 85% | 78.4% | 90% | 78.30% | 85% | 91.04% | 90% | 94.12% |
| Community, Frailty & Therapy | 85% | 85.4% | 90% | N/A | 85% | 89.18% | 90% | 100% |
| Family Services | 85% | 77.4% | 90% | 88.80% | 85% | 89.04% | 90% | 95.65% |
| Neuroscience | 85% | 72.9% | 90% | N/A | 85% | 92.41% | 90% | 84.62% |
| Pathology Network Group | 85% | 61.9% | 90% | N/A | 85% | 76.68% | 90% | 91.30% |
| Site Management & Discharge Teams | 85% | 80.7% | 90% | N/A | 85% | 47.83% | 90% | N/A |
| Specialist Medicine | 85% | 80.5% | 90% | 88.90% | 85% | 93.50% | 90% | 94.74% |
| Specialist Surgery | 85% | 73.9% | 90% | 89.90% | 85% | 91.01% | 90% | 98.18% |
| Corporate | 85% | 77.1% | 90% | 100% | 85% | 91.62% | 90% | 100% |
| Estates, Facilities and Development | 85% | 93.0% | 90% | N/A | 85% | 93.44% | 90% | N/A |

# Workforce Performance – Appraisals by Staff Group

| | HUTH | | | | NLAG | | | |
|---|---|---|---|---|---|---|---|---|
| | % Appraisal AFC Staff | | % Medical PADR | | % Appraisal AFC Staff | | % Medical PADR | |
| **Staff Group** | **Target** | **Rate** | **Target** | **Rate** | **Target** | **Rate** | **Target** | **Rate** |
| Additional Clinical Services | 85% | 82.3% | N/A | N/A | 85% | 81.49% | N/A | N/A |
| Add Prof Scientific and Technical | 85% | 89.8% | N/A | N/A | 85% | 86.81% | N/A | N/A |
| Administrative and Clerical Staff | 85% | 81.4% | N/A | N/A | 85% | 83.03% | N/A | N/A |
| Allied Health Professionals | 85% | 89.2% | N/A | N/A | 85% | 85.07% | N/A | N/A |
| Estates and Ancillary | 85% | 91.8% | N/A | N/A | 85% | 87.85% | N/A | N/A |
| Healthcare Scientists | 85% | 86.6% | N/A | N/A | 85% | 80.33% | N/A | N/A |
| Medical & Dental | N/A | N/A | 90% | 90.3% | N/A | N/A | 90% | 96.47% |
| Nursing and Midwifery Registered | 85% | 83.5% | N/A | N/A | 85% | 88.79% | N/A | N/A |
| **Trust Total** | **85%** | **84.2%** | **90%** | **90.3%** | **85%** | **84.97%** | **90%** | **96.47%** |

# Workforce Performance – Core and role specific mandatory training by Health Group

| | HUTH | | | | NLAG | | | |
|---|---|---|---|---|---|---|---|---|
| | Core | | Role Specific | | Core | | Role Specific | |
| **Health Group** | **Target** | **Rate** | **Target** | **Rate** | **Target** | **Rate** | **Target** | **Rate** |
| Cancer Network | 85% | 85.7% | 85% | 79.3% | 85% | 98.35% | 85% | 50.00% |
| Cardiovascular | 85% | 84.2% | 85% | 72.3% | 85% | 92.47% | 85% | 85.59% |
| Digestive Diseases | 85% | 86.6% | 85% | 76.5% | 85% | 86.80% | 85% | 77.13% |
| Head & Neck | 85% | 88.6% | 85% | 73.7% | 85% | 91.87% | 85% | 75.22% |
| Major Trauma Network | 85% | 95.6% | 85% | 88.8% | 85% | 96.66% | 85% | 89.27% |
| Patient Services | 85% | 95.3% | 85% | 87.7% | 85% | 94.91% | 85% | 84.82% |
| Specialist Cancer and Support Services | 85% | 91.4% | 85% | 79.8% | 85% | 92.05% | 85% | 86.40% |
| Chief Delivery Officer | 85% | 86.6% | 85% | 68.7% | 85% | 92.35% | 85% | 80.95% |
| Theatres, Anaesthetics and Critical Care | 85% | 93.3% | 85% | 84.9% | 85% | 87.89% | 85% | 77.06% |
| Acute and Emergency Medicine | 85% | 87.8% | 85% | 80.5% | 85% | 83.64% | 85% | 70.64% |
| Community, Frailty & Therapy | 85% | 90.6% | 85% | 77.6% | 85% | 90.24% | 85% | 79.44% |
| Family Services | 85% | 90.6% | 85% | 79.7% | 85% | 85.73% | 85% | 76.23% |
| Neuroscience | 85% | 82.1% | 85% | 70.4% | 85% | 85.70% | 85% | 75.07% |
| Pathology Network Group | 85% | 89.0% | 85% | 70.1% | 85% | 85.06% | 85% | 70.59% |
| Site Management & Discharge Teams | 85% | 88.8% | 85% | 73.3% | 85% | 89.42% | 85% | 64.17% |
| Specialist Medicine | 85% | 87.2% | 85% | 76.5% | 85% | 89.49% | 85% | 79.35% |
| Specialist Surgery | 85% | 83.3% | 85% | 73.5% | 85% | 84.65% | 85% | 72.68% |
| Corporate | 85% | 77.7% | 85% | 62.7% | 85% | 90.60% | 85% | 90.85% |
| Estates, Facilities and Development | 85% | **NA** | 85% | **NA** | 85% | 96.32% | 85% | 94.71% |

*Please note that Estates, Facilities and Development Care Group data will be available from next month, this is due to the new Care Group Infrastructure changes, this data currently sits within the Corporate Care Group for March 24 for HUTH

# Workforce Performance – Core and Role Specific by Staff Group

| | HUTH | | | | NLAG | | | |
|---|---|---|---|---|---|---|---|---|
| | Core | | Role Specific * | | Core | | Role Specific | |
| **Health Group** | **Target** | **Rate** | **Target** | **Rate** | **Target** | **Rate** | **Target** | **Rate** |
| Additional Clinical Services | 85% | 87.7% | 85% | NA | 85% | 85.06% | 85% | 74.71% |
| Add Prof Scientific and Technical | 85% | 92.8% | 85% | NA | 85% | 93.55% | 85% | 90.20% |
| Administrative and Clerical Staff | 85% | 93.5% | 85% | NA | 85% | 92.78% | 85% | 72.63% |
| Allied Health Professionals | 85% | 93.0% | 85% | NA | 85% | 90.98% | 85% | 82.25% |
| Estates and Ancillary | 85% | 94.8% | 85% | NA | 85% | 92.59% | 85% | 94.70% |
| Healthcare Scientists | 85% | 94.9% | 85% | NA | 85% | 88.95% | 85% | 81.61% |
| Medical & Dental – Consultant | 85% | 86.3% | 85% | NA | 85% | 79.87% | 85% | 71.39% |
| Medical & Dental – SAS | 85% | 83.4% | 85% | NA | 85% | 77.90% | 85% | 53.82% |
| Medical & Dental – Trainee Grades | 85% | 75.5% | 85% | NA | 85% | 60.23% | 85% | 43.59% |
| Nursing and Midwifery Registered | 85% | 90.7% | 85% | NA | 85% | 89.96% | 85% | 82.27% |
| **Trust Total** | **85%** | **89.4%** | **85%** | NA | **85%** | **85.06%** | **85%** | **77.11%** |

*Please note that Role Specific Training by staff group will be available from next month, this is due to the new Care Group Infrastructure changes, this data is not available for March 24 for HUTH

# Workforce Performance Group Summary

| HUTH | NLAG |
|---|---|
| The Trust is currently not meeting the sickness target (4.27%) of 4%. | The Trust is currently not meeting the sickness target (4.87%) of 4%. |
| Additional Clinical Services (6.57%), Admin & Clerical (4.12%) and Nursing and Midwifery Registered (4.52%) are all above the Trust target | Additional Clinical Services (6.29%), Admin & Clerical (4.02%), Allied Health Professionals (4.69%), Estates and Ancillary (6.83) and Nursing and Midwifery Registered (5.11%) are all above the Trust target |
| Appraisals (84.2%) The Trust is 0.8% below the target for AfC staff appraisals and is 0.3% above the target for Cons/SAS appraisals (90.3%) | Appraisals (84.97%) The Trust is 0.03% below the target for AfC staff appraisals and is 6.47% above the target for Cons/SAS appraisals (96.47%) |
| Core Mandatory Training – The Trust is 4.4% above the Trust target of 85% | Core Mandatory Training – The Trust is 0.06% above the Trust target of 85% |
| Role Specific Training – The Trust is 8.6% below the Trust target of 85% | Role Specific Training – The Trust is 7.89% below the Trust target of 85% |

# Culture Indicators

| | HUTH | | | | NLAG | | | |
|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Most Recent Score** | **Previous Score Q2** | **Previous Score Q1** | **Previous Score Q4** | **Most Recent Score** | **Previous Score Q2** | **Previous Score Q1** | **Previous Score Q4** |
| Friends & Family Staff – Care of Treatment (Quarterly) | TBC | TBC | TBC | TBC | 35.90% | 52.03% | 48.0% | 48.60% |
| Friends & Family Staff – Place to Work (Quarterly) | TBC | 54.70% | 50.50% | 49.20% | 28.2% | 52.95% | 41.7% | 41.7% |

# Staff Survey

| | HUTH | | | | NLAG | | | |
|---|---|---|---|---|---|---|---|---|
| **Theme** | **Trust** | **Best** | **Average** | **Worst** | **Trust** | **Best** | **Average** | **Worst** |
| We are compassionate and inclusive | 7.15 | 7.71 | 7.24 | 6.85 | 7.03 | 7.71 | 7.24 | 6.85 |
| We are recognised and rewarded | 5.87 | 6.37 | 5.94 | 5.5 | 5.76 | 6.37 | 5.94 | 5.5 |
| We each have a voice that counts | 6.51 | 7.16 | 6.7 | 6.21 | 6.52 | 7.16 | 6.7 | 6.21 |
| We are safe and healthy | 6.01 | 6.55 | 6.06 | 5.75 | 5.99 | 6.55 | 6.06 | 5.75 |
| We are always learning | 5.69 | 6.07 | 5.61 | 5.05 | 5.39 | 6.07 | 5.61 | 5.05 |
| We work flexibility | 5.99 | 6.87 | 6.2 | 5.6 | 5.82 | 6.87 | 6.2 | 5.6 |
| We are a team | 6.61 | 7.19 | 6.75 | 6.35 | 6.49 | 7.19 | 6.75 | 6.35 |
| Staff Engagement | 6.66 | 7.32 | 6.91 | 6.34 | 6.65 | 7.32 | 6.91 | 6.34 |
| Morale | 5.88 | 6.52 | 5.91 | 5.54 | 5.84 | 6.52 | 5.91 | 5.54 |

# Glossary - Staff Groups and Roles

| Staff Group | Example Roles |
|---|---|
| Add Scientific and Tech Staff | ACPs<br>Chaplain<br>Optometrist<br>Pharmacist<br>Pharmacy Technicians<br>Physician Associate |
| Additional Clinical Services | Dental Surgery Assistant<br>Healthcare Assistant<br>Pre-reg Pharmacist<br>Health Care Support Worker<br>Healthcare Science Assistant<br>Nursing Associate<br>Phlebotomist<br>Trainee Healthcare Science Practitioner<br>Trainee Healthcare Scientist<br>Trainee Nursing Associate<br>Trainee Practitioner |

| Staff Group | Example Roles |
| --- | --- |
| Administrative | Accountant<br>Chief Executive and Exec Directors<br>Managers and Senior Managers<br>Clerical Worker and Officers |
| AHPs | Dietitian<br>Occupational Therapist<br>Orthoptist<br>Physiotherapist<br>Radiograper - Diagnostic and Therapeutic<br>Speech and Language Therapist |
| Estates and Ancillary | Building Craftsperson<br>Building Officer<br>Cook<br>Gardener/Groundsperson<br>Housekeeper<br>Maintenance Craftsperson<br>Porter |

| Staff Group | Example Roles |
|---|---|
| Healthcare Scientists | Consultant Healthcare Scientist<br>Healthcare Science Practitioner<br>Healthcare Scientist (e.g. BMS) |
| Medical Staff | Consultants<br>SAS<br>Trainee Grades |
| Registered Nurses | Staff Nurse<br>Sister/Charge Nurse<br>Midwife<br>Modern Matron |

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)122**

| | |
|---|---|
| **Name of Meeting** | Trust Boards-in-Common – Public Meeting |
| **Date of the Meeting** | Thursday, 13 June 2024 |
| **Director Lead** | Dr Kate Wood, Group Chief Medical Officer |
| **Contact Officer / Author** | Dr Harish Lad, Clinical Lead for Organ Donation (HUTH and NLaG) |
| **Title of Report** | Organ Donation Annual Report 2023-24 – HUTH and NLaG |
| **Executive Summary** | Summary of key data from NHS Blood and Transplant explaining how HUTH and NLaG have contributed to the UK's deceased donation programme.<br><br>This document includes:<br>1) Performance against quality-of-care indicators<br>- Referral of potential donors<br>- Presence of Specialist Nurses for discussion<br>2) Number of consents<br>3) Number of donors and organs transplanted.<br>4) Educational and promotional successes<br><br>Highlight to the Board the requirement to appoint a new Organ Donation Committee Chair for HUTH – this is in the discussion stages with NHSBT due to the sad death of the Chair this week. |
| **Background Information and/or Supporting Document(s) (if applicable)** | N/A |
| **Prior Approval Process** | N/A |
| **Financial Implication(s)** (if applicable) | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/A |
| **Recommended action(s) required** | ☐ Approval ✓ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

# HUTH / NLAG Organ Donation

April 2023 – March 2024

Level 1 Centre

> 12 Donors per year

Level 3 Centre

> 3 but < 6 donors per year

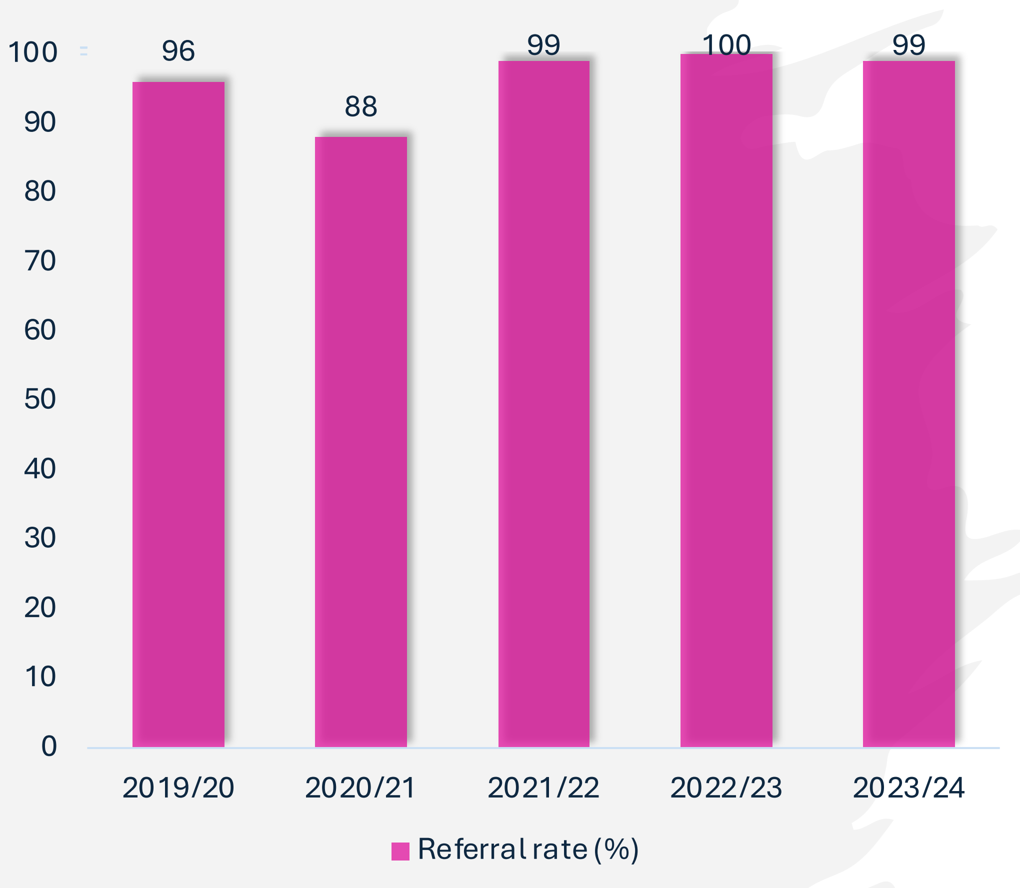
# NHSBT Goals

Every patient who meets referral criteria should be referred to Organ donation service

A Specialist Nurse should be present during formal approach for organ donation

# HUTH Referral rate (%)

# NLAG Referral rate (%)



National referral rate 23/24 – 94%

# SNOD presence for organ donation decision – consent rate (%)

- Consent rate with SNOD NOT present 22%
- Consent rate with SNOD present 65%

NHSBT PDA data 2022-23

# HUTH SNOD presence rate (%)

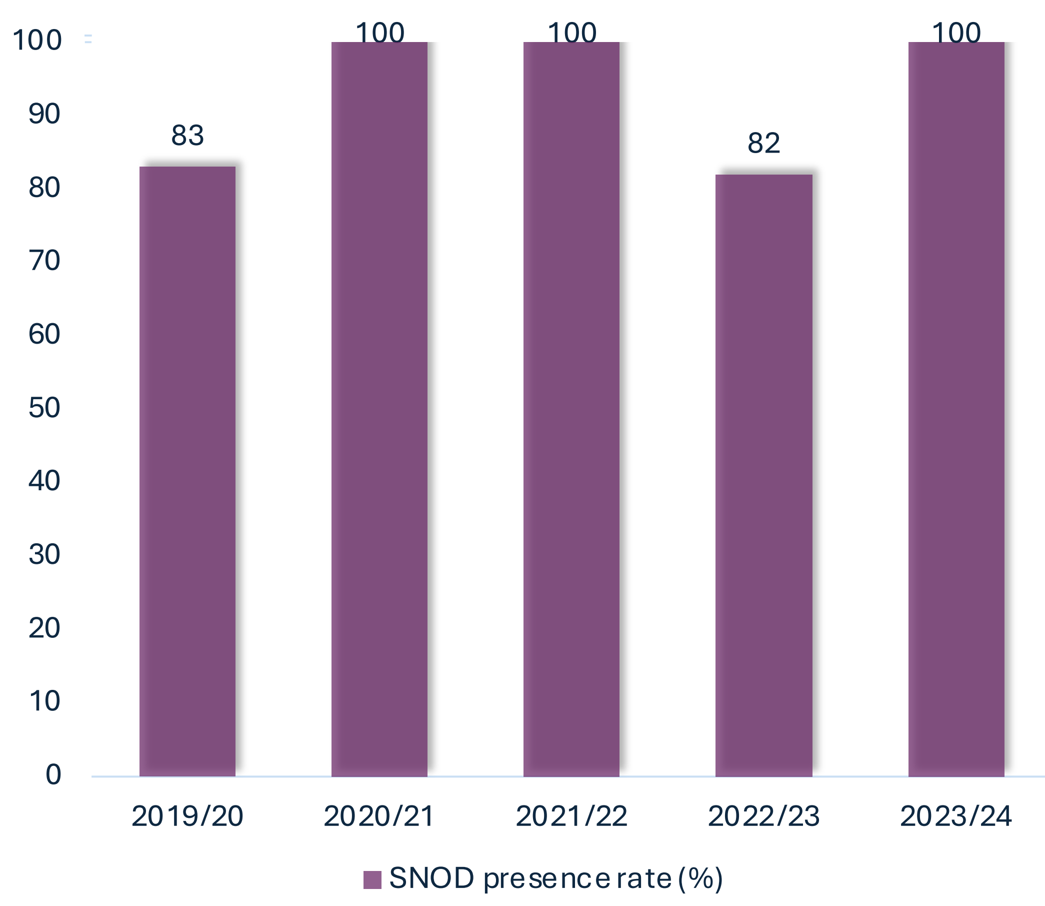
100
90
80
70
60
50
40
30
20
10
0

98 100 100 100 91

2019/20 2020/21 2021/22 2022/23 2023/24

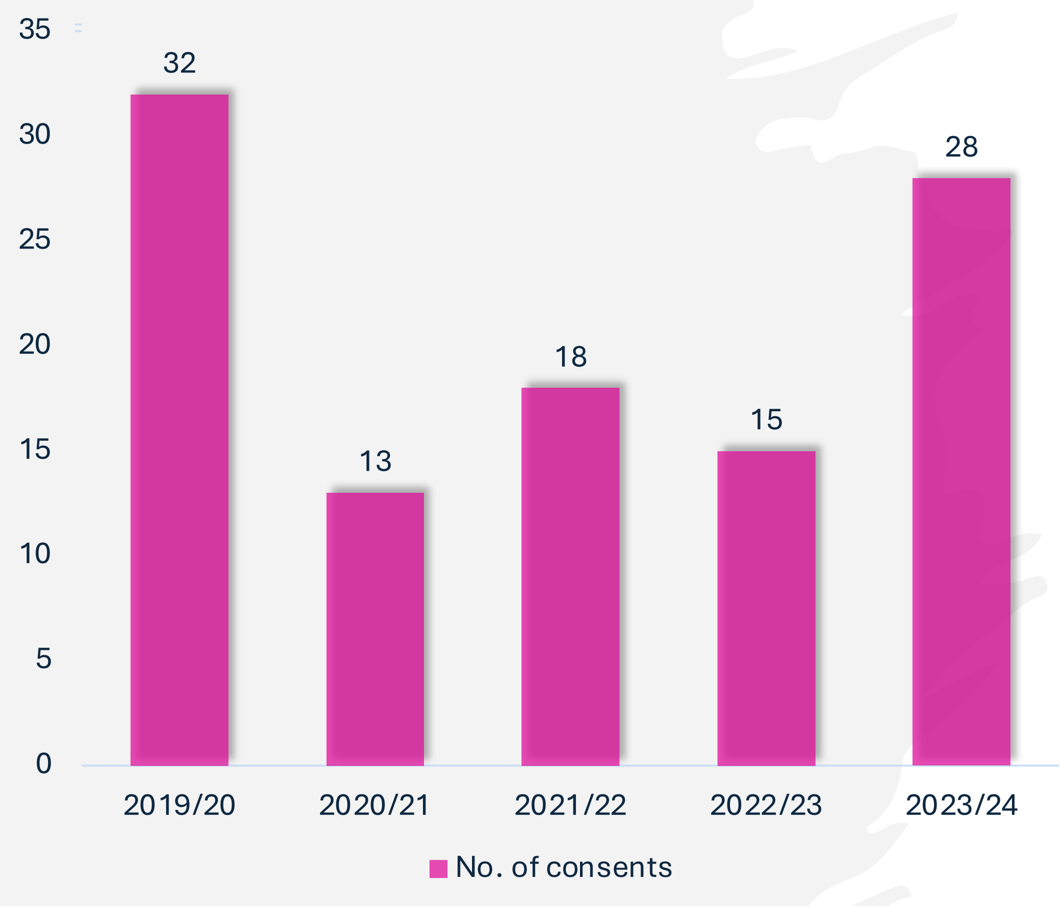
SNOD presence rate (%)

# NLAG SNOD presence rate (%)

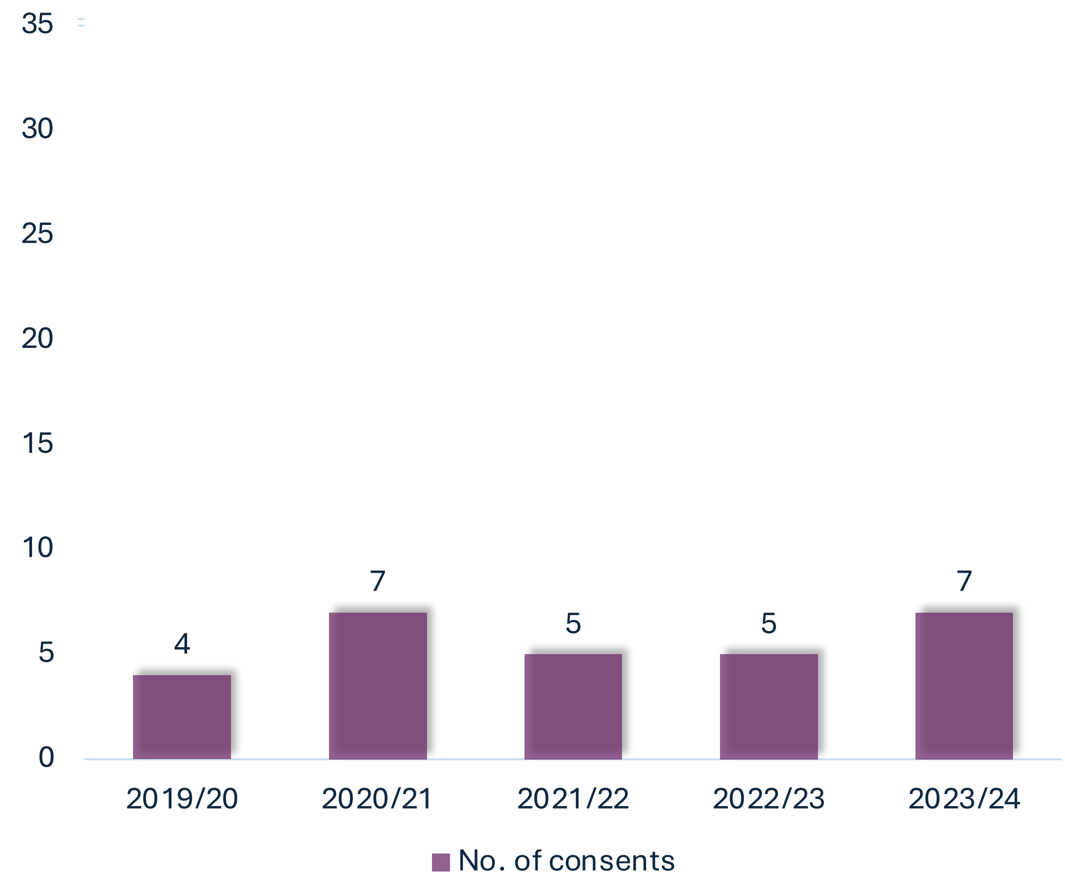



National SNOD presence rate 23/24 – 93%

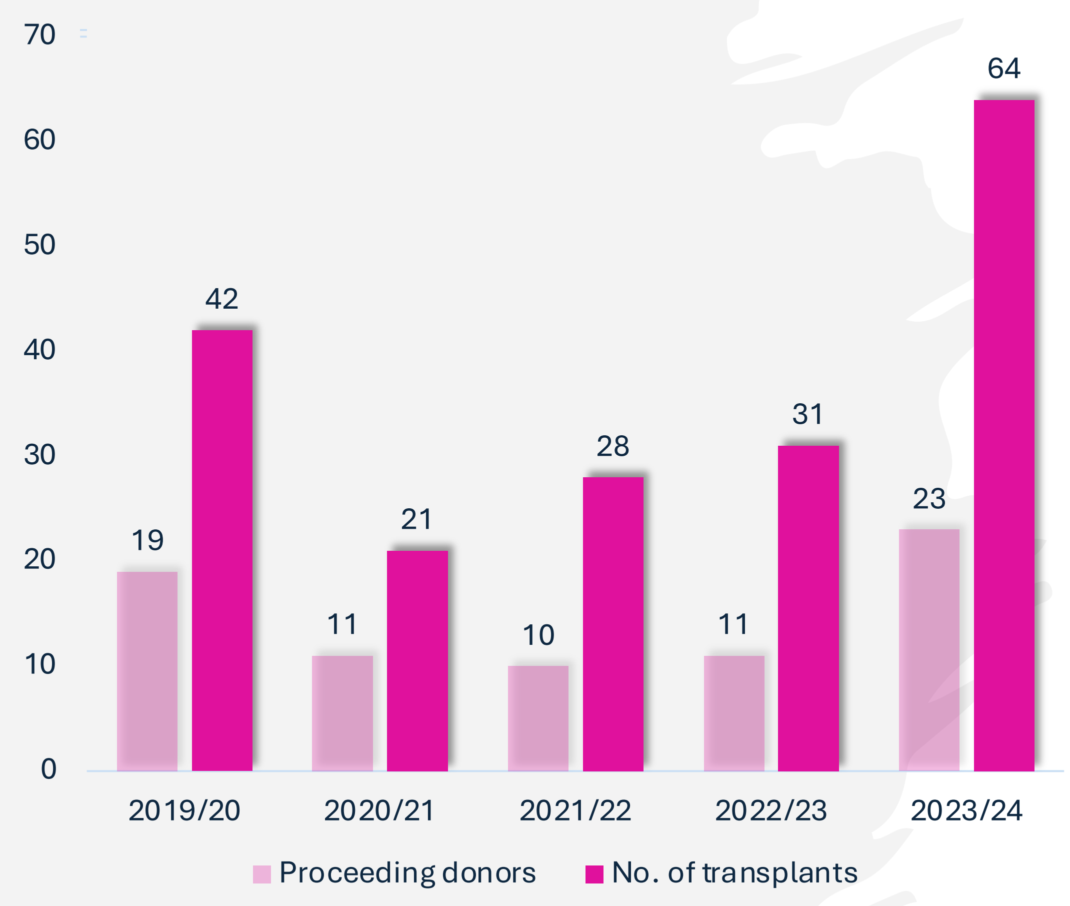
# HUTH – No. of consents for donation



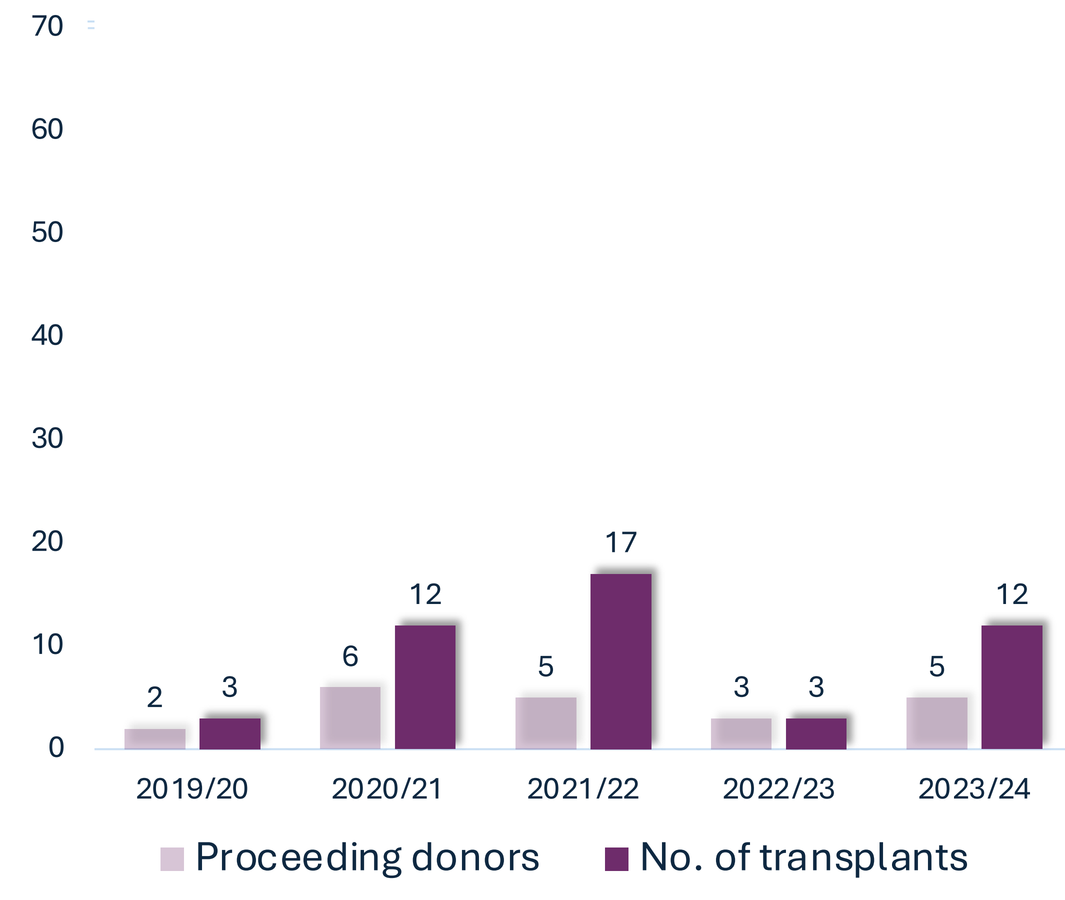

# NLAG – No. of consents for donation

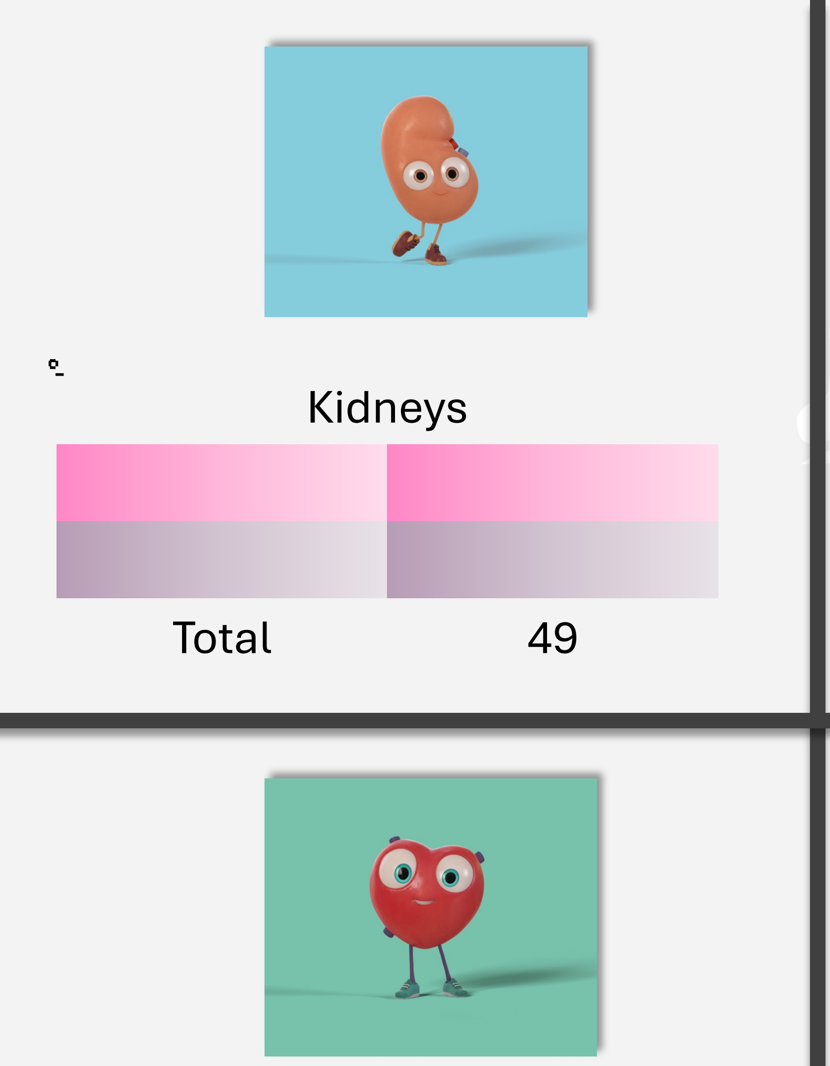


# HUTH – Proceeding donors and transplants



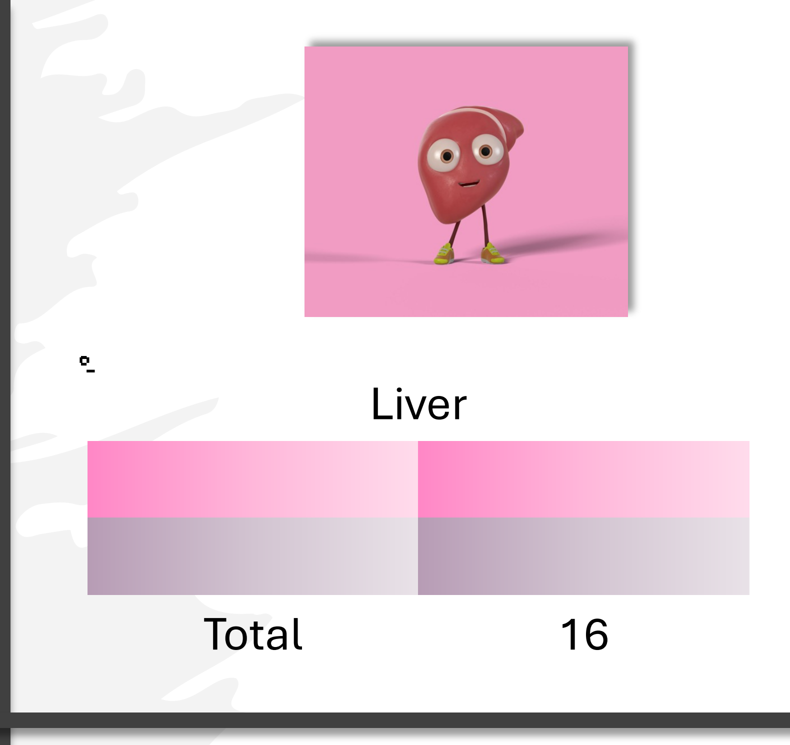

# NLAG – Proceeding donors and transplants





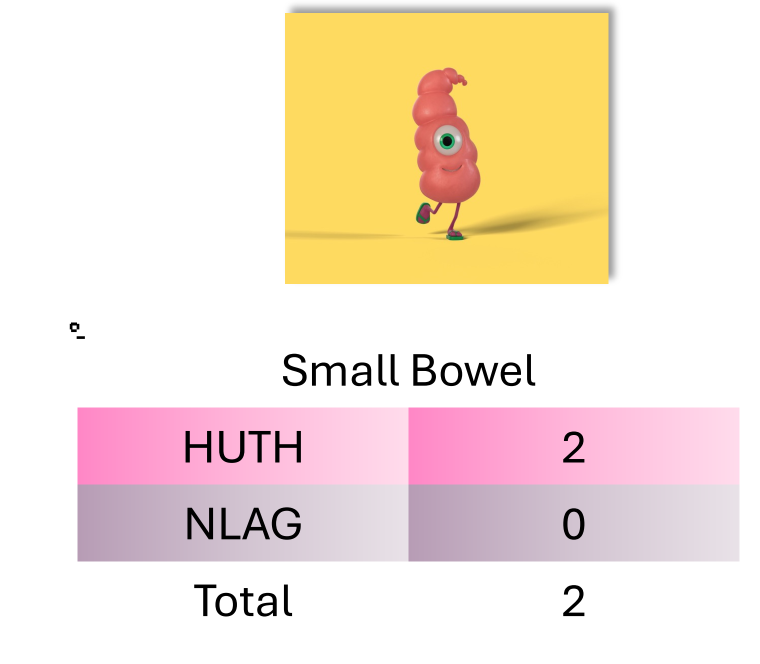
## Kidneys

| | |
|---|---|
| | 2 |
| | |
| Total | 49 |



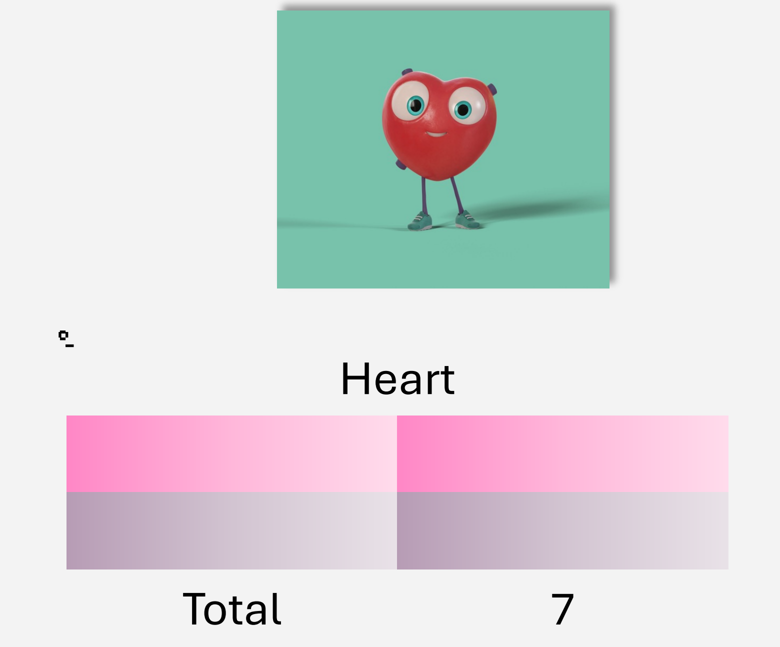
## Liver

| | |
|---|---|
| | |
| | |
| Total | 16 |



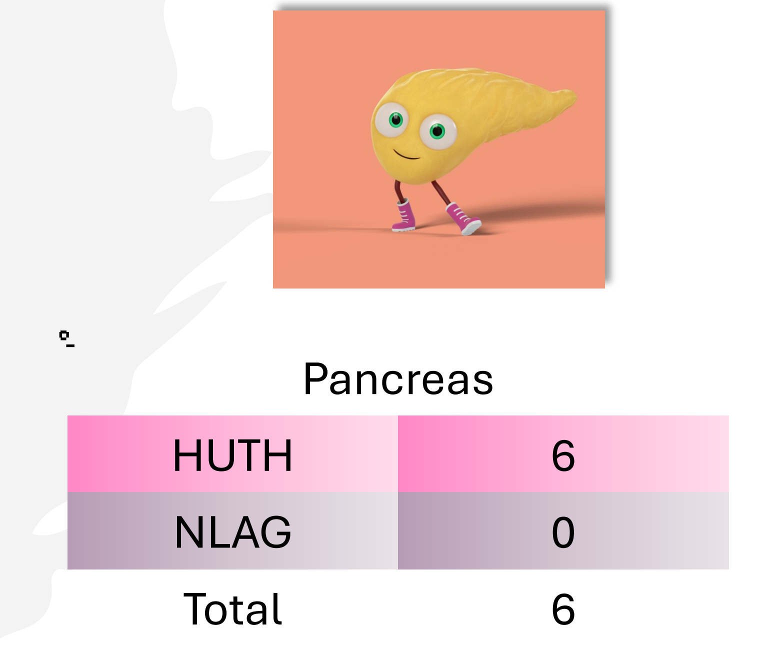
## Small Bowel

| | |
|---|---|
| HUTH | 2 |
| NLAG | 0 |
| Total | 2 |



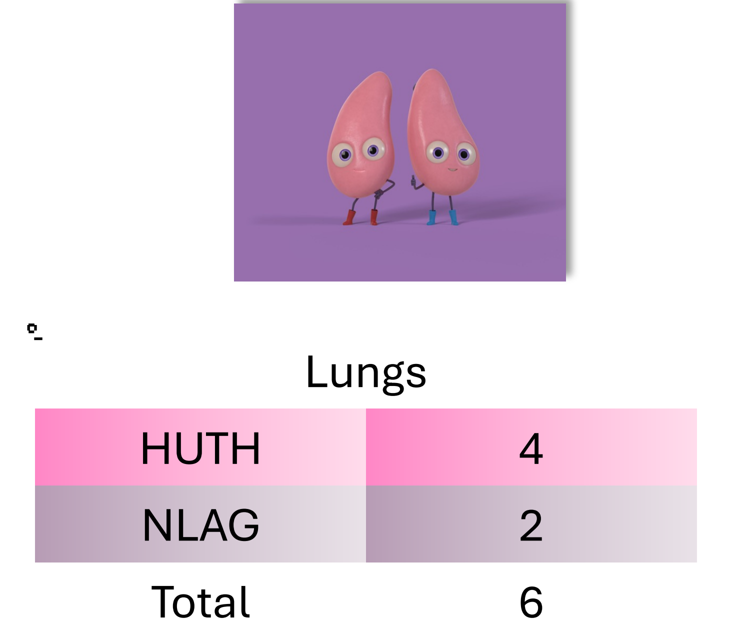
## Heart

| | |
|---|---|
| | |
| | |
| Total | 7 |



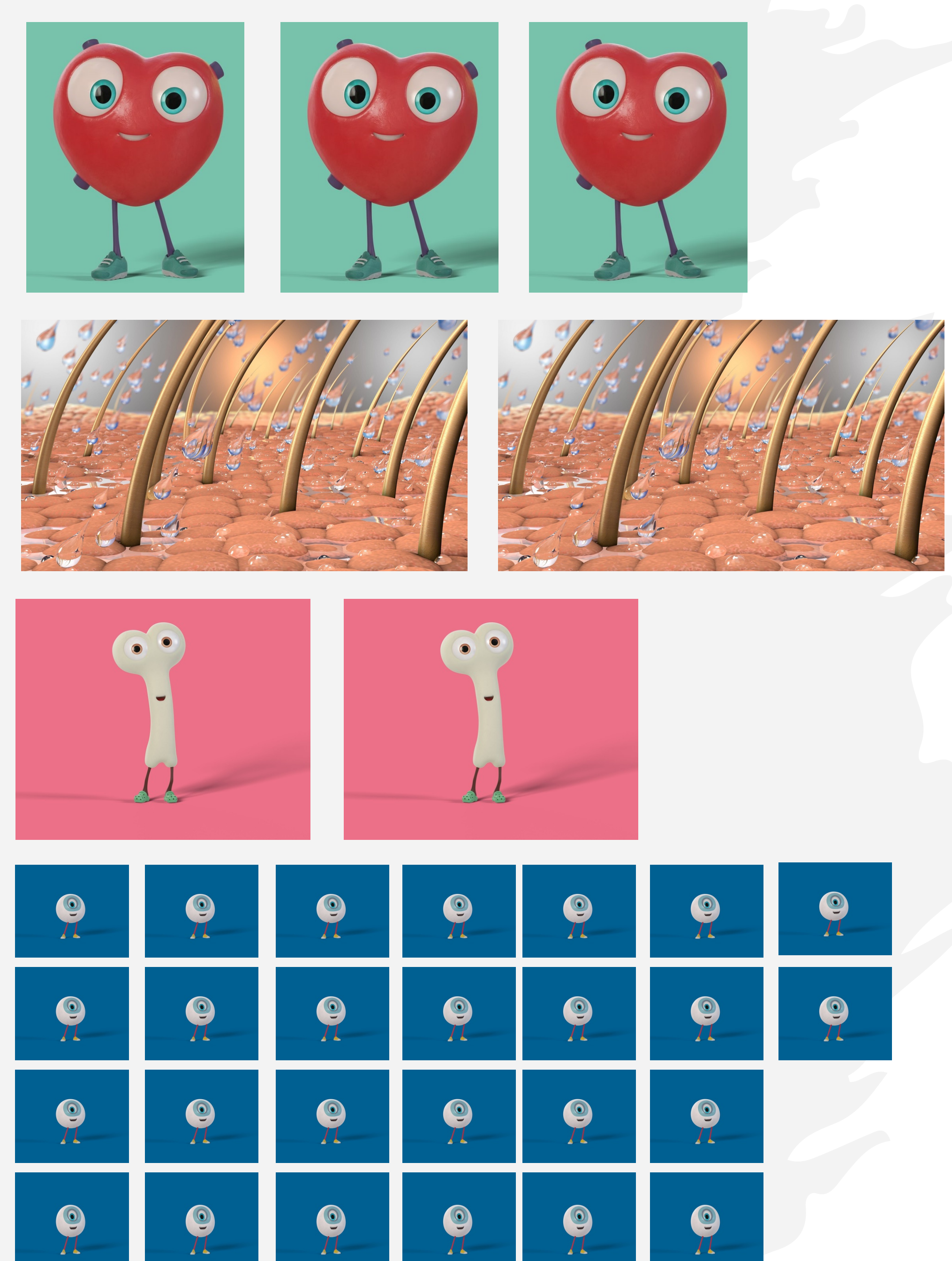
## Pancreas

| | |
|---|---|
| HUTH | 6 |
| NLAG | 0 |
| Total | 6 |



## Lungs

| | |
|---|---|
| HUTH | 4 |
| NLAG | 2 |
| Total | 6 |



3 hearts for valves

2 skin donors

2 bone/ligament donations

26 corneas (HUTH and NLAG)

# Successes

- **Promotion**

- Driffield Show
- OD week
- Staff engagement
- Public engagement
- Race for recipients

- **Education**

- Virtual regional nurse study day
- TBI study day – NSx nurses
- ODP training
- ACCP study day
- ICU nurse training
- Paediatric student nurses
- FLO for North Yorkshire and Humberside

# The Future

Education – HUTH

Anaesthetists/ICU/Surgical and ED trainees
ACCP training
Tissue Promotion

Community involvement/promotion

Appoint new HUTH Organ Donation Committee Chair

# Sadness

- Lorraine McLeavy (centre)
- ODC Chair
- Passionate
- Dedicated
- Champion for donation for HUTH
- Rest in Peace

# Thank You

# Trust Boards-in-Common Front Sheet

**Agenda Item No: BIC(24)124**

| **Name of the Meeting** | Trust Boards-in-Common |
|---|---|
| **Date of the Meeting** | 13 June 2024 |
| **Director Lead** | David Sharif, Group Director of Assurance |
| **Contact Officer/Author** | David Sharif, Group Director of Assurance |
| **Title of the Report** | Trust Boards-in-Common & Committees Meeting Cycle |
| **Executive Summary** | The report provides the planned dates and times of Trust Boards & Committees-in-Common meetings for the period between January 2024 and December 2024. Now included are the North & South Site Review Meetings. |
| **Background Information and/or Supporting Document(s)** (if applicable) | This is a routine report in the agreed format. |
| **Prior Approval Process** | None |
| **Financial implication(s)** (if applicable) | N/A |
| **Implications for equality, diversity and inclusion, including health inequalities** (if applicable) | N/A |
| **Recommended action(s) required** | ☐ Approval ✓ Information<br>☐ Discussion ☐ Review<br>☐ Assurance ☐ Other – please detail below: |

**MEETING SCHEDULE - 2024 - V14**

| | Quarter 4 (23/24) | | | Quarter 1 (24/25) | | | Quarter 2 (24/25) | | | Quarter 3 (24/25) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MEETING** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| **Trust Board** | | | | | | | | | | | | |
| Public & Private<br>(Thursdays - 9.00 am - 5.00 pm) | | 08.02.24 | | 11.04.24 | | 13.06.24 | | 08.08.24 | | 10.10.24 | | 12.12.24 |
| Board Development<br>(Tuesdays - 9.00 am - 5.00 pm) | 02.01.24 | | 05.03.24 | | 14.05.24 | | 02.07.24 | | | | 05.11.24 | |
| **Committees in Common** | | | | | | | | | | | | |
| Performance, Estates & Finance<br>(Wednesdays - 9.00 am - 12.30 pm) | 24.01.24 | 28.02.24 | 27.03.24 | 24.04.24 | 29.05.24 | 26.06.24 | 24.07.24 | 28.08.24 | 25.09.24 | 30.10.24 | 27.11.24 | 18.12.24 |
| Capital & Major Projects<br>(Tuesdays - 9.00 am - 12.00 pm) | | 20.02.24 | | 23.04.24 | | 25.06.24 | | 27.08.24 | | 29.10.24 | 26.11.24 | |
| Quality & Safety<br>(Thursdays - 9.00 am - 12.30 pm with exceptions as stated) | 25.01.24<br>(1.30 pm - 5.00 pm) | 29.02.24 | 28.03.24 | 25.04.24<br>(1.30 pm - 5.00 pm) | 23.05.24 | 27.06.24 | 31.07.24<br>(Wednesday) | 29.08.24 | 26.09.24 | 24.10.24 | 28.11.24 | 17.12.24<br>(Tuesday) |
| Remuneration<br>(Thursdays - 9.00 am - 11.30 am) | 11.01.24 | | | 04.04.24 | 22.05.24 | | 11.07.24 | | | 03.10.24 | | |
| Workforce, Education & Culture<br>(Thursdays - 1.30 pm - 5.00 pm with exceptions as stated) | 30.01.24<br>(Tuesday -<br>9.00 am - 12.30 pm) | 29.02.24 | 28.03.24 | 30.04.24<br>(Tuesday -<br>9.00 am - 12.30 pm) | 23.05.24 | 27.06.24 | 25.07.24 | 29.08.24 | 26.09.24 | 24.10.24 | 28.11.24 | |
| Audit, Risk & Governance Committee<br>(Thursdays - 9.00 am - 12.30 pm with exceptions as stated) | 25.01.24 | | | 25.04.24 | | 21.06.24<br>(Friday -<br>9.00 am - 10.30 am)<br>**HUTH ONLY** | 25.07.24 | 06.08.24<br>(Tuesday -<br>9.00 am - 10.30 am)<br>**NLAG ONLY** | | 31.10.24 | | |
| **Charitable Funds** | | | | | | | | | | | | |
| NLAG<br>(9.00 am - 12.00 pm) | 10.01.24 | | | 03.04.24 | | | 04.07.24 | | | 09.10.24 | | |
| HUTH<br>(9.00 am - 12.00 pm) | | 21.02.24 | | | 30.05.24 | | | 22.08.24 | | | 13.11.24 | |
| **Executive Team Meetings** | | | | | | | | | | | | |
| Executive Team<br>(Tuesdays - 2.00 pm - 5.00 pm) | 09.01.24<br>16.01.24<br>23.01.24<br>30.01.24 | 06.02.24<br>13.02.24<br>20.02.24<br>27.02.24 | 12.03.24<br>19.03.24<br>26.03.24 | 02.04.24<br>09.04.24<br>16.04.24<br>23.04.24<br>30.04.24 | 14.05.24<br>21.05.24<br>28.05.24 | 04.06.24<br>11.06.24<br>18.06.24<br>25.06.24 | 09.07.24<br>16.07.24<br>23.07.24<br>30.07.24 | 06.08.24<br>13.08.24<br>20.08.24<br>27.08.24 | 10.09.24<br>17.09.24<br>24.09.24 | 01.10.24<br>08.10.24<br>15.10.24<br>22.10.24<br>29.10.24 | 12.11.24<br>19.11.24<br>26.11.24 | 03.12.24<br>10.12.24<br>17.12.24<br>24.12.24 |
| **Site Review Meetings** | | | | | | | | | | | | |
| North Site Review | | | | | 30.05.24 | 24.06.24 | 29.07.24 | 21.08.24 | 23.09.24 | 28.10.24 | 25.11.24 | 23.12.24 |
| South Site Review | | | | | 30.05.24 | 24.06.24 | 29.07.24 | 21.08.24 | 23.09.24 | 28.10.24 | 25.11.24 | 23.12.24 |
| **Governors** | | | | | | | | | | | | |
| Council of Governors<br>(Thursdays - Business Meetings - 2.00 pm - 5.00 pm, with exceptions as stated) | 11.01.24 | | | 18.04.24<br>(9.30 am - 12.30 pm) | | 18.06.24<br>**Business Meeting**<br>9.00 am - 12.00 pm | | **Annual Review Meeting**<br>22.08.24 | **Annual Members Meeting**<br>12.09.24 | 31.10.24 | | |
| Member & Public Engagement & Assurance Group (MPEAG)<br>(Tuesdays - 5.30 pm - 7.00 pm with exceptions as stated) | | 15.02.24<br>(Thursday) | | | 21.05.24 | | 16.07.24 | | 24.09.24 | | | |
| Appointments & Remuneration Committee<br>(Thursdays - 1.30 pm - 3.00 pm) | | | 14.03.24 | | 30.05.2024<br>(2.30 pm - 4.00 pm) | | | | | 03.10.24 | | |
| **NED & CEO Meetings** | | | | | | | | | | | | |
| NED & CEO Meetings<br>(Thursdays - 2.00 pm - 4.00 pm - with exceptions as stated) | 09.01.24<br>(Tuesday -<br>10.00 am-12.00 pm) | 15.02.24 | 14.03.24<br>(10.00 am-12.00 pm) | | 16.05.24 | 19.06.24<br>(Wednesday) | 09.07.24<br>(Tuesday -<br>10.00 am - 12.00 pm) | 15.08.24 | 10.09.24<br>(Tuesday -<br>10.00 am - 12.00 pm) | 17.10.24 | 14.11.24 | 19.12.24 |
| **Union Meetings** | | | | | | | | | | | | |
| JNCC - NLAG<br>(Mondays - 2.30 pm - 4.30 pm) | 15.01.24 | 19.02.24 | 18.03.24 | 15.04.24 | 20.05.24 | 17.06.24 | 15.07.24 | 19.08.24 | 16.09.24 | 21.10.24 | 18.11.24 | 16.12.24 |
| JNCC - HUTH<br>(Thursdays - 10.45 am - 12.45 pm) | 04.01.24 | | 07.03.24 | | 02.05.24 | | 04.07.24 | | 05.09.24 | | 07.11.24 | |
| **Consultant Meetings** | | | | | | | | | | | | |
| JLNC - NLAG<br>(Tuesdays - 1.00 pm - 3.00 pm) | 16.01.24 | 20.02.24 | 19.03.24 | 16.04.24 | 21.05.24 | 18.06.24 | 16.07.24 | 20.08.24 | 17.09.24 | 15.10.24 | 19.11.24 | 17.12.24 |
| LNC - HUTH<br>(Wednesdays - 10.00 am - 12.00 pm) | 17.01.24 | | 20.03.24 | | 15.05.24 | | 17.07.24 | | 18.09.24 | | 20.11.24 | |